DLP-Harris Regional Hospital, LLC &

DLP-Swain Community Hospital, LLC

MEDICAL STAFF BYLAWS

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MEDICAL STAFF BYLAWS

OF

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals

PREAMBLE

WHEREAS, Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals, hereinafter referred to as "Hospital", is operated by DLP Harris Regional Hospital, LLC and DLP Swain Community Hospital, LLC hereinafter referred to as "Corporation", a private corporation organized under the laws of the state of North Carolina and is lawfully doing business in North Carolina, and is not an agency or instrumentality of any state, county or federal government; and

WHEREAS, no practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Board of Trustees; and

WHEREAS, the cooperative efforts of the Medical Staff, management and the Board of Trustees are necessary to fulfill these goals as well as the mutual goals of patient safety and enhanced quality of care.

NOW, THEREFORE, the practitioners practicing in Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals hereby organize themselves into a Medical Staff conforming to these bylaws.

1 Appendix A: Fair Hearing Plan – 42 USC 11101 et seq.; MS 10.01.01
2 Appendix B: Medical Staff Rules and Regulations-MS 01.01.01 EP 1
3 Appendix C: Policy Regarding Behavior that Undermines a Culture of Safety – LD 03.01.01 EP 4-5; Joint Commission Sentinel Event Alert (July 9, 2008)
4 Appendix D: Impaired Practitioner Policy – MS 11.01.01
5 Appendix E: Peer Review Policy
DEFINITIONS

1. "Active Staff" members shall be those physicians (D.O.'s and M.D.'s) licensed in the state of North Carolina that has the privilege of admitting patients, holding office and voting.

2. "Advanced Practice Registered Nurse" (APRN) means a registered nurse who has gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles, and who has been certified by the board of nursing to engage in the practice of advanced practice nursing. This category includes CRNA, CNM and NP.

3. "Allied Health Professional" or “AHP” means an individual, who is qualified to render direct or indirect medical or surgical care, either independently, in collaboration with or under the supervision of a physician who has been afforded privileges to provide such care in the Hospital. Such AHPs shall include, without limitation, Dentist (DDS), Podiatrist, Psychologist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Nurse Practitioner, Physician’s Assistant, Radiology Practitioner Assistant, and other such professionals and APRNs. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.

4. "Board” means the Board of Trustees of the DLP- Harris Regional Hospital, LLC & DLP- Swain Community Hospital, LLC.

5. "Board Certification" shall mean certification in one of the Member Boards of the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).

6. "Chief Executive Officer" or “CEO” means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

7. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.

8. "Clinical Privileges" means the Board’s recognition of the practitioners’ competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.

9. "Corporation” means DLP-Harris Regional Hospital, LLC and DLP-Swain Community Hospital, LLC.

10. "Data Bank” means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

11. “Designee” means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these bylaws.

12. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

13. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician’s clinical privileges are adversely affected by a determination based on the physician’s professional conduct or competence.

14. “Hospital” means Harris Regional & Swain Community Hospitals.
14. “Licensed Independent Practitioner” means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges.

15. “Medical Executive Committee” or “MEC” means the Executive Committee of the Medical Staff.

16. "Medical Staff" or “Organized Medical Staff” means the formal organization of practitioners who have been granted privileges by the Board to attend patients in the Hospital.

17. "Medical Staff Bylaws” means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan, policies and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

18. "Medical Staff Year" means calendar year.

19. "Member" means a practitioner who has been granted Medical Staff membership and clinical privileges pursuant to these bylaws.

20. “Peer Review Policy” means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix “X” hereto.7

21. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in North Carolina.

22. "Practitioner" means any individual who is licensed and qualified to practice a health care profession (for example, physician, nurse, social worker, clinical psychologist, psychiatrist, or respiratory therapist) and is engaged in the provision of care, treatment, or services.

23. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these bylaws and in other hospital and Medical Staff policies.

24. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

25. “Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

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7 Please note that the Peer Review Policy is not included in the Bylaws at this point. However, Clinical Operations can provide facility with a policy for use upon request.
ARTICLE I - NAME

The name of this organization shall be the Medical Staff of Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals.

ARTICLE II - PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of staff membership may be fulfilled;

2.1(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;  

2.1(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other PSCQ (Patient Safety Clinical Outcomes) activities in accordance with the Hospital's PSCQ program;

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each practitioner’s performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHPs;

2.1(e) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill.

2.1(f) To promulgate, maintain and enforce bylaws, rules and regulations, and other policies and procedures related to medical care for the proper functioning of the Medical Staff;

2.1(g) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

2.1(h) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;
2.1(i) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO; and

2.1(j) To accomplish its goals through appropriate committees and departments.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners authorized to practice in the Hospital, by taking action to:

(1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;\(^\text{16}\)

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;\(^\text{17}\)

(3) Participates in continuing medical education programs addressing issues of PSCQ and including the types of care offered by the Hospital;\(^\text{18}\)

(4) Implement a utilization management program, based on the requirements of the Hospital's Utilization Management Plan;\(^\text{19}\)

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPS;\(^\text{20}\)

(6) Initiate and pursue corrective action with respect to practitioners, when warranted;\(^\text{21}\)

(7) Develop, administer and enforce these bylaws, the rules and regulations of the staff and other hospital policies related to medical care;\(^\text{22}\)

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;\(^\text{23}\) and

(9) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy, which is incorporated herein and attached as Appendix “D” hereto.\(^\text{24}\)

2.2(b) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.\(^\text{25}\)

\(^{15}\) LD 01.05.01; MS 01.01.01
\(^{16}\) 42 CFR 482.24; 42 CFR 482.11; LD 01.05.01; MS 01.01.01
\(^{17}\) MS 01.01.01 EP 14 and 26; MS 03.01; 01 EP 2 MS 06.01.01 - MS 06.01.09
\(^{18}\) MS 12.01.01
\(^{19}\) MS 05.01.01; MS 05.01.03; 42 CFR 482.30(f).
\(^{20}\) MS 07.01.01; MS 03.01.01
\(^{21}\) MS 01.01.01 EP 28-34; MS 10.01.01; MS 09.01.01
\(^{22}\) MS 01.01.01 EP 1-2 and 5-6
\(^{23}\) MS 09.01.01; MS 07.01.01; MS 03.01.01; MS 05.01.03 EP 4.
\(^{24}\) MS 11.01.01
\(^{25}\) 45 CFR Parts 164 (HIPAA Security and Privacy Regulations)
2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital’s Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

26 45 CFR 164.506(b)(5)
ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. Membership on the Medical Staff shall confer on the practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she is a member of the Medical Staff with appropriate privileges, or has been granted temporary privileges as provided herein.27

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications28

The only people who shall qualify for membership on the Medical Staff are those practitioners legally licensed in North Carolina, who continuously:29

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;30

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities;31

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;32

(4) Have professional liability insurance that meets the requirements of these Bylaws;33

(5) Are graduates of an approved educational institution holding appropriate degrees;34

(6) Have successfully completed an approved internship program or the equivalent where applicable,35

27 MS 03.01.03
28 42 CFR 482.22; MS 01.01.01 EP 13
29 Refer to State Medical Practice Statute
30 MS 06.01.03
31 MS 07.01.03
32 MS 06.01.05 EP 9
33 This language is strongly recommended for legal and risk management purposes.
34 MS 06.01.03
35 MS.06.01.03
(7) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals\textsuperscript{36} and have the physical and mental health to adequately practice his/her profession;\textsuperscript{37}

(8) Show evidence of the following educational achievements: CME or relevant documentation for additional training specific to their board certified specialty or the specialty they have been granted privileges to practice at the Hospital. The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital;\textsuperscript{38}

(9) Meet one of the following requirements, in addition to those listed above:

   (i) Initial Board certification, sufficiently related to the privileges sought; or

   (ii) Adequate progress toward Board certification sufficiently related to the privileges sought. The determination of adequacy shall be made by the MEC and must be approved by the Board of Trustees. Board Certification shall be achieved within five (5) years of completing residency; or

   (iii) demonstration to the satisfaction of the MEC and the Board of Trustees, competency and training equal or equivalent to that required for Board certification sufficiently related to the privileges sought.

The above requirement shall not apply to any practitioner already a member of the Medical Staff as of June 9, 2009\textsuperscript{39}

(10) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital;\textsuperscript{40} and

(11) Practice in such a manner as not to interfere with the orderly and efficient rendering services by the Hospital or by other practitioners within the hospital.\textsuperscript{41}

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership at this Hospital or at another health care facility or in another practice setting.\textsuperscript{42}

\textsuperscript{36} MS.06.01.03 (describes the hospital’s requirements with respect to credentialing and emphasizes the six areas of “General Competencies” adapted from the joint initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). Among these areas are professionalism and interpersonal and communication skills.

\textsuperscript{37} MS.06.01.05 EP 6 (requires the medical staff to evaluate applicants' health status and ability to practice.)

\textsuperscript{38} MS 06.01.03; MS 12.01.01

\textsuperscript{39} 42 CFR 482.12(a)(7)

\textsuperscript{40} MS.06.01.01 requires the hospital to determine that it has sufficient resources to support the clinical privileges sought to be exercised.

\textsuperscript{41} LD.03.01.01 rationale indicates that behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to the patient. Thus, willingness to practice in such a way as not to interfere with hospital operations is important.

\textsuperscript{42} Medicare CoPs require that the governing body ensure that “under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.” 42 C.F.R. § 482.12(a)(7). Furthermore, the Note to TJC MS.07.01.01, EP 1 provides: “Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty society or body.”
3.2(c) Non-Discrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.\textsuperscript{43}

3.2(d) Ethics

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past, and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.\textsuperscript{44}

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP\textsuperscript{45}

Each member of the Medical Staff shall:

3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;\textsuperscript{46}

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;\textsuperscript{47}

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff;\textsuperscript{48}

3.3(d) Discharge the staff, department, committee and hospital functions for which he/she is responsible by staff category assignment, appointment, election or otherwise;\textsuperscript{49}

3.3(e) Cooperate with other members of the Medical Staff, management, the Board of Trustees and employees of the Hospital;\textsuperscript{50}

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;\textsuperscript{51}

3.3(g) Adequately enter all orders for treatment within the timeframe required by the applicable Medical Staff Rules, Regulations and Policies using Computerized Physician Order Entry as required by the Rules & Regulations;

\textsuperscript{43} 42 USC 1981; LD 04.01.01; MS 07.01.01 EP 3, require that gender, race, creed and national origin are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

\textsuperscript{44} 42 CFR 482.12(a)(6)
\textsuperscript{45} 42 CFR 482.22
\textsuperscript{46} 42 CFR 482.12(a)(5) (Interpretive Guidelines)
\textsuperscript{47} 42 CFR 482.30(f)
\textsuperscript{48} MS 01.01.01 EP 5-6
\textsuperscript{49} MS 01.01.01 EP 5-6
\textsuperscript{50} MS 01.01.01
\textsuperscript{51} 42 CFR 482.24
3.3(h) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the hospital drug testing program;  

3.3(i) Abide by the ethical principles of his/her profession and specialty;  

3.3(j) Refuse to engage in improper inducements for patient referral;  

3.3(k) Notify the CEO and Chief of Staff immediately if:  

(1) His/her professional licensure in any state is suspended or revoked;  

(2) His/her professional liability insurance is modified or terminated;  

(3) He/she is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;  

(4) He/she is the subject of a successful or current pending challenge to, or the voluntary relinquishment of, any of the following:  

   (i) Specialty board certifications;  

   (ii) License to practice any profession in any jurisdiction;  

   (iii) National Drug Enforcement Agency (DEA) number or state licensure certificate issued by the state;  

   (iv) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges;  

   (v) The practitioner’s management of patients which may have given rise to investigation by the state medical board;  

   (vi) Participation in federal or state health insurance, including Medicare or Medicaid; or  

   (vii) Voluntary or mandatory participation in a drug and/or alcohol rehabilitation program.  

(5) He/she has had any criminal charges, other than minor traffic violations, brought/initiated against him/her.  

Failure to provide any such notice, as required above, shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.  

3.3(l) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.  

3.3(m) Acknowledge and comply with the following standards concerning conflicts of interest:  

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52 MS 06.01.05 EP 2 and 6  
53 42 CFR 482.12(a)(6)  
54 42 USC 1320a-7b; 42 USC 1395nn  
55 42 CFR 482.12(a)(6); MS 06.01.05 EP 9  
56 45 CFR Parts 164 (HIPAA Security and Privacy Regulations)
The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member’s opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/or clinical privileges and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member’s status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

1. Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to membership on the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

4. Business practices that may adversely affect the Hospital or community.

In addition to the foregoing a new Medical Staff leader (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital’s Board of Trustees) shall file the written statement immediately upon being elected or appointed to his/her leadership position.

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each leader’s written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.
3.4 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented by a licensed practitioner who is credentialed and privileged by the Medical Staff to perform a history and physical examination for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care.

Physical examinations may be used from the previous hospitalization if the examination was within 30 days. Physical examinations may be accepted from a doctor’s office if the examination was done within 30 days of admission and meets the standards as defined by hospital policy and procedure. If the patient was transferred from another hospital, the physical examination may be accepted if done within the last 30 days provided they are updated within 24 hours of admission or registration by the attending physician. In the above three cases, the attending physician must validate the physical examination in the medical record (on the physical exam) by noting that there are no significant findings or changes and signs and dates the report.

When the history and physical examination is conducted within thirty (30) days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital’s medical staff to perform a history and physical examination. An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician (as defined in Section 1861(r) of the Act) an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

The update must accompany an examination for any changes in the patient’s condition since the patient’s history and physical examination was performed that might be significant for the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient’s condition since the history and physical examination was completed, he/she may indicate in the patient’s medical record that the history and physical examination was reviewed, the patient was examined, and that “no change” has occurred in the patient’s condition since the history and physical examination was completed.

At minimum, the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that establishes medical necessity in concise manner; (b) a history of the present illness; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances; (e) past medical and surgical history; (f) immunization history; (g) family history and social history; (h) comprehensive physical examination; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient’s symptoms; and (k) the plan outlining the evaluation and treatment strategy.

The admitting practitioner is responsible for the H&P.

Pursuant to recent revisions, the Interpretive Guidelines for 42 C.F.R. §482.22(c)(5)(i) now mandate that the requirements of history and physical examinations be delineated in the medical staff bylaws rather than the rules & regulations. Further, Lifepoint Hospitals, Inc. has queried CMS as to whether such requirements may remain in the rules & regulations if incorporated by reference in the medical staff bylaws. CMS responded that such a practice would violate the provisions of the Hospital Conditions of Participation, and therefore requirements of history and physical examinations must be delineated in the medical staff bylaws. MS.01.01.01 EP 16 also requires that the requirement for completing and documenting medical histories and physical examination be located in the Bylaws.
H&Ps performed prior to admission by a practitioner that is not credentialed and privileged are acceptable provided that the following criteria are met.

- The practitioner is appropriately licensed and permitted to complete the history and physical by state law
- A practitioner that is authorized and privileged by the organization, and is familiar with the organization’s policy for the defined minimal content of the H&P must:
  - Review the history and physical examination document;
  - Determine if the information is compliant with the organization’s defined minimal content;
  - Obtain missing information through further assessment
  - Update information and findings as necessary, which may include, but are not limited to:
    - Inclusion of absent or incomplete required information
    - A description of the patient’s condition and course of care since the history and physical examination was performed
    - A signature and date on any document with updated or revised information as an attestation that it is current

A history and physical exam performed within the prior 30 days and which meets the above required elements may be accepted from a referring licensed independent practitioner provided it receives the required review and update from a member of the Medical or Allied Health Professional Staff with privileges to do so.

Each department or service will determine for its members which outpatient procedures require a history and physical examination as a prerequisite and, if required, the scope of such history and physical. Notwithstanding the foregoing, a history and physical examination shall be required for all invasive operative procedures performed in the outpatient setting. Where required, a history and physical must be completed and documented in accordance with the timeframes described above.

### 3.5 DURATION OF APPOINTMENT

#### 3.5(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed 2 years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

#### 3.5(b) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed 2 years.

#### 3.5(c) Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member to be made in accordance with the procedures for initial appointment as outlined herein.

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59 48 CFR 482.22(a)(1) (Interpretive Guidelines); MS 06.01.07 EP 9; MS 07.01.01 EP 3 requires the organized medical staff to use criteria in appointing members to the medical staff and that appointment does not exceed a period of two years.
3.6 LEAVE OF ABSENCE

3.6(a) Leave Status

A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year. If the leave is granted, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement. If the staff member’s period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

3.6(b) Termination of Leave

(1) At least sixty (60) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2) If a member requests leave of absence for any reason and for any length of time, including but not limited to obtaining further medical training or an armed services commitment the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both. Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.
ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall include Active, Courtesy, Consulting, Honorary, and Affiliate categories.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

(1) Meet the basic qualifications set forth in these bylaws;

(2) Have an office and/or residence located within 30 miles of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board; and

(3) Regularly admit to, or are otherwise regularly involved in the care of at least 12 patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;

(2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the staff organization, departments and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

60 42 CFR 482.22(c)(2)-(c)(3); MS 01.01.01 EP 15
61 For example, language such as “30 miles” or “30 minutes” should be inserted. It is strongly suggested that a specific mileage requirement or definite response time be included. This may vary based on geographical considerations, but should be reasonable to ensure that continuous care is provided to the practitioner’s patients.
62 It is strongly recommended that this number be no less than 24.
4.2(c) **Responsibilities**

Each member of the Active Staff shall:

1. Meet the basic responsibilities set forth in Section 3.3;\(^63\)

2. Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care unit no later than 2 hours after admission or sooner if warranted by the patient’s condition;\(^64\)

3. Actively participate:
   
   - (i) in the PSCQ program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;\(^65\)
   
   - (ii) in supervision of other appointees where appropriate;\(^66\)
   
   - (iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules and Regulations and *as recommended by the MEC and, approved by the Board*, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician\(^67\)
   
   - (iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and
   
   - (v) in discharging such other staff functions as may be required from time-to-time.

4. Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and

5. Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the departments and committees of which he/she is a member.

4.2(d) **Failure**

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

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\(^63\) 42 CFR 482.22; MS 01.01.01 EP 5  
\(^64\) 42 CFR 482.12(a)(5) (Interpretive Guidelines); PC 01.02.03 EP 1  
\(^65\) MS 05.01.01; MS 05.01.03  
\(^66\) MS 08.01.01; MS 03.01.01 EP 1 and 3  
\(^67\) 42 CFR 489.20(r)(2)
4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of practitioners, who:

(1) Meet the basic qualifications set forth in these bylaws;

(2) Do not admit or participate in the care of more than 12 patients in a calendar year. Courtesy members who admit or are involved in the care of more than 12 patients in a calendar year must transfer to active staff. The requirement to transfer to active staff may be waived by the Board for practitioners who have their primary practice outside the community and provide services not otherwise available in the community; and

(3) Are members of the Active Staff of another hospital where he/she actively participates in the PSCQ program.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a);

(2) Exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) Attend meetings of the staff and any staff or hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, except that he/she shall not be entitled to vote for Chief of any department and are not entitled to vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;

(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service;

(3) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member; and

(4) Take ER call if there are an inadequate number of Active Staff physicians to provide coverage within a specific specialty. The MEC shall make recommendations to the Board of Trustees regarding the determination of which specialties require coverage by Courtesy Staff members, and the Board shall have final authority for determining if such requirement of Courtesy Staff members is necessary in order to provide quality care and meet the hospital’s obligations under all applicable State and Federal laws.

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68 Should be one less than the amount in 4.2(a) (3) (We recommend that this number not exceed 23.)
69 Should be one less than the amount in 4.2(a) (3)
70 Insert either “shall” or “shall not”.
71 42 CFR 482.12(a)(5) (Interpretive Guidelines)
4.4 CONSULTING STAFF

4.4(a) Qualifications

Consulting Staff shall consist of a special category of physicians each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

4.4(b) Prerogatives

(1) Prerogatives of a Consulting Staff member shall be to:

   (i) consult on patients within his/her specialty; and

   (ii) attend all meetings of the staff and the applicable department that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

(3) Consulting Staff members may provide an unlimited number of consultation reports/recommendations (without managing the direct patient care) during a calendar year. Consulting Staff members shall not admit patients to the Hospital, perform inpatient or outpatient procedures, transfer patients from the Hospital, or act as the physician of primary care or responsibility for any patient within the Hospital.

(4) Are members of the Active Staff of another hospital where he/she actively participates in the PSCQ program.

4.4(c) Responsibilities

Each member of the Consulting Staff shall assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients.

4.5 HONORARY STAFF

4.5(a) Qualifications

The Honorary and Retired Staff shall consist of physicians who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active hospital services, but continue to demonstrate a genuine concern for the Hospital; or

(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

Honorary Staff members shall not be required to meet the qualifications set forth in Section 3.2(a) of these bylaws.
4.5(b) **Prerogatives**

(1) Prerogatives of an Honorary Staff member shall be:

   (i) attending by invitation any such meetings that he/she may wish to attend as a non-voting visitor.

(2) Honorary Staff members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Honorary Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.6 **AFFILIATE STAFF**

4.6(a) **Qualifications**

Appointees of the affiliate staff shall consist of those physicians who desire to be associated with the hospital, but who do not intend to care for or treat patients at this hospital. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing education endeavors. Affiliate Staff shall not be granted clinical privileges and shall not be subject to the requirements for ongoing professional practice evaluation or focused professional practice evaluation.

4.6(b) **Prerogatives**

Affiliate Staff Appointees:

(1) May refer patients for outpatient diagnostic testing and specialty services provided by the hospital;

(2) May refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment;

(3) May visit their hospitalized patients, review their hospital medical records and provide advice and guidance to the attending physician, but shall NOT be permitted to admit patients, to attend patients, to exercise any clinical privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the hospital. They are encouraged to attend educational programs sponsored by the hospital or Medical Staff and attend meetings of the full Medical Staff and the Department to which they are assigned; and

(4) Shall not vote on staff matters, or hold office, but may serve and vote on Medical Staff Committees, if assigned.

4.6(c) **Responsibilities**

Individuals requesting Affiliate Staff appointment shall be required to:

(1) Submit an application for initial appointment, or for reappointment no less than every two years as prescribed by Article VI of these Bylaws;

(2) Submit documentation of a current license, DEA certificate, malpractice insurance in the amounts required by Section 14.2 of these Bylaws, and shall not currently be ineligible as defined in Section 6.3(d)(5) of these Bylaws. Affiliate Staff members are not granted clinical privileges, therefore Board Certification is not required; and
(3) Acknowledge that appointment and reappointment to the Affiliate Staff is a courtesy which may be terminated by the Board of Trustees upon recommendation of the Medical Executive Committee with sixty (60) days written notice, without right to a hearing or appeal as set forth in these Bylaws.

4.6(d) **Reappointment Requirements**

Individuals requesting re-appointment to the Affiliate Staff:

1. Shall provide evidence of a current license and Drug Enforcement Agency (DEA) registration;

2. Shall provide evidence of current malpractice insurance in the amounts required by Section 14.2

3. Shall not currently be an ineligible person as defined in Section 6.3(d)(5) of these Bylaws;

4. Shall provide peer references from Medical Staff members who are members of the Hospital’s Medical Staff and are familiar with the Affiliate Staff member’s competence.
ARTICLE V - ALLIED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

Allied Health Professionals (“AHPs”) shall be identified as any person(s) other than physicians who are granted privileges to practice in the Hospital and are directly involved in patient care. Advanced Practice Registered Nurses (CNM, CRNA & NP), Physician Assistants and Radiology Practitioner Assistants may be employed by physicians on the staff; but whether or not so employed, must be under the direct supervision and direction of a staff physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations) and not exceed the limitations of practice set forth by their respective licensure.

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

5.2(a) AHPs must:

1. Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

2. Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

3. Have professional liability insurance in the amount required by these bylaws;

4. Provide a needed service within the Hospital; and

5. Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

Upon establishing experience, training and current competence, AHPs, as identified in Section 5.1, shall have the following prerogatives:

5.3(a) To exercise judgment within the AHP’s area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;
5.3(b) To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff; and

5.3(c) To participate as appropriate in the patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

5.3(d) Take ER first call to provide coverage within a specific specialty. The MEC shall make recommendations to the Board of Trustees regarding the determination of which specialties require coverage by Allied Health Professionals, and the Board shall have final authority for determining if such requirement of Allied Health Professionals is necessary in order to provide quality care and meet the hospital’s obligations under all applicable State and Federal laws.

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for the credentialing of physicians. Each AHP shall be assigned to one (1) of the clinical departments and shall be granted clinical privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

5.4(b) Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity to be heard by the Committee concerning the AHP’s grievance. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. A record of the appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP.

5.4(c) The AHP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP’s written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

80 MS 03.01.03 EP 4; 42 CFR 482.12(c)(2)
81 MS 05.01.01; MS 05.01.03
82 MS 01.01.01 EP 26 and MS 06.01.07
83 MS 01.01.01 EP 30, 34-35; MS 10.01.01
84 MS 01.01.01 EP 30, 34-35; MS 10.01.01
5.4(d) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon’s privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.\(^{85}\)

5.4(e) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.\(^{86}\)

5.5 **RESPONSIBILITIES**

Each AHP shall:

5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality.\(^{87}\)

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable.\(^{88}\)

5.5(c) Discharge any committee functions for which he/she is responsible.\(^{89}\)

5.5(d) Cooperate with members of the Medical Staff, administration, the Board of Trustees and employees of the Hospital.\(^{90}\)

5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible.\(^{91}\)

5.5(f) Participate in performance improvement activities and in continuing professional education.\(^{92}\)

5.5(g) Abide by the ethical principles of his/her profession and specialty; and\(^{93}\)

5.5(h) Notify the CEO and the Chief of Staff immediately if:\(^{94}\)

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\(^{85}\) MS 01.01.01 EP 30.34-35; MS 01.01.01
\(^{86}\) This language is strongly recommended for legal and risk management purposes
\(^{87}\) 42 CFR 482.12(a)(5) (Interpretive Guidelines)
\(^{88}\) MS 01.01.01 EP 5
\(^{89}\) MS 01.01.01 EP 5
\(^{90}\) MS 01.01.01
\(^{91}\) 45 CFR 482.24
\(^{92}\) MS 12.01.01 requires all licensed independent practitioners and other practitioners privileged through the medical staff process to participate in continuing education. Continuing education is an adjunct to maintaining clinical skills and current competence.
\(^{93}\) 42 CFR 482.12(a)(6)
\(^{94}\) 42 CFR 482.12(a)(6); MS 06.01.05 EP 9
(1) His/her professional license in any state is suspended or revoked;

(2) His/her professional liability insurance is modified or terminated;

(3) He/she is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) He/she is the subject of a successful or current pending challenge to, or the voluntary relinquishment of, any of the following:

   (i) Specialty board certifications;

   (ii) License to practice any profession in any jurisdiction;

   (iii) National Drug Enforcement Agency (DEA) number or state licensure certificate issued by the state;

   (iv) Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges;

   (v) The AHP’s management of a patient which may have given rise to investigation by a state licensing board/agency;

   (vi) Participation in federal or state health insurance program, including Medicare or Medicaid; or

   (vii) Voluntary or mandatory participation in a drug and/or alcohol rehabilitation program.

(5) He/she has had any criminal charges, other than minor traffic violations, brought/initiated against him/her;

(6) He/she ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privilege;

Failure to provide any such notice, as required above, shall result in immediate loss of Allied Health membership and clinical privileges, without right of fair hearing procedures.

5.5(i) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.\(^{95}\)

5.5(j) Refuse to engage in improper inducements for patient referral; and\(^{96}\)

5.5(k) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the hospital drug testing program.\(^{97}\)

\(^{95}\) 45 CFR Part 164 (HIPAA Privacy and Security Regulations).

\(^{96}\) 42 USC 1320a-7b describes criminal penalties for acts involving federal health care programs.

\(^{97}\) MS.06.01.05, EP 6 requires that the applicant submit a statement that no health problems exist that could affect his or her ability to perform the privileges requested.
6.1 **GENERAL PROCEDURES**

The Medical Staff through its designated committees and departments shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.99

6.2 **CONTENT OF APPLICATION FOR INITIAL APPOINTMENT**

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all practitioners except pathologists), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. The application fee or Medical Staff dues (if any) shall be determined by the MEC. Applicants shall supply the Hospital with all information requested on the application.100

The application form shall include, at a minimum, the following:101

6.2(a) **Acknowledgment & Agreement**: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

(1) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

(2) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

6.2(b) **Administrative Remedies**: A statement indicating that the practitioner agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges;102

6.2(c) **Criminal Charges**: Any current criminal charges, except minor traffic violations, pending against the applicant and any past convictions or pleas. The practitioner shall acknowledge the Hospital’s right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

6.2(d) **Fraud**: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;103

6.2(e) **Health Status**: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested. In instances where there is doubt about an applicants’ ability to

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98 42 CFR 482.22; MS 01.01.01 EP 14. 26 and 27  
99 MS 06.01.07; MS 01.01.01 EP 26  
100 MS 06.01.03; MS 01.01.01 EP 26  
101 MS 01.01.01 EP 26  
102 42 USC 11101 et seq.  
103 MS 06.01.05 EP 9
perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board. Applicant agrees to be bound by the hospital drug testing policy; 104

6.2(f) **Program Participation:** Information concerning the applicant’s current participation and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

6.2(g) **Information on Malpractice Experience:** All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The practitioner shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of a professional liability action against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions; 105

6.2(h) **Education:** Detailed information concerning the applicant’s education and training. 106

6.2(i) **Insurance:** Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant’s coverage change at any time. Each practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage; 107

6.2(j) **Notification of Release and Immunity Provisions:** Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions; 108

6.2(k) **Professional Sanctions:** Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following: 109

   (1) membership/fellowship in local, state or national professional organizations;

   (2) specialty board certifications;

   (3) license to practice any profession in any jurisdiction;

   (4) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists);

   (5) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or

   (6) the practitioner’s management of patients which may have given rise to investigation by the state medical board; or

   (7) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The practitioner shall have a continuing duty to notify the MEC, in writing through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of any

104 MS 06.01.05 EP 2 and 6
105 MS 06.01.05 EP 2
106 MS 06.01.05 EP 2; MS 06.01.07
107 This language is strongly recommended for legal and risk management purposes
108 This language is strongly recommended for legal and risk management purposes
109 MS 06.01.05 EP 9
of the above actions against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions.

6.2(l) **Qualifications:** Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;\(^{110}\)

6.2(m) **References:** The names of at least three (3) practitioners\(^ {111}\) (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others. In the event the applicant is less than 2 years from training, at least one reference shall be a faculty member, program director, or Chairman from his or her program;\(^ {112}\)

6.2(n) **Practice Affiliations:** The name, phone number, fax number, web page and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;\(^ {113}\)

6.2(o) **Request:** Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;\(^ {114}\)

6.2(p) **Photograph:** A recent, wallet sized government issued photograph of the applicant;\(^ {115}\)

6.2(q) **Citizenship Status:** Proof of United States citizenship or legal residency;\(^ {116}\)

6.2(r) **Professional Practice Review Data:** For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner’s professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant; clinical logs for new graduates; and\(^ {117}\)

6.2(s) **Continuing Education:** Evidence of satisfactory completion of continuing education requirements.

### 6.3 PROCESSING THE APPLICATION

#### 6.3(a) **Request for Application**

A practitioner wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her written request for an application form to the CEO or his/her designee.

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10. MS 06.01.03; 06.01.05 EP 2; MS 06.01.07
11. At the discretion of the MEC, the MEC may choose to delete the exclusion of partners, associates in practice, employers, employees or relatives. However, if the MEC chooses to delete the language, it must be deleted from the references process altogether and cannot be used on a case by case basis. This deletion would occur if the facility was in a community too rural to meet the requirement.
12. MS 07.01.03
13. MS 06.01.05
14. MS 06.01.05
15. MS 06.01.03 EP 5
16. MS 06.01.03 EP 5. Additionally, CMS requires verification of citizenship or legal residence for physicians applying for enrollment in Medicare. This provision helps avoid billing Medicare or other payers for services provided by someone who is not in the country legally.
17. MS 06.01.05 EP 2
6.3(b) **Applicant's Burden**

By submitting the application, the applicant:

1. Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and clinical privileges;

2. Authorizes hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

3. Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

4. Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights;

5. Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall be deemed to have immediately relinquished his/her appointment and clinical privileges, without fair hearing rights;

6. Pledges to provide continuous care for his/her patients treated in the Hospital; and

7. Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights.

6.3(c) **Statement of Release & Immunity from Liability**

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated.

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118 MS 06.01.03; MS 06.01.05; MS 06.01.07
119 42 CFR 482.12(a)(5) (Interpretive Guidelines)
120 This language is strongly recommended for legal and risk management purposes
and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges, without fair hearing rights. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I shall be deemed to have immediately relinquished my appointment and clinical privileges, without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

(i) applications for appointment or clinical privileges, including temporary privileges;

(ii) periodic reappraisals;

(iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

(viii) any other Hospital, Medical Staff, department, service or committee activities;

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.
(3) The term “Hospital” and “its authorized representatives” means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital’s attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term “third parties” means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that: (1) Medical Staff appointments at this Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Hospital through the CEO, of any change in the areas of inquiry contained herein; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital. Appointment and continued clinical privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff, including these Bylaws and Rules & Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) Submission of Application &Verification of Information

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the CEO or his/her designee. The application shall be returned to the practitioner and shall not be processed further if one (1) or more of the following applies:

(1) Not Licensed. The practitioner is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or

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121 MS 06.01.03
122 MS 06.01.05 EP 1-2
(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the practitioner has had his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or

(3) Exclusive Contract. The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital; or 123

(4) Inadequate Insurance. The practitioner does not meet the liability insurance coverage requirements of these bylaws; or

(5) Ineligible for Medicare Provider Status. The practitioner has been excluded, suspended or debarred from any government payer program or is currently the subject of a pending investigation by any government payer program; or 124

(6) No DEA number. The practitioner’s DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists); or 125

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active Staff, failure to maintain an office or residence within the geographical area required by these bylaws; or

(8) Application Incomplete. The practitioner has failed to provide any information required by these bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application.

The refusal to further process an application form for any of the above reasons shall not entitle the practitioner to any further procedural rights under these bylaws.

In the event that none of the above apply to the application, the CEO or his/her designee shall promptly seek to collect or verify the references, licensure and other evidence submitted. The CEO or his/her designee shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete. 126

123 MS 06.01.01
124 42 USC 1128A(a)(6)
125 MS 06.01.05 EP 9
126 MS 06.01.03; MS 06.01.05 EP 7; MS 06.01.07
6.3(e) **Description of Initial Clinical Privileges**

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the hospital. Each practitioner who is appointed to the Medical Staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.\(^{127}\)

6.3(f) **Recommendation of Department Chief**

The Chief of the appropriate department shall review the application, the supporting documentation, reports and recommendations, and such other relevant information available to him/her, and shall transmit to the Credentials Committee on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered. Documentation shall be transmitted with the report.\(^{128}\)

6.3(g) **Credentials Committee Action**

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Department Chief and such other information available as may be relevant to consideration of the applicant’s qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.\(^{129}\)

6.3(h) **Medical Executive Committee Action**

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant’s ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant’s satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(i). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.\(^{130}\)

\(^{127}\) MS 06.01.05; MS 06.01.07  
\(^{128}\) MS 01.01.01 EP 26  
\(^{129}\) MS 01.01.01 EP 26  
\(^{130}\) MS 06.01.03; MS 06.01.05; MS 01.01.01 EP 26
6.3(i) **Effect of Medical Executive Committee Action**

(1) **Deferral**: Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.\(^{131,132}\)

(2) **Favorable Recommendation**: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Department Chief. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.\(^{133}\)

(3) **Adverse Recommendation**: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the practitioner by special notice which shall specify the reason or reasons for denial and the practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan, or for AHPS, the procedure outlined in 5.4(b). The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b).\(^{134}\)

6.3(j) **Board Action**

(1) **Decision; Deadline**: The Board of Trustees may accept, reject or modify the MEC recommendation. The Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the MEC. If the committee returns a positive decision concerning the application, the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board.

The expedited process may not be used in the following circumstances:

(i) The applicant submits an incomplete application;

(ii) The MEC makes a recommendation that is adverse or with limitation;

(iii) There is a current challenge or a previously successful challenge to licensure or registration;

\(^{131}\) MS 06.01.05; MS 06.01.03; MS 01.01.01 EP 26

\(^{132}\) Please consult State Law regarding time periods for processing applications

\(^{133}\) MS 06.01.05; MS 06.01.03; MS 01.01.01 EP 26

\(^{134}\) MS 06.01.09; MS 01.01.01 EP 34; MS 10.01.01; 42 USC 11101 et seq.
(iv) The applicant has received an involuntary termination of Medical Staff membership at another organization;

(v) The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or

(vi) There has been a final judgment adverse to the applicant in a professional liability action.

Any of the above circumstances will require review and consideration by the full Board.

In either case, and in situations in which no committee has been appointed, the Secretary of the Board shall reduce the full Board’s decision to writing and shall set forth therein the reasons for the decision. The Board shall make specific findings as to the applicant’s satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(l). The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Trustees shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC’s recommendation.135

(2) **Favorable Action.** In the event that the Board of Trustees’ decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been granted. The CEO or his/her designee shall also keep each patient care area/department adequately informed concerning the current clinical privileges granted to each newly approved applicant as well as existing members of the medical staff. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of PSCQ that does not materially restrict the applicant’s ability to exercise the requested clinical privileges.136

(3) **Adverse Action.** In the event that the MEC’s recommendation was favorable to the applicant, but the Board of Trustees’ action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b). The CEO or his/her designee shall immediately deliver to the applicant by special notice, a letter enclosing the Board of Trustees’ written decision and containing a summary of the applicant’s rights as specified in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b).

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.137

**6.3(k) Interview**

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

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135 MS 06.01.03; MS 06.01.05; MS 06.01.07 EP 8
136 MS 06.01.07 EP 8; MS 06.01.09
137 MS 06.01.09; MS 01.01.01 EP 34; MS 10.01.01; 42 USC 11101 et seq.
6.3(l) Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require. For purposes of this section, “final adverse decision” shall include denial after exercise or waiver of fair hearing rights and/or refusal to further process an application (or relinquishment of privileges) due to the applicant’s provision of false or misleading information on, or the omission of information from, the application materials.

6.3(m) Time Periods for Processing\(^{138}\)

Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the Department Chief upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the practitioner has failed to provide requested information needed to complete the verification process.\(^ {139}\)

6.3(n) Denial for Hospital's Inability to Accommodate Applicant\(^ {140}\)

A decision by the Board to deny staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of professional contracts the hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

\(^ {138}\) Please consult State Law regarding time periods for processing applications

\(^ {139}\) MS 06.01.09

\(^ {140}\) 42 USC 11101 et seq.; MS 06.01.01
6.3(o) **Appointment Considerations**

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant’s experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant’s proficiency in areas such as the following:

1. **Patient Care** with the expectation that practitioners provide patient care that is compassionate, appropriate and effective;

2. **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;

3. **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

4. **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients’ families, members of the Medical Staff, Hospital Administration and employees, and others;

5. **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

6. **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 **REAPPOINTMENT PROCESS**

6.4(a) **Information Form for Reappointment**

At least ninety (90) days prior to the expiration date of a practitioner’s present staff appointment, the CEO or his/her designee shall provide the practitioner a reapplication form for use in considering reappointment. The staff member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the member’s current term.142

6.4(b) **Content of Reapplication Form**

The Reapplication Form shall include, at a minimum, updated information regarding the following:

1. **Education**: Continuing training, education, and experience during the preceding appointment period that qualifies the staff member for the privileges sought on reappointment;143

2. **License**: Current licensure;144

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141 MS 06.01.01; MS 06.01.03
142 MS 01.01.01 EP 26
143 MS 06.01.05 EP 2; MS 06.01.07
144 MS 06.01.05 EP 1-2
(3) **Health Status:** Current physical and mental health status only to the extent necessary to determine the practitioner’s ability to perform the functions of staff membership or to exercise the privileges requested; 145

(4) **Program Participation:** Information concerning the applicant’s current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

(5) **Previous Affiliations:** The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding appointment period; 146

(6) **Professional Sanctions:** Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period: 147

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists); or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or

(vi) the practitioner’s management of patients which may have been given rise to investigation by the state medical board; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

(7) **Information on Malpractice Experience:** Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period; 148

(8) **Criminal Charges:** Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or pleas during the preceding appointment period;

(9) **Insurance:** Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant’s coverage change at any time. Each practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage; 149

145 06.01.05 EP 2 and 6
146 MS 06.01.05
147 MS 06.01.05 EP 9
148 MS 06.01.05 EP 9
149 This language is strongly recommended for legal and risk management purposes
(10) **Current Competency**: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including, but not limited to an evaluation by the Department Chief and by one (1) other Medical Staff member who is not a partner, employer, employee or relative of the practitioner or two (2) Medical Staff members who are not partners, employers or employees, or relatives, and results from the PSCQ process of the Medical Staff. Such evidence shall include as the results of the applicant’s ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the practitioner’s professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.  

Practitioners and who refer their patients to a Hospitalist for inpatient treatment may satisfy this requirement by producing the above information in the form of quality profiles from other facilities where the practitioner has actively practiced during the prior appointment period; quality profiles from managed care organizations with whom the practitioner has been associated during the prior appointment period, or by submitting relevant medical record documentation from his/her office or other practice locations that demonstrates current competency for the privileges he/she is seeking. Practitioners who refer their patients to a Hospitalist for inpatient treatment may have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist may provide his/her evaluation of the practitioner's care based upon consultation and interaction with the practitioner with regard with regard to the practitioner's hospitalized patients. The Hospitalist may provide his/her opinion as to the practitioner's current competency based upon the condition of the practitioner's patients upon admission/readmission to the Hospital, with particular emphasis on any readmission related to complications of a previous admission;

(11) **Fraud**: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period;

(12) **Notification of Release & Immunity Provisions**: The acknowledgments and statement of release;

(13) **Information on Ethics/Qualifications**: Such other specific information about the staff member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the hospital;

(14) **References**: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant’s exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least one (1) practitioner (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others; and

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150 42 CFR 482.12(a)(6); MS 08.01.03
151 MS 06.01.05
152 MS 06.01.05 EP 9
153 42 CFR 482.12(a)(6)
154 MS 07.01.03
Continuing Education: Evidence of satisfactory completion of continuing education requirements.

6.4(c) Verification of Information

The CEO or his/her designee shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in the hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the CEO or his/her designee shall transmit the Reapplication Form and supporting materials to the Chairman of the appropriate department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.155

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.156

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Section 6.3(l) as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners and with patients, results of the hospital monitoring and evaluation process, including practitioner-specific information compared to aggregate information from PSCQ activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the hospital.157

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the CEO. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No staff member may seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Notwithstanding the foregoing, a staff member may not request modification of his/her staff category more than once in any two year appointment term.

155 MS 06.01.03
156 MS 06.01.05; MS 06.01.07; MS 01.01.01 EP 26
157 MS 06.01.03
158 MS 06.01.05; MS 06.01.07; MS 01.01.01 EP 26

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6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

A practitioner who is providing contract services to the hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or staff member.

6.6(b) Requirements for Service

In approving any such practitioners for Medical Staff membership, the Medical Staff must require that the services provided meet JOINT COMMISSION requirements and CMS Conditions of Participation, are subject to appropriate quality controls, and are evaluated as part of the overall hospital quality assessment and improvement program.159

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6 shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. Upon approval of the Hospital, Practitioners may retain their privileges if they enter into a new contract with the Hospital for the provision of services or, if approved by the Hospital the Practitioner provides services pursuant to an Agreement between the Hospital and a provider. The Fair Hearing does not apply in this case.160

159 42 CFR 482.11; 42 CFR 482.12(e)
160 MS 01.01.01 EP 34; MS 10.01.01
ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 **EXERCISE OF PRIVILEGES**

Every practitioner providing direct clinical services at this hospital shall, in connection with such practice and except as provided in Section 7.6, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner and each practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 **DELINEATION OF PRIVILEGES IN GENERAL**

7.2(a) **Requests**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner’s qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for medical staff membership, each practitioner must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a staff member for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) **Basis for Privileges Determination**

Granting of clinical privileges shall be based upon community and hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner’s education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from PSCQ activities, when available. For practitioners who have not actively practiced in the hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(12) herein. In addition, those practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual’s credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a staff member.

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161 42 CFR 482.22
162 MS 06.01.05; 42 CFR 482.22
163 MS 07.01.03; MS 06.01.05
164 MS 06.01.05; MS 06.01.07; MS 06.01.01; MS 06.01.03
7.2(c) **Procedure**

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new privileges are requested.\(^{165}\)

7.2(d) **Limitations on Privileges**

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.\(^{166}\)

7.2(e) **Initial and Additional Grants of Privileges**\(^{167}\)

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice. The evaluation period may be renewed for additional periods up to the conclusion of the member’s period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner’s evaluation for reappointment.

7.3 **SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES**

Requests for clinical privileges from dentists and podiatrists shall be processed, evaluated and granted in the manner specified in Article V.\(^{168}\) Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the Chief of Surgery. However, other dentists and/or oral surgeons or podiatrists, as applicable, shall participate in the review of the practitioner through the performance improvement process. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. Doctors of dental surgery or of dental medicine, and doctors of podiatric medicine may perform a history and physical for outpatient procedures in which they are named the attending practitioner. These practitioners will be credentialed and privileged to perform histories and physicals. An H&P update will be required when applicable as outlined above in section 3.4.

7.4 **SPECIAL CONDITIONS FOR PSYCHOLOGY PRIVILEGES**

Clinical privileges granted to Psychologists shall be based on their training, experience and demonstrated competence and judgment and shall be processed, evaluated and granted in the manner specified in Article V. In outpatient settings, they may diagnose and treat a patient’s psychological illness. They will ensure that their patients receive referral to appropriate medical care. Psychologists may not admit patients to the hospital facilities. However, in inpatient settings, they may diagnose and treat the patient’s psychological illness as a part of the comprehensive care offered by their program. Psychologists may provide consultation within their area of expertise on the care of patients within the clinic and hospital. They may receive consultation from other Members concerning their patient’s care, with the collaboration of a physician on their Service. Psychologists will not prescribe drugs, order diagnostic tests, perform surgical procedures, or otherwise practice outside the area of their expertise. They shall practice under the overall supervision of the Chief of Medicine. All psychological patients shall receive the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff shall be responsible for admission evaluation.

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\(^{165}\) MS 06.01.05; MS 01.01.01 EP 26

\(^{166}\) MS 07.01.01; MS 06.01.05; MS 06.01.07

\(^{167}\) MS 08.01.01
history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization.  

7.5 **CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS**

7.5(a) **Temporary Privileges**

The CEO or his/her designee, upon recommendation of the Chief of Staff or Chief of the applicable department, and upon proof of current licensure, appropriate malpractice insurance, and completion of the required Data Bank query; may grant temporary privileges for no more than 120 days in the following circumstances:

1. **Pendency of Applications:** The CEO or his/her designee, upon recommendation of the Chief of Staff may grant such privileges upon completion of the appropriate application, consent, and release; proof of current licensure, DEA certificate, and appropriate malpractice insurance; completion of the required Data Bank query; verification that there are no current or prior successful challenges to licensure or registration, that the physician has not been subject to involuntary termination of Medical Staff membership at another facility; and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility.

2. **One-Case Privileges:** Upon receipt of a written request, an appropriately licensed person who is not an applicant for membership may be granted temporary privileges for the care of one (1) patient. Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual patient’s best interest, and no practitioner shall be granted one-case privileges on more than five (5) occasions in any given year. The letter approving such privileges shall include the name of the patient to be treated and the specific privileges granted. Practitioners granted one-case privileges shall attend the patient for whom privileges were granted within thirty (30) days of the request for one-case privileges. If a given practitioner exceeds the five (5) case requirement, such person shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Prior to any award of one-case privileges, the practitioner must submit a copy of current license, DEA certificate, proof of appropriate malpractice insurance, the name of the physician designated to care for the patient in the event the practitioner is unavailable and curriculum vitae and the CEO or his/her designee must obtain telephone verification of the physician’s privileges at his/her primary hospital and query the Data Bank.

3. **Locum Tenens:** Upon receipt of a written request, an appropriately licensed person who is serving as locum tenens for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive consecutive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service as locum tenens within a calendar year. All physicians providing coverage through such locum tenens services must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of locum tenens privileges pursuant to this section. Further, prior to award of locum tenens privileges, the applicant must submit a completed application, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner’s license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner’s primary hospital. The letter approving locum tenens privileges shall identify the specific privileges granted.

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170 MS 06.01.13
Members of the Medical Staff seeking to provide coverage through locum tenens physicians shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.5(b) **Conditions**

Temporary, one-case and locum tenens privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such practitioner be admitted upon dual admission with a member of the Active Staff. Before temporary or locum tenens privileges are granted, the practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

7.5(c) **Termination**

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the Chief of Staff terminate any or all of such practitioner's temporary, one-case or locum tenens privileges. Where the life or well-being of a patient is endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the practitioner's patients then in the hospital shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute practitioner.

7.5(d) **Rights of the Practitioner**

A practitioner shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary, one-case or locum tenens privileges or because of any termination or suspension of such privileges.\(^{171}\)

7.5(e) **Term**

No term of temporary or locum tenens privileges shall exceed a total of one hundred and twenty (120) days.\(^{172}\)

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\(^{171}\) 42 USC 11101  
\(^{172}\) MS 06.01.13
For the purpose of this section, an “emergency” is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger, and delay in administering treatment immediately would add to that danger and no appropriately credentialed individual can be available in the time required to respond. A “disaster” for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available medical staff members is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, or disaster as defined herein, any practitioner, or licensed independent practitioner, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CEO or his/her designee or the Chief of Staff, be permitted to do, and be assisted by hospital personnel in doing everything reasonable and necessary to save the life of a patient or to treat patients as needed.

Disaster privileges may be granted by the CEO or Chief of Staff when, and for so long as, the Hospital’s emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner’s qualifications. The CEO and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis. As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.5(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer’s credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Chief of Staff, or his or her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner’s disaster privileges. In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner’s disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

173 EM 02.02.11; EM 02.02.13; EM 02.02.15
7.7 **TELEMEDICINE**

7.7(a) **Scope of Privileges**

The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.7(b) **Telemedicine Practitioners**

Any practitioner who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the “telemedicine practitioner”), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception is outlined below for those circumstances in which the practitioner’s distant-site entity or distant-site hospital is Joint Commission accredited and the Hospital places in the practitioner’s credentialing file a copy of written documentation confirming such accreditation.

In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telemedicine practitioner’s credentialing information from the distant-site entity or distant-hospital to credential and privilege the telemedicine practitioner ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

1. The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity’s or distant-site hospital’s physicians and practitioners providing telemedicine services;

2. The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;

3. The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation and the Joint Commission Medical Staff (MS) chapter for hospitals or ambulatory care organizations, as applicable;

4. The telemedicine practitioner is privileged at the distant-site entity or distant-site hospital providing the telemedicine services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the telemedicine practitioner’s privileges at the distant-site entity or distant-site hospital;

5. The telemedicine practitioner holds a license issued or recognized by the State of North Carolina; and

6. The Hospital has evidence, or will collect evidence, of an internal review of the telemedicine practitioner’s performance of telemedicine privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the telemedicine practitioner and all complaints the Hospital has received about the telemedicine practitioner) for use in the...
periodic appraisal of the telemedicine practitioner by the distant-site entity or distant-site hospital.

For the purposes of this Section 7.7, the term “distant-site entity” shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare-participating hospital; (3) is Joint Commission accredited; and (4) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of practitioners providing telemedicine services. For the purposes of this Section 7.7, the term “distant-site hospital” shall mean a Medicare-participating and Joint Commission accredited hospital that provides telemedicine services.

If the telemedicine practitioner’s site is also accredited by Joint Commission, and the telemedicine practitioner is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telemedicine practitioner’s credentialing information from that site may be relied upon to credential the telemedicine practitioner in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.
ARTICLE VIII - CORRECTIVE ACTION\textsuperscript{175}

8.1 ROUTINE CORRECTIVE ACTION\textsuperscript{176}

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the Chief of the Department of which the practitioner is a member, by the CEO, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed in the event of corrective action against a physician or dentist with clinical privileges, and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The MEC may also initiate corrective action on its own initiative based on information received from other sources. The MEC shall reference the specific activities or conduct constituting the basis of the action. The Chief of Staff shall promptly notify the CEO or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital’s impaired practitioner policy. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but not limited to:

(1) Rejecting the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation or required consultation;

\textsuperscript{175} 42 USC 11101; MS 10.01.01; MS 01.01.01 EP 28-34

\textsuperscript{176} MS 01.01.01 EP 33
(5) Recommending reduction, suspension or revocation of clinical privileges;

(6) Recommending reduction of staff category or limitation of any staff prerogatives; or

(7) Recommending suspension or revocation of staff membership.

8.1(e) **Procedural Rights**

Any action by the MEC pursuant to Section 8.1(d)(4), (5) (6), or (7) (where such action materially restricts a physician’s exercise of privileges) or any combination of such actions, shall entitle the physician to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

8.1(f) **Other Action**

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3) or (d)(4) (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) **Board Action**

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the practitioner to the procedural rights as specified in the Fair Hearing Plan.

8.2 **SUMMARY SUSPENSION**

8.2(a) **Criteria & Initiation**

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these bylaws or other hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended practitioner's patients still in the hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the Chief of Staff and the CEO in enforcing all suspensions and in caring for the suspended practitioner's patients.

8.2(b) **Medical Executive Committee Action**

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

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177 MS 01.01.01 EP 32
8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the physician's or dentist's clinical privileges, the physician or dentist shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 AUTOMATIC SUSPENSION

8.3(a) License

A staff member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in North Carolina is revoked relinquished, suspended or restricted shall immediately and automatically be suspended from the staff and practicing in the hospital.

8.3(b) Drug Enforcement Administration (DEA) Registration Number

Any practitioner (except a pathologist) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended, relinquished or expired shall immediately and automatically be suspended from the staff and practicing in the Hospital until such time as the registration is reinstated.

8.3(c) Medical Records

(1) Automatic suspension of a practitioner's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Notwithstanding the provision of Section 8.3(c)(1), any staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.3(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

8.3(d) Malpractice Insurance Coverage

Any practitioner or AHP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO.

178 MS 01.01.01 EP 28
8.3(e) **Failure to Appear/Cooperate**

Failure of a practitioner or AHP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner or AHP’s clinical privileges as the MEC may direct.

8.3(f) **Exclusions/Suspension from Medicare**

Any practitioner or AHP who is excluded from the Medicare program or any state government payer program will be automatically suspended.

8.3(g) **Automatic Suspension - Fair Hearing Plan Not Applicable**

No staff member whose privileges are automatically suspended under this Section 8.3, shall have the right of hearing or appeal as provided under Article IX of these bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended practitioner's patients.

8.3(h) **Chief of Staff**

It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Chief of Staff informed of the names of staff members who have been suspended or expelled under Section 8.3.

8.4 **CONFIDENTIALITY**

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these bylaws for peer review and corrective action.

8.5 **PROTECTION FROM LIABILITY**

All members of the Board, the Medical Staff and hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 8.3(c) of these bylaws.

8.6 **SUMMARY SUPERVISION**

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the practitioner’s privileges. Any of the following shall have the right to impose supervision: Chief of Staff, applicable department chairman, the Board and/or CEO.

8.7 **REAPPLICATION AFTER ADVERSE ACTION**

An applicant who has received a final adverse decision pursuant to Section 8.1 or 8.2 which does not include a specific timeframe shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.
8.8 FALSE INFORMATION ON APPLICATION

Any practitioner who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.8 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner, permit the practitioner to appear before it and present information solely as to the issue of whether the practitioner made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.
ARTICLE IX - INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a practitioner, it may in its discretion give the practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a physician requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.179

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the physician’s exercise of clinical privileges, shall give rise to any right to a hearing.180

9.3 ADVERSE ACTION AFFECTING AHPs

Any adverse actions affecting AHPs shall be accomplished in accordance with Section 5.4 of these bylaws.

179 MS 10.01.01; MS 01.01.01 EP 34
180 42 USC 11101

BMC Review 5/18/2016
ARTICLE X - OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

(1) Chief of Staff;
(2) Vice-Chief of Staff;
(3) Immediate Past Chief of Staff.
(4) Chief of Medicine
(5) Chief of Surgery

10.1(b) Qualifications

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

10.1(c) Nominations

(1) The Nominating Committee shall consist of the Chief of Staff, the Past-Chief of Staff of the Medical Staff and the CEO. This committee shall offer one (1) or more nominees for each office (with the exception of the office of Immediate Past Chief of Staff) to the Medical Staff thirty (30) days before the annual meeting.

(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least thirty (30) days before the annual meeting.

10.1(d) Election

Officers shall be elected at the annual meeting of the staff and when otherwise necessary to fill vacancies. Only members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Board of Trustees, which approval may be withheld only for good cause.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or to be disruptive to the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff. Reasons for removal may include, but shall not be limited to violation of these bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer’s Medical Staff membership or clinical privileges and shall not be considered an adverse action.
10.1(f) **Term of Elected Officers**

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(g) **Vacancies in Elected Office**

Vacancies in office, other than Chief of Staff, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.

10.1(h) **Duties of Elected Officers**

(1) **Chief of Staff.** The Chief of Staff shall serve as the principal official of the staff. As such he/she will:

(i) appoint multi-disciplinary Medical Staff committees;\(^{186}\)

(ii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;\(^{187}\)

(iii) in concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;\(^{188}\)

(iv) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and hospital management committees;\(^{189}\)

(v) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;\(^{190}\)

(vi) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;\(^{191}\)

(vii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

(viii) serve as a voting member of the MEC and an ex-officio member of all other staff committees or functions;\(^{192}\)

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\(^{186}\) MS 02.01.01 EP 12
\(^{187}\) MS 01.01.01; LD 01.05.01
\(^{188}\) MS 12.01.01; MS 05.01.01; MS 05.01.03; MS 02.01.01 EP 10
\(^{189}\) MS 02.01.01 EP 12
\(^{190}\) MS 01.01.01
\(^{191}\) MS 01.01.01 EP 5-6
\(^{192}\) MS 01.01.01 EP 20
(ix) assist in coordinating the educational activities of the Medical Staff;¹⁹³

(x) confer with the CEO, CFO, CNO and Department or Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and¹⁹⁴

(xi) assist the Department or Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.¹⁹⁵

(2) **Vice-Chief of Staff**: The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

(3) **Secretary/Treasurer**: The MEC shall designate one of the above members (except the Chief of Staff) to serve as Secretary/Treasurer. The duties of the Secretary/Treasurer shall be to:

(i) give proper notice of all staff meetings on order of the appropriate authority;

(ii) prepare accurate and complete minutes for MEC and Medical Staff meetings;

(iii) assure that an answer is rendered to all official Medical Staff correspondence;

(iv) be responsible for the preparation of financial statements and report status of Medical Staff funds, if any; and

(v) perform such other duties as ordinarily pertain to his/her office.

The Immediate Past Chief of Staff shall be a member of the MEC and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

### 10.1(i) **Conflict of Interest of Medical Staff Leaders**¹⁹⁶

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital’s Board of Trustees) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member’s opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

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¹⁹³ MS 12.01.01
¹⁹⁴ MS 06.01.01 EP 1
¹⁹⁵ MS 08.01.01; MS 08.01.03 EP 2
¹⁹⁶ LD 02.02.01
No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Annually, on or before the annual meeting, each Medical Staff leader shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff leader, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

1. Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to member of the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

4. Business practices that may adversely affect the hospital or community.

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical Staff leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each member’s written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

Medical Staff leaders with a direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly with the Hospital shall not be eligible for service on the Medical Executive Committee, Credentials Committee, Bylaws Committee, Quality Assurance Committee or the Board of Trustees.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these
provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board on majority vote.
ARTICLE XI - CLINICAL DEPARTMENTS & SERVICES

11.1 DEPARTMENTS & SERVICES

11.1(a) There shall be clinical departments of:

   (1) Medicine, including internal medicine, family medicine, general practice, radiology, psychiatry and all subspecialties thereof including outpatient and ambulatory care physicians; and

   (2) Surgery, including general surgery and all subspecialties thereof, pathology, OB/GYN, anesthesia and outpatient services.

11.1(b) Further departmentalization of specialties may be made by unanimous vote of the MEC, subject to the bylaws amendment procedures as described in Article XV of these bylaws.

11.2 DEPARTMENT FUNCTIONS

The primary function of each department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this overall function, each department shall:

11.2(a) Require that patient care evaluations be performed and that appointees exercising privileges within the department be reviewed on an ongoing basis and upon application for reappointment;

11.2(b) Establish guidelines for the granting of clinical privileges within the department and submit the recommendations as required under these bylaws regarding the specific clinical privileges for applicants and reapplicants for clinical privileges;

11.2(c) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

11.2(d) Monitor on an ongoing basis the compliance of its department members with these bylaws, and the rules and regulations, policies, procedures and other standards of the Hospital;

11.2(e) Monitor on an ongoing basis the compliance of its department members with applicable professional standards;

11.2(f) Coordinate the patient care provided by the department’s members with nursing, administrative, and other non-Medical Staff services;

11.2(g) Foster an atmosphere of professional decorum within the department;

11.2(h) Review all deaths occurring in the Department and all unexpected patient care events and report findings to the MEC; and

11.2(i) Submit written reports or minutes of department meetings to the MEC on a regular basis concerning:

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197 MS 01.01.01 EP 12
198 MS 08.01.03; MS 03.01.01
199 MS 06.01.07 EP 2
200 MS 12.01.01
201 MS 01.01.01 EP 6
202 MS 08.01.03; MS 01.01.01 EP 6
203 MS 03.01.03 EP 6
204 PI 01.01.01; PI 02.01.01
Findings of the department’s review and evaluation activities, actions taken thereon, and the results thereof;\(^{205}\)

Recommendations for maintaining and improving the quality of care provided in the department and in the Hospital; and\(^{206}\)

Such other matters as may be requested from time to time by the MEC.\(^{207}\)

11.2(j) Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from department subcommittees regarding all pertinent recommendations and actions by the subcommittees.\(^{208}\)

11.3 SERVICES

In addition to the departments of the Medical Staff, there shall be services within the Medical Staff. The various services within the Medical Staff (e.g., anesthesiology service, radiology service, emergency service, pathology service, etc.) shall not constitute departments as that term is used herein without the express designation by the MEC and the Board of Trustees. Each service shall be headed by a chief selected in the manner and having the authority and responsibilities set forth in these bylaws. The purpose of the services shall be to provide specialized care within the Hospital and to monitor and evaluate the quality of care rendered in the service and to be accountable to the department to which such service is assigned for the discharge of these functions.

11.4 DEPARTMENT CHIEF\(^{209}\)

11.4(a) Each Department shall have a Chief, who shall be approved by the Board after election by the department members and shall be a member of the Active Staff, qualified by training, certification by an appropriate specialty board or equivalent, (as described in Section 3.2(a)(9)), experience and administrative ability for the position. The Department Chief may be removed by affirmative vote of two-thirds (2/3) of the Department members as provided for removal of officers in Section 10.1(e).

11.4(b) The responsibilities of the Department Chief includes:

(1) Accountability to the MEC for all professional and Medical Staff administrative activities within the department;\(^{210}\)

(2) Continuing review of the professional performance qualifications and competence of the Medical Staff members and AHPs who exercises privileges in the department;\(^{211}\)

(3) Assuring that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the departments is carried out;\(^{212}\)

(4) Assuring the participation of department members in department orientation, continuing education programs and required meetings;\(^{213}\)

\(^{205}\)MS 02.01.01 EP 12
\(^{206}\)MS 02.01.01 EP 12
\(^{207}\)MS 02.01.01 EP 12
\(^{208}\)MS 08.01.03 EP 2
\(^{209}\)MS 01.01.01 EP 36
\(^{210}\)MS 01.01.01 EP 36
\(^{211}\)MS 01.01.01 EP 36
\(^{212}\)MS 01.01.01 EP 36; 42 CFR 482.21
\(^{213}\)MS 01.01.01 EP 36
(5) Assuring participation in risk management activities related to the clinical aspects of patient care and safety;\(^{214}\)

(6) Assuring that required PSCQ and quality control functions including surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and therapeutics, risk management, safety, infection control and utilization review, are performed within the department, and that findings from such activities are properly integrated with the primary functions of the department level;\(^{215}\)

(7) Recommending criteria for clinical privileges and specific clinical privileges for each member of the department;\(^{216}\)

(8) Implementing within the Department any actions or programs designated by the MEC;\(^{217}\)

(9) Assisting in the preparation of reports as may be required by the MEC, the CEO or the Board;\(^{218}\)

(10) Developing, implementing and enforcing the Medical Staff Bylaws, Rules & Regulations, and policies and procedures that guide and support the provision of services;\(^{219}\)

(11) Participating in every phase of administration with other departments or services, in cooperation with nursing, hospital administration and the Board;\(^{220}\)

(12) Assessing and recommending to the CEO any off-site sources for needed patient care services not provided by the department or organization;\(^{221}\)

(13) Making recommendations for a sufficient number of qualified and competent persons to provide care or services within the department and\(^{222}\)

(14) Integration of the department into the primary functions of the organization and coordination and integration of inter- and intradepartmental services;

(15) Determination of the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment and services; and

(16) Recommending space and other resources needed by the department or service.

11.4(c) Department Chiefs shall be elected biennially and serve for a term of two (2) year.

\(^{214}\) MS 01.01.01 EP 36  
\(^{215}\) MS 01.01.01 EP 36; 42 CFR 482.21  
\(^{216}\) MS 01.01.01 EP 36  
\(^{217}\) MS 01.01.01 EP 36  
\(^{218}\) MS 02.01.01 EP 12  
\(^{219}\) MS 01.01.01 EP 6  
\(^{220}\) MS 01.01.01 EP 36  
\(^{221}\) MS 01.01.01 EP 36  
\(^{222}\) MS 01.01.01 EP 36
11.5 **ORGANIZATION OF DEPARTMENT**

11.5(a) All organized departments shall have written rules and regulations which govern the activity of the department. These rules and regulations shall be approved by the Governing Board. The exercise of clinical privileges within any department is subject to the department rules and regulations and to the authority of the Department Chief.  

11.5(b) Each Department shall meet separately but such meetings shall not release the members from their obligations to attend the general meetings of the Medical Staff as provided in Article XIII of these bylaws. Additionally, each department shall meet a minimum of 6 times per year to present educational programs and conduct clinical review of practice within their department. Written minutes must be maintained and furnished to the MEC.

11.5(c) Each staff member, at the beginning of each year, shall designate his/her primary department and he/she may only vote for the Chief of that Department. The practitioner’s designation of department shall be approved by the MEC and shall be the department in which the practitioner’s practice is concentrated. Should the practitioner exercise privileges relevant to the care in more than one (1) department, each department shall make a recommendation to the MEC regarding the granting of such privileges.

11.6 **SERVICE CHAIR**

11.6(a) Chairs of Service shall be selected by the Board in consultation with the Chief of Staff and the general medical staff. Chairs of Service may be removed by affirmative vote of two thirds (2/3) of the Board for those reasons described in these Bylaws with respect to removal of Medical Staff officers. The Chair of each service shall have the following duties with respect to his/her service:

(1) Account to the appropriate department Chief and to the MEC for all professional activities within the service;

(2) Develop and implement service programs in cooperation with the department Chief;

(3) Maintain continuing review of the professional performance of all Medical Staff and AHP Staff appointees having clinical privileges in the service and report regularly thereon to the department Chief;

(4) Implement within his/her service any actions or programs designated by the MEC;

(5) Participate in every phase of administration of his/her service in cooperation with the department Chief, the nursing service, other departments, administration and the Board;

(6) Assist in the preparation of such annual reports regarding the service as may be required by the MEC, the CEO or the Board of Trustees;

(7) As applicable, establish a system for adequate professional coverage within the service, including an on-call system, which systems shall be fair and non-discriminatory; and

(8) Perform such other duties as may reasonably be requested by the Chief of Staff, the MEC, the Department Chief or the Board of Trustees.

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223 MS 01.01.01 EP 1
224 MS 12.01.01; MS 01.01.01 EP 12
225 MS 03.01.01; MS 02.01.01 EP 12
226 MS 03.01.01; MS 08.01.03; MS 09.01.01
227 MS 02.01.01 EP 12
228 42 CFR 489.20(r)(2)
ARTICLE XII - COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.²²⁹

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.²³⁰

12.1(c) All information pertaining to activities performed by the Medical Staff and its committees and departments shall be privileged and confidential to the full extent provided by law.²³¹

12.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.²³²

12.2 MEDICAL EXECUTIVE COMMITTEE²³³

12.2(a) Composition²³⁴

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson;
(2) The Vice Chief of Staff;
(3) The Immediate Past Chief of Staff;
(4) Chief of Medicine;
(5) Chief of Surgery;
(6) Medical Management Committee Chair;
(7) Credentialing Committee Chair;
(8) Medical Operations Committee Chair- Harris;
(9) Medical Operations Committee Chair- Swain; and
(10) The CEO, ex-officio, or his/her designee.

12.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of department leadership are delegated to the MEC, it shall represent to the Board the organized medical staff’s views on issues of patient safety and quality of care. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 12.2(b) and additional functions may be delegated or removed through amendment of this Section 12.2(b). The functions and responsibilities of the MEC shall include, at least the following:²³⁵

²²⁹ MS 02.01.01 EP 12; MS 01.01.01 EP 12
²³⁰ MS 02.01.01 EP 12; MS 01.01.01 EP 12
²³¹ Refer to State Peer Review Statute
²³² MS 02.01.01 EP 2
²³³ 42 CFR 482.22(b); MS 01.01.01; MS 02.01.01
²³⁴ MS 01.01.01 EP 20
²³⁵ MS 01.01.01 EP 20-23; MS 02.01.01
(1) Receiving and acting upon department and committee reports;\(^{(1)}\)

(2) Implementing the approved policies of the Medical Staff;\(^{(2)}\)

(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action;\(^{(3)}\)

(4) Fulfilling the Medical Staff’s accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital;\(^{(4)}\)

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;\(^{(5)}\)

(6) Assuring regular reporting of PSCQ and other staff issues to the MEC and to the Board of Trustees and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate staff members;\(^{(6)}\)

(7) Assuring an annual evaluation of the effectiveness of the Hospital’s PSCQ program is conducted;\(^{(7)}\)

(8) Developing and monitoring compliance with these bylaws, the rules and regulations, policies and other Hospital standards;\(^{(8)}\)

(9) Recommending action to the CEO on matters of a medico-administrative nature;\(^{(9)}\)

(10) Developing and implementing programs to inform the staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;\(^{(10)}\)

(11) Requesting evaluation of practitioners in instances where there is doubt about an applicant’s ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that an practitioner to the Medical Staff may not be complying with the bylaws, may be rendering care below the standards established for practitioners to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards; \(^{(11)}\)

(12) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated;\(^{(12)}\)

(13) Developing and implementing programs for continuing medical education for the Medical Staff;

(14) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

\(^{236}\) MS 02.01.01 EP 12
\(^{237}\) MS 02.01.01; MS 01.01.01 EP 6
\(^{238}\) MS 02.01.01 EP 8
\(^{239}\) MS 02.01.01; MS 01.01.01
\(^{240}\) MS 02.01.01 EP 6
\(^{241}\) MS 02.01.01 EP 12; MS 05.01.01; MS 05.01.03
\(^{242}\) MS 05.01.01; MS 05.01.03
\(^{243}\) MS 01.01.01 EP 5-6
\(^{244}\) MS 02.01.01; MS 01.01.01 EP 20
\(^{245}\) MS 11.01.01
\(^{246}\) MS 09.01.01
\(^{247}\) MS 01.01.01 EP 26; MS 10.01.01; MS 06.01.07 EP2
(15) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Hospital; and

(16) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(17) Approving the charters of all Medical Staff and clinical hospital committees.

12.2(c) **Meetings**

The MEC shall meet as needed, but at least ten times annually and maintain a permanent record of its proceedings and actions.\(^{248}\)

12.2(d) **Special Meeting of the Medical Executive Committee**

A special meeting of the MEC may be called by the Chief of the Medical Staff, when a majority of the MEC can be convened.\(^{249}\)

12.2(e) **Removal of MEC Members**

All members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions. Officers of the Medical Staff who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e). Department Chiefs who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 11.4(a).

12.3 **MEDICAL STAFF FUNCTIONS**

12.3(a) **Composition of Committees**

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.\(^{250}\)

12.3(b) **Functions**

The functions of the staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;\(^{251}\)

(2) Conduct or coordinate appropriate PSCQ reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record, core measures and other appropriate reviews;\(^{252}\)

(3) Conduct or coordinate utilization review activities;\(^{253}\)

\(^{248}\) MS 02.01.01

\(^{249}\) MS 02.01.01

\(^{250}\) MS 02.01.01; MS 01.01.01 EP 12

\(^{251}\) MS 03.01.01; MS 05.01.01; MS 05.01.03

\(^{252}\) MS 05.01.01; MS 05.01.03

\(^{253}\) MS 05.01.01; MS 05.01.03
(4) Assist the Hospital in providing continuing education opportunities responsive to PSCQ activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital’s professional library services;254

(5) Develop and maintain surveillance over drug utilization policies and practices;255

(6) Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other hospital patient care and administrative services;256

(7) Ensure that when the findings of assessment processes are relevant to an individual’s performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner’s competence;257

(8) Investigate and control nosocomial infections and monitor the Hospital’s infection control program;258

(9) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;259

(10) Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;260

(11) Provide as part of the Hospital and Medical Staff’s obligation to protect patients and others in the organization from harm, the Medical Staff has adopted an Impaired Practitioner Policy;261

(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:

  (i) medical assessment and treatment of patients;

  (ii) use of medications, use of blood and blood components;

  (iii) use of operative and other procedure(s);

  (iv) efficiency of clinical practice patterns; and

  (v) significant departure from established patterns of clinical practice.262

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

  (i) education of patients and families;

254 MS 12.01.01
255 MM 01.01.01 et seq.; MS 01.01.01 EP 6
256 42 CFR 482.13(b); MS 03.01.03
257 MS 08.01.03
258 42 CFR 482.42; IC 01.01.01 et seq.
259 EC 01.01.01 et seq.
260 MS 01.01.01
261 MS 11.01.01
262 MS 05.01.01 EP 2 and 4-8
(ii) coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care of an individual patient;

(iii) accurate, timely and legible completion of patients’ medical records including history and physicals;

(iv) Patient satisfaction;

(v) Sentinel events; and

(vi) Patient safety. 263

(14) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner’s performance and evaluation of a practitioner’s performance by peers. 264

(15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis; 265

(16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges; 266

(17) Review, on a periodic basis, professional practice evaluations and applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments; 267

(18) Investigate any breach of ethics that is reported to it; 268

(19) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and 269

(20) To prepare and recommend a slate of nominees for the officers of the Medical Staff. 270

12.3(c) Meetings

These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

263 MS 05.01.01 EP 10-11
264 MS 08.01.01; LD 01.05.01
265 MS 01.01.01 EP 2
266 MS 06.01.07; MS 08.01.03; MS 06.01.03; LD 01.05.01
267 MS 08.01.03; LD 01.05.01
268 MS 09.01.01
269 MS 01.01.01 EP 34
270 MS 01.01.01 EP 18
The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two members of the Organized Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two non-physician Board members who are selected by the Board Chair, and the CEO. The CNO shall serve as a non-voting, ex-officio member of the Committee whose presence or absence will not be considered in determining a quorum. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.
ARTICLE XIII - MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

The annual Medical Staff meeting shall be held at a date, time and place determined by the MEC.

13.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

1. Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;
2. Administrative reports from the CEO or his/her designee, the Chief of Staff and appropriate Department Chief;
3. The election of officers and other officials of the Medical Staff when required by these bylaws;
4. Recommendations for maintenance and improvement of patient care; and
5. Other old or new business.

13.2 REGULAR STAFF MEETINGS

13.2(a) Meeting Frequency & Time

The Medical Staff shall meet at least 6 times per year272. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.2(b) Order of Business & Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff.

13.2(c) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by the Chief of Staff or CEO and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally, by e-mail or by mail, to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

272 For example, monthly, quarterly, etc.
13.4 **QUORUM**

13.4(a) **General Staff Meeting**

The voting members of the Active Staff who are present at any staff meeting shall constitute a quorum for the transaction of all business at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

13.4(b) **Committee Meetings**

The members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee; except that the MEC shall require fifty (50%) percent of members to constitute a quorum.

13.5 **MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

13.6 **MINUTES**

Minutes of all meetings shall be prepared by the Secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

Complete and detailed minutes must be recorded and maintained.

13.7 **ATTENDANCE**

13.7(a) **Regular Attendance**

Members of the Active Staff shall be required to attend 50% of regular Medical Staff meetings. Failure to comply with this requirement without an acceptable excuse will result in loss of Medical Staff voting privileges. Members of the Active Staff shall also be required to attend 50% of their applicable department and committee meetings. Failure to comply with this requirement without an acceptable excuse will result in loss of voting privileges with regard to such department and/or committee matters. The MEC shall be the final arbiter with regard failure to meet the requirements described herein.

13.7(b) **Absence from Meetings**

Any member who is compelled to be absent from any Medical Staff, departmental or committee meeting shall promptly provide, in writing to the regular presiding officer thereof, the reason for such absence.

13.7(c) **Special Appearance; Cooperation with Medical Executive Committee**

Any committee or department of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee or department is questioning the practitioner’s clinical course of treatment. Such special appearance requirement shall not be considered an adverse
action and shall not constitute a hearing under these bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner’s appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice shall and/or failure to comply with any reasonable directive of the MEC, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner’s clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.274
ARTICLE XIV - GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS AND POLICIES

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.  

14.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

14.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

14.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board’s final authority as to such issues.

275 42 CFR 482.22; MS 01.01.01 EP 1 and 8-11
14.1(d) **Final Authority of the Board**

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

14.2 **PROFESSIONAL LIABILITY INSURANCE**

Each practitioner or Allied Health Professional granted clinical privileges in the hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the hospital, and shall be on an occurrence basis or, if on a claims made basis, the practitioner shall agree to obtain tail coverage covering his/her practice at the hospital. Each practitioner shall also inform the MEC and CEO of the details of such coverage annually in December. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.276

14.3 **CONSTRUCTION OF TERMS & HEADINGS**

Words used in these bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these bylaws.

14.4 **CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES**

14.4(a) **Reports to be Confidential**

Information with respect to any practitioner, including applicants, staff members or AHPs, submitted, collected or prepared by any representative of the hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.277

14.4(b) **Release from Liability**

No representative of the hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the hospital, provided such disclosure or representation is in good faith and without malice.278

14.4(c) **Action in Good Faith**

The representatives of the hospital, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative’s duties, if such representative acts

276 This language is strongly recommended for legal and risk management purposes
277 Refer to State Peer Review Statute
278 This language is strongly recommended for legal and risk management purposes
in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.\textsuperscript{279}

\textsuperscript{279} 42 USC 11101 et seq.; Refer to State Peer Review Statute
ARTICLE XV - ADOPTION & AMENDMENT OF BYLAWS\textsuperscript{280}

15.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

15.2 ADOPTION, AMENDMENT & REVIEWS

The bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a two-thirds of the Medical Staff members eligible to vote, who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

15.2(b) Board

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.\textsuperscript{281}

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these bylaws approved as set forth herein shall be documented by either:

15.3(a) Appending to these bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved by corporate legal counsel as to form; or

15.3(b) Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

Each member of the Medical Staff shall be given a copy of any amendments to these bylaws in a timely manner.

\textsuperscript{280} MS 01.01.01; MS 01.01.03

\textsuperscript{281} 42 CFR 482.12
MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: ____________________________________________  __________________________
    Chief of Staff                                    Date

BOARD OF TRUSTEES:

By: ____________________________________________  __________________________
    Chairperson                                    Date

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals:

By: ____________________________________________  __________________________
    Chief Executive Officer                        Date

APPROVED AS TO FORM:

By: ____________________________________________  __________________________
    Legal Counsel for DLP Harris Regional Hospital, LLC and DLP Swain Community Hospital, LLC
    Date

APPROVED:

By: ____________________________________________  __________________________
    Division President                            Date
APPENDIX “A” – FAIR HEARING PLAN

This Fair Hearing Plan is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the Fair Hearing Plan and proceedings hereunder.

DEFINITIONS

The following definitions, in addition to those stated in the Medical Staff Bylaws or herein, shall apply to the provisions of this Fair Hearing Plan.

1. "Appellate Review Body" means the group designated pursuant to this Plan to hear a request for Appellate Review that has been properly filed and pursued by the practitioner.

2. "Corporation" shall mean DLP Harris Regional Hospital, LLC and DLP Swain Community Hospital, LLC.

3. "Hearing Committee" means the committee appointed pursuant to this Plan to hear a request for an evidentiary hearing that has been properly filed and pursued by a practitioner.

4. "Parties" means the practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.

5. "Special Notice" means written notification sent by certified or registered mail, return receipt requested, or delivered by hand with a written acknowledgment of receipt.
ARTICLE I - INITIATION OF HEARING

1.1 **RECOMMENDATION OR ACTIONS**

The following recommendations or actions shall, if deemed adverse pursuant to Article I, Section 1.2 of this Fair Hearing Plan, entitle the practitioner affected thereby to a hearing:

(1) Denial of initial staff appointment;
(2) Denial of reappointment;
(3) Suspension of staff membership;
(4) Revocation of staff membership;
(5) Denial of requested advancement of staff category, if such denial materially limits the physician’s exercise of privileges.
(6) Reduction of staff category due to an adverse determination as to a practitioner’s competence or professional conduct;
(7) Limitation of the right to admit patients;
(8) Denial of an initial request for particular clinical privileges;
(9) Reduction of clinical privileges;
(10) Permanent suspension of clinical privileges;
(11) Revocation of clinical privileges;
(12) Terms of probation, if such terms of probation materially restrict the physician's exercise of privileges; and
(13) Summary suspension of privileges or staff membership for a period in excess of thirty (30) days.

1.2 **WHEN DEEMED ADVERSE**

A recommendation or action listed in Article I, Section 1.1 of this Plan shall be deemed adverse only if it is based upon competence or professional conduct, is practitioner-specific and has been:

(1) Recommended by the MEC; or
(2) Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or
(3) Taken by the Board on its own initiative without prior recommendation by the MEC.

1.3 **NOTICE OF ADVERSE RECOMMENDATION OR ACTION**

A practitioner against whom an adverse recommendation or action has been taken pursuant to Article I, Section 1.1 of this Plan shall promptly be given special notice of such action. Such notice shall:

(1) Advise the practitioner of the basis for the action and his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws of this Plan;
(2) Specify that the practitioner has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;

(3) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter;

(4) State that upon receipt of this hearing request, the practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action;

(5) Provide a summary of the practitioner's rights at the hearing; and

(6) Inform the practitioner if the recommended action may be reportable to the National Practitioner Data Bank and appropriate licensing agencies.

1.4 REQUEST FOR HEARING

A practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Article I, Section 1.3 to file a written request for a hearing. Such request shall be delivered to the CEO either in person or by certified or registered mail.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

A practitioner who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any Appellate Review to which he/she might otherwise have been entitled. Such waiver in connection with:

(1) An adverse recommendation or action by the Board, CEO or their designees, shall constitute acceptance of that recommendation or action. (hereinafter, references to decisions by these entities or individuals shall be designated as decisions or actions of the Board); and

(2) An adverse recommendation by the MEC or its designee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the MEC's recommendation at its next regular meeting following the waiver. In its deliberations, the Board shall review all relevant information and material considered by the MEC and may consider all other relevant information received from any source. The Board's action on the matter shall constitute a final decision of the Board. The CEO shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Article I, Section 1.5(2) and shall notify the Chief of Staff and the MEC of each such action.
ARTICLE II - HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

Upon receipt of a timely request for hearing, the CEO shall deliver such request to the Chief of Staff or to the Board, depending on whose recommendation or action prompted the request for hearing. The CEO shall send the practitioner special notice of the time, place and date of the hearing. The hearing date shall not be less than thirty (30) nor more than ninety (90) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect shall, at the practitioner's request, be held as soon as arrangements for it reasonably may be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

2.2 STATEMENT OF ISSUES & EVENTS

The notice of hearing required by Article II, Section 2.1 shall contain a concise statement of the practitioner's alleged act or omissions, and a list by number of specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. The notice shall further contain a list of witnesses expected to testify in support of the adverse recommendation or action.

2.3 PRACTITIONER'S RESPONSE

Within ten (10) days of receipt of the notice of hearing under Section 2.2, the affected practitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the due process hearing.

2.4 EXAMINATION OF DOCUMENTS

The practitioner may request that he/she be allowed to examine any documents to be introduced in support of the adverse recommendation. If the practitioner so requests, the body initiating the adverse action shall also be entitled to examine all documents expected to be produced by the practitioner at the hearing. The parties shall exchange such documents at a mutually agreeable time at least ten (10) days prior to the hearing. Copies of any patient charts, which form the basis for the adverse action shall be made available to the practitioner, at his/her expense, within a reasonable time after a request is made for same.

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

A hearing occasioned by an adverse MEC recommendation pursuant to Article I, Section 1.2(1) shall be conducted by a Hearing Committee appointed by the Chief of Staff and composed of three (3) members of the Medical Staff. None of the Hearing Committee members shall be partners, associates, relatives or in direct economic competition with the affected individual. Should the Chief of Staff find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize practitioners outside the staff, he/she may, upon approval by the CEO, appoint an independent panel of three (3) practitioners meeting all requirements of this section with the exception of Medical Staff membership.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee members which the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the Chief of Staff shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, a replacement shall be appointed within seven (7) days of the
determination. The Chief of Staff shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(b) **By Board**

A hearing occasioned by an adverse action of the Board pursuant to Article I, Section 1.2(2) or 1.2(3) shall be conducted by a Hearing Committee appointed by the Chairperson of the Board and composed of three (3) people. At least one (1) Active Medical Staff member shall be included on this committee. Should the Board Chairperson find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize a practitioner outside the staff, he/she may, upon approval by the CEO, appoint a practitioner meeting all requirements of this section with the exception of Active Medical Staff membership. One (1) of the appointees to the committee shall be designated as Chairperson. If the matter concerns or arises from issues regarding a practitioner’s clinical competence or performance, the Hearing Committee must be composed of three (3) physicians who may or may not be members of the Hospital’s Medical Staff.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the Board Chairman shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, a replacement shall be appointed within seven (7) days of the determination. The Board Chairman shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(c) **Service on Hearing Committee**

A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee solely because he/she has participated in investigating the action or matter at issue.
ARTICLE III - HEARING PROCEDURE

3.1 PERSONAL PRESENCE

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Article I, Section 1.5.

3.2 PRESIDING OFFICER

Either the Hearing Officer, if one is appointed pursuant to Article VIII, Section 8.1, or the Chairperson of the Hearing Committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.

3.3 REPRESENTATION

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of the Medical Staff in good standing, a member of his/her local professional society, or other individual of the physician's choice. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine the witnesses. Representation of either party by an attorney at law shall be governed by the provisions of Article VIII, Section 8.2 of this Plan.

3.4 RIGHTS OF THE PARTIES

During a hearing, each of the parties shall have the right to:

(1) Call and examine witnesses;

(2) Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

(3) Cross-examine any witness on any matter relevant to the issues;

(4) Impeach any witness;

(5) Rebut any evidence;

(6) Have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and

(7) Submit a written statement at the close of the hearing.

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

3.5 PROCEDURE & EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence although these rules may be considered in determining the weight of the evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall
become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents in the state where the hearing is held.

3.6 **OFFICIAL NOTICE**

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical, medical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. Any party shall be given opportunity on timely motion, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

3.7 **BURDEN OF PROOF**

(1) When a hearing relates to the matters listed in Article I, Sections 1.1(1), 1.1(5) or 1.1(8), the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory.

(2) For the other matters listed in Article I, Section 1.1, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

3.8 **RECORD OF HEARING**

A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that later may be called upon to review the record and render a recommendation or decision in the matter. The method of recording the hearing shall be by use of a court reporter.

3.9 **POSTPONEMENT**

Request for postponement of a hearing shall be granted by agreement between the parties or the Hearing Committee only upon a showing of good cause and only if the request therefore is made as soon as is reasonably practical.

3.10 **PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING**

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from a substantial portion of the proceedings, he/she shall not be permitted to participate in the deliberations of the decision.

3.11 **RECESSES & ADJOURNMENT**

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence for consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties and without a record of the deliberation being made. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

July, 2014
ARTICLE IV - HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

Within fourteen (14) days after the transcript of the proceedings has been delivered to the proper officer of the hearing, or if no transcript is ordered, then thirty (30) days after the hearing ends, the Hearing Committee shall make a written report of its findings and recommendations in the matter. The Hearing Committee shall forward the same, together with the hearing record and all other documentation considered by it, to the Board or the MEC, for action consistent with Section 4.2 below. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it. Recommendations must be made by a majority vote of the members and the committee may only consider the specific recommendations or actions of the Board or MEC. The practitioner who requested the hearing shall be entitled to receive the written recommendations of the Hearing Committee, including a statement of the basis for the recommendation.

4.2 ACTION ON HEARING COMMITTEE REPORT

If the MEC initiated the action, and the Hearing Committee's report alters, amends or modifies the MEC's recommendation, the MEC shall take action on the Hearing Committee report no later than twenty-eight (28) days after receipt of same, and prior to any appeal by the practitioner. If the MEC initiated the action and the Hearing Committee has not altered, amended or modified the MEC recommendation, or if the Board initiated the action and the action remains adverse to the practitioner, the practitioner shall be given notice of the right to appeal pursuant to Section 4.3(c) prior to final action by the Board. If the Board initiated the action, and the Hearing Committee recommendation is favorable to the practitioner, the Board shall take action on the Hearing Committee’s report no later than twenty-eight (28) days from receipt of same.

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

The CEO shall promptly send a copy of the result to the practitioner by special notice, including a statement of the basis for the decision.

4.3(b) Effect of Favorable Result

(1) Adopted by the Board: If the Board's result is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered finally closed.

(2) Adopted by the Medical Executive Committee: If the MEC's result is favorable to the practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the matter back to the MEC for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, and consultation with the Corporation as necessary, the Board shall take final action. The CEO shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Article IV, Section 4.3(b)(2). Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed.
4.3(c) **Effect of Adverse Result**

At the conclusion of the process set forth in Section 4.2, if the result continues to be adverse to the practitioner in any of the respects listed in Article I, Section 1.1 of this Plan, the practitioner shall be informed, by special notice of his/her right to request an Appellate Review as provided in Article V, Section 5.1 of this Plan. Said notice shall be delivered to the practitioner no later than fourteen (14) days from the MEC action, or Hearing Committee report, as appropriate under Section 4.2.
ARTICLE V - INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

A practitioner shall have fourteen (14) days following his/her receipt of a notice pursuant to Article IV, Section 4.3(c) to file a written request for an Appellate Review. Such request shall be delivered to the CEO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in reaching the adverse result.

5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A practitioner who fails to request an Appellate Review within the time and manner specified in Article V, Section 5.1 shall be deemed to have waived any right to such review.

Such waiver shall have the same force and effect as that provided in Article I, Section 1.5 of this Plan.

5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for Appellate Review, the CEO shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an Appellate Review which shall be not less than twenty-one (21) days from the date of receipt of the Appellate Review request; provided, however, that an Appellate Review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than twenty-one (21) days from the date of receipt of the request for review. At least ten (10) days prior to the Appellate Review, the CEO shall send the practitioner special notice of the time, place and date of the review. The time for the Appellate Review may be extended by the Appellate Review Body for good cause and if the request therefore is made as soon as reasonably practical.

5.4 APPELLATE REVIEW BODY

The Appellate Review Body shall be composed of the Board of Trustees or a committee of at least three (3) members of the Board of Trustees. One (1) of its members shall be designated as the Chairperson of the committee.
ARTICLE VI - APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

The proceedings of the Appellate Review Body shall be in the nature of an Appellate Review based upon the record of the hearing before the Hearing Committee, and the committee's report, and all subsequent results and actions thereon. The Appellate Review Body also shall consider the written statements, if any, submitted pursuant to Article VI, Section 6.2 of this Plan and such other material as may be presented and accepted under Article VI, Sections 6.4 and 6.5 of this Plan. The Appellate Review Body shall apply the standards of proof set forth in Article III, Section 3.7.

6.2 WRITTEN STATEMENTS

The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, but may not raise new factual matters not presented at the hearing. The statement shall be submitted to the Appellate Review Body through the CEO at least seven (7) days prior to the scheduled date of the Appellate Review, except if such time limit is waived by the Appellate Body. A written statement in reply may be submitted by the MEC or by the Board, and if submitted, the CEO shall provide a copy thereof to the practitioner at least three (3) days prior to the scheduled date of the Appellate Review.

6.3 PRESIDING OFFICER

The Chairperson of the Appellate Review Body shall be the Presiding Officer. He/She shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4 ORAL STATEMENT

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements supporting their positions. If the Appellate Review Body allows one of the parties to make an oral statement, the other party shall be allowed to do so. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, and not otherwise reflected in the record shall not be introduced at the Appellate Review, except by leave of the Appellate Review Body. The Appellate Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted, following establishment of good cause by the party requesting the consideration of such matter or evidence as to why it was not presented earlier. If such additional evidence is considered, it shall be subject to cross examination and rebuttal.

6.6 PRESENCE OF MEMBERS & VOTING

A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member of the Appellate Review Body is absent from a substantial portion of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of consultation. Upon the conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Body shall thereupon,
at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 **ACTIONS TAKEN**

The Appellate Review Body may affirm, modify or reverse the adverse result or action taken by the MEC or by the Board pursuant to Article IV, Section 4.2 or Section 4.3(b)(2) or, in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within fourteen (14) days and in accordance with its instructions. Within seven (7) days after such receipt of such recommendations after referral, the Appellate Review Body shall make its final determination.

6.9 **CONCLUSION**

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.
ARTICLE VII - FINAL DECISION OF THE BOARD

7.1 No later than twenty-eight (28) days after receipt of the recommendation of the Appellate Review Body, or twenty-eight (28) days after waiver of Appellate Review, the Board shall consider the same and affirm, modify or reverse the recommendation. When a matter of hospital policy or potential liability is presented, the Board shall consult with Corporation prior to taking action. The decision made by the full Board after receipt of the written recommendation from the Appellate Review Body will be deemed final, subject to no further appeal under the provisions of this Fair Hearing Plan. The action of the Board will be promptly communicated to the practitioner in writing by certified mail.
ARTICLE VIII - GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

The use of a Hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Board. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/She shall act as the Presiding Officer of the hearing and participate in the deliberations.

8.2 ATTORNEYS

If the affected practitioner desires to be represented by an attorney at any hearing or any Appellate Review appearance pursuant to Article VI, Section 6.4, his/her initial request for the hearing should state his/her wish to be so represented at either or both such proceedings in the event they are held. The MEC or the Board may also be represented by an attorney.

8.3 NUMBER OF HEARINGS & REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no practitioner shall be entitled as of right to more than one (1) evidentiary hearing and Appellate Review with respect to an adverse recommendation or action.

8.4 RELEASE

By requesting a hearing or Appellate Review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability in all matters relating thereto.

8.5 WAIVER

If any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request of appearance or otherwise fails to comply with this Fair Hearing Plan or to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.
FAIR HEARING PLAN
ADOPTED & APPROVED:

MEDICAL STAFF:

By: ____________________________________________  ______________________________
    Chief of Staff                          Date

BOARD OF TRUSTEES:

By: ____________________________________________  ______________________________
    Chairperson                          Date

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals:

By: ____________________________________________  ______________________________
    Chief Executive Officer                Date

APPROVED AS TO FORM:

By: ____________________________________________  ______________________________
    Legal Counsel for DLP Harris Regional Hospital, LLC and DLP Swain Community Hospital, LLC Date

APPROVED:

By: ____________________________________________  ______________________________
    Division President                Date
APPENDIX “B” – RULES & REGULATIONS

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

ARTICLE I - ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

1.1(a) Excluding emergencies, all patients admitted to the hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

1.1(b) A patient may be admitted to the hospital by an attending member of the Medical Staff or his/her designated alternate. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership.

1.1(c) Physicians or his/her designated alternate who are admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self-harm.

1.1(e) The management and coordination of each patient’s care, treatment and services shall be the responsibility of a physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient to any referring practitioner and to relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician’s responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

1.1(f) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician or his/her designated alternate, the following should be contacted, in order of priority listed below:

(1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);

(2) The Chief of Staff, who may assume care for the patient or designate any appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.
1.2  ADMITTING POLICY

Priorities for admission are as follows:

1.2(a)  Emergency Admissions

Within twenty-four (24) hours following all admissions, the Attending Physician or his/her designated alternate shall have a history and physical dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b)  Preoperative Admissions

This includes all patients scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgery may decide the urgency of any specific admission.

1.2(c)  Routine Admissions

This will include elective admissions involving all services.

1.3  PATIENT TRANSFERS

1.3(a)  Transfer priorities shall be as follows:

(1) Emergency Department to appropriate patient bed;
(2) From any department to ICU in an emergency;
(3) From ICU in an emergency;
(4) From any department to Skilled Nursing Facility;
(5) From obstetric patient care area (unit) to general care area when medically indicated; and
(6) From temporary placement in an inappropriate area to the appropriate area for that patient.

1.3(b)  No patients will be transferred between departments without notification to the Attending Physician or his/her designated alternate.

1.3(c)  If the intensive care unit is full and a patient requires ICU care; all practitioners attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Chief of Staff may consult any appropriate specialist in making this determination, and shall make the decision.

1.4  SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staff, and the hospital, the care of the potentially suicidal patient shall be as follows:

1.4(a)  A patient suspected to be suicidal in intent shall be admitted to a security room consistent with the patients’ medical needs. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate
restraints may be used as permitted by these Rules & Regulations or hospital policy. The patient will be afforded psychiatric consultation;

1.4(b) Care Coordination should be consulted for assistance; and

1.4(c) If the patient presents to the emergency room, the steps set forth in Section 1.4(a) shall be followed, except that the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the hospital’s EMTALA policy, that the benefits of transfer outweigh the risks.

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

1.5(a) Patients shall be discharged only on order of the Attending Physician or his/her designated alternate. Should a patient leave the hospital against the advice of the Attending Physician or his/her designated alternate or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician or his/her designated alternate. The discharge process and corresponding documentation shall provide for continuing care based on the patient’s assessed needs at the time of discharge.

1.5(b) If any questions as to the validity of admission to or discharge from the facility should arise, the subject shall be referred to the Utilization Review Committee Physician Advisor for assistance.

1.5(c) The Attending Physician or his/her designated alternate is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee, the Attending Physician or his/her designated alternate must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

1.5(d) The Attending Physician or his/her designated alternate shall keep the patient and the patient’s family informed concerning the patient’s condition throughout the patient’s term of treatment. The Attending Physician or his/her designated alternate and hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:

(1) Conditions that may result in the patient’s transfer to another facility or level of care;

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

(4) The anticipated need for continued care following discharge;
(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient’s needs, which are arranged by or assisted by the hospital; and

(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.6 **DECEASED PATIENT**

In the event of a patient death the deceased shall be pronounced dead by the Attending Physician, another member of the Medical Staff, the Emergency Department Physician or the medical examiner, as appropriate. Such pronouncement shall be documented in the patient’s medical record.

1.7 **AUTOPSIES**

Autopsies shall be secured by the Attending Physician or his/her designated alternate as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner. If an autopsy is indicated, the Attending Physician or his/her designated alternate should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law.

1.8 **UNANTICIPATED OUTCOMES**

In the event of an unanticipated outcome or adverse event, the patients’ treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital’s Policy on Disclosure of Unanticipated Patient Outcomes.

1.9 **CONSULTATIONS**

a. **Indications**
   - Specialist available whose expertise offers a reasonable hope of improving outcome of hospitalization and/or long term health
   - Assistance in making or confirming diagnosis
   - Assistance in resolving treatment choices
   - Patient or family request

b. **Types of Consultations**

   **Routine / 7 days a week, 0800 – 1700**
   - requested with the expectation of being seen within 24 hours
   - direct contact with the consulting practitioner or his/her office staff by the nursing staff (nurse and/or unit secretary)
   - practitioner on call at the time that the consultation is requested will be the practitioner who provides the consult
   - it is preferable for all consults to be called personally to the consultant by the referring practitioner whenever feasible.

   **Routine / 7 days a week 1700 – 0800**
   - Requires direct communication from requesting to consulting practitioner

   **Immediate (‘STAT’)(Life-threatening)**
   - Requested with the expectation of being seen within 1 hour or less
   - Requires direct communication from requesting to consulting practitioner
c. Responsibility of Requesting Practitioner
   - Indication in order or through direct contact of the reason for the consultation
   - Indication of the nature of the urgency (routine assumed if not otherwise specified)
   - Indication of whether the consult is “recommendation only” or whether management assistance is requested (management assistance is assumed unless “advice only” is specified)

d. Responsibility of Consulting Practitioner
   - Assess the patient within the time frame as above
   - Document findings and recommendation in the medical record
   - Communicate with requesting practitioner when situation warrants
   - All consults must be documented as ordered in the patient chart
   - All consults must be documented in the patient chart as completed by the consultant, even if the consultant deems the consult unnecessary
   - The consultant must document why he/she feels it is unnecessary
   - The consultant must document in the chart why a consult is refused
   - This does not apply to ED consultations (see On-Call Practitioners Policy)

1.10 CONTINUING AMBULATORY CARE SERVICES (SERIES PATIENTS)

   a. Definition of Recurring Patient: Patients receiving repetitious treatments outside of the office such as bladder therapy instillation, chemotherapy, injections, blood transfusions, port flushes, paracentesis/thoracentesis and epidural for pain control.

   b. All recurring patients must have an initial history and physical within thirty (30) days of admission with an update within 24 hours prior to the first visit.

   c. Any patient classified as a recurring outpatient who has a high risk procedure or therapy shall have a history and physical dictated or written at least every thirty (30) days and as changes occur. Updates may be documented at the end of the history and physical, in the progress notes or on a history and physical update form.

   d. An initial H&P meeting the bylaw requirements must be documented in the medical record prior to the initiation of the treatment. The H&P may remain valid for one year, but must be updated on an as needed basis as the underlying medical condition of the patient changes. Hospital staff receiving the patient will notify the ordering physicians of any identified changes in the patient’s condition.

   e. If any procedure requires moderate sedation or above, an H&P completed within the past 30 days is required.

   f. In the interim, should the patient receive services for anything other than recurring outpatient, then a new and complete history and physical must be done in accordance with established Rules and Regulations of the Medical Staff.
ARTICLE II - MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, clinical résumé and autopsy report, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants. The record shall also contain a written plan of care, treatment and services appropriate to the patient’s needs, identifying the patient’s needs, goals, timeframes, settings, and services required to meet the patient’s needs. Such plan of care shall be discussed with the patient and shall be revised as necessary, and where appropriate, consider strategies to limit the use of restraints and/or seclusion of the patient.

The Medical Record shall include Computerized Physician Order Entries as required by these Rules & Regulations in order to be considered complete.

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have a complete admission history and physical examination as required by the Medical Staff Bylaws.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam must be recorded before all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Practitioner documents that such delay would be a threat to the patient’s health.

2.4 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written or dictated at least daily on all patients except on the day of admission. The written admission note shall serve as the progress note for the day of admission, unless the patient’s condition warrants further progress notes on that date.

2.4 SHORT-STAY SUMMARY/INPATIENT OR OBSERVATION

1. If a patient is hospitalized less than 24 hours, a short-stay summary may be dictated instead of a history and physical and a discharge summary.

2. If a patient is expected to stay less than 24 hours, then a progress note is to be written at the time of admission. This progress note is to include the pertinent history, pertinent examination, assessment if a patient is hospitalized less than 24 hours, a short-stay summary may be dictated instead of a history and physical and a discharge summary.
3. If a patient is expected to stay less than 24 hours, then a progress note is to be written at the time of admission. This progress note is to include the pertinent history, pertinent examination, assessment and plan.

4. If the patient’s stay exceeds or is expected to exceed 24 hours, a complete history and physical is required. If a patient is hospitalized greater than 36 hours, is discharged to another acute care facility or expires, a complete H&P plus a dictated discharge summary is required.

5. If a patient is hospitalized greater than 24 hours and less than 36 hours, a dictated discharge summary or a handwritten discharge note must be done.

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient’s current medical record within six (6) hours after completion of surgery. An operative progress note must be entered immediately, and before the patient is transferred to the next level of care, if the operative report is not placed in the record immediately after surgery. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.6 OUTPATIENT INVASIVE PROCEDURE RECORD

1. A Medical Staff approved form may be used for outpatient procedures

2. An assessment of the patient by the Practitioner performing the outpatient invasive procedure is required and must be documented on every patient prior to performing the procedure.

   a. When anesthesia is involved in the patient’s care, the documented assessment must be completed and placed on the chart before a certified nurse anesthetist or an anesthesiologist assesses the patient.

3. Assessment will include the following:

   a. Indications (initial impression, indications for procedure)
   b. Planned procedure
   c. Relevant medical history
      1. Allergies
      2. Past Medical and Surgical History
      3. Current medications
   d. Physical examination as indicated by the procedure being performed; to include assessment of heart, lung, neurological status, abdomen and the organ system involved.

4. Documentation of the assessment may be done using either:

   a. Outpatient Invasive Procedure Record form
   b. Dictation into Medical Record Dictation system if dictated timely to be available on the record at the time of the procedure
   c. Handwritten History & Physical form

5. Procedure note for all invasive procedures performed by a practitioner is to be written immediately following the procedure and should include:

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282 This language is designed to facilitate compliance with TJC standard RC 02.01.03.

July, 2014
- primary surgeon
- assistants
- findings
- procedure performed
- pre-op diagnosis
- post-op diagnosis
- complications
- patient’s tolerance
- Estimated blood loss
- Specimens removed

This documentation is sufficient for the following procedures:
- paracentesis
- thoracentesis
- bone marrow aspiration
- radiology procedures
- liver biopsy
- epidurals
- pain management blocks
- catheter insertion/removal
- manipulations
- needle biopsies
- bladder therapy

A detailed/dictated operative report is required for all other outpatient procedures plus an immediate post-op note including all the elements listed above.

6. Impression and the disposition of the patient are to be documented.

7. In the event of a stay greater than 24 hours, a complete history and physical must be done.

2.7 Non-operative and other low-risk procedures

This category contains any low risk procedure involving light (anxiolysis) or no sedation where protective reflexes are expected to remain unchanged, no amnesia experienced, and pain or anxiety is reduced. Procedures such as the following are included in this category: Diagnostic imaging without IV sedation, lumbar punctures, amniocentesis, arthrography, sonograms, voiding cystourethrogram, myelograms, paracentesis, thoracentesis, PICC placement, injections, gastronomy tube and non-implanted IV access device removal, and ophthalmologic laser procedures without sedation. Non-operative and other low-risk procedures do not require a complete H&P, but at a minimum, require a procedural note. A radiology imaging report or result in the chart suffices.

If any procedure requires moderate sedation or above, an H&P completed within the past 30 days is required.
2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the consultation section of the Rules & Regulations. Consultations shall be obtained through written order of the Attending Physician or his/her designated alternate. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record.

2.7 OBSTETRICAL PATIENT HISTORIES

The history for obstetrical patients, when adequately updated (within 30 days of service), with progress notes setting forth the current history and changes in physical findings, shall be accepted as a valid and actual history and physical throughout the hospital for surgery and other procedures related to obstetrical patients.

2.8 CLINICAL ENTRIES/AuthENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately and promptly dated, timed, authenticated and legible. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. The use of a rubber stamp signature is not acceptable.283

2.9 ABBREVIATIONS/SYMBOLS

Abbreviations and symbols utilized in medical records are to be those approved by the MEC and filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.10 FINAL DIAGNOSIS

The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. It shall also be dated and signed by the responsible practitioner at the time of discharge of all patients.

2.11 REMOVAL OF MEDICAL RECORDS

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician or his/her designated alternate. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

2.12 ACCESS TO MEDICAL RECORDS

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

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283 Please note that the use of a rubber stamp is prohibited pursuant to Medicare Transmittal 248 Change Requests 5971.
Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute, and require a signed release from the patient or a court order before being released to any person.

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.13 **PERMANENTLY FILED MEDICAL RECORDS**

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the MEC, the Chief of Staff or CEO with an explanation of why it was not completed by the responsible practitioner(s).

2.14 **STANDING ORDERS**

In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed semi-annually. Standing orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

2.15 **COMPLETION OF MEDICAL RECORDS**

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.16 **DELINQUENT MEDICAL RECORDS**

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician or AHP with a list of his/her incomplete medical records every seven (7) days. At the twenty-first (21st) day for any incomplete medical records, the letter will include a warning that the record(s) will be delinquent at thirty (30) days and the physician’s or AHP’s privileges will be suspended if any records become delinquent.

2.16(a) **Suspension.** A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible practitioner’s privileges. When a practitioner is notified of suspension, the practitioner may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended practitioner may not cover Emergency Room call, may not provide coverage for partners or other practitioners, nor admit under a partner’s or other practitioners name. Any exceptions must be approved by the Chief of Staff and the CEO.

2.16(b) The suspended practitioner is obligated to provide to the hospital CEO and the Chief of Staff the name of another practitioner who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations and any other services that practitioner provides.

2.16(c) All hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

2.16(d) Any physician or AHP who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.
A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the appropriate department chair, the CEO, or the chairperson of the Quality Management Committee, or equivalent Medical Staff committee.

2.17 **TREATMENT & CARE WRITTEN ORDERS**

Orders for treatment and care of patients may be written by APRN’s and PA’s or other non-physician personnel under the supervision of the Attending Physician without the physician’s cosignature to the extent consistent with privileges granted, state and federal law, and Hospital policy.

When a physician’s cosignature is required, preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by the physician as prescribed in Article III, Section 3.2 of these Rules & Regulations.

2.18 **ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES**

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of “white-out”.

To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.19 **COMPUTERIZED PHYSICIAN ORDER ENTRY**

CPOEs shall be utilized by physicians and Allied Health Professionals to the extent available and operational.

2.20 **MEDICAL/ALLIED HEALTH PROFESSIONAL STUDENT OBSERVATION AND CLINICAL CLERKSHIP**

Individuals in training, such as medical students, Physician Assistant students, Advanced Practice Registered Nurse (APRN) students and residents may be granted permission to participate in the care of patients only under the supervision of a responsible Medical Staff member in good standing, with relevant Clinical Privileges, and subject to appropriate training policies and manuals as noted in the Patient Care Activities by Medical, Physician Assistant and Advanced Practice Registered Nurse Students Policy.

Individuals in training may perform clinical activities at DLP Harris/Swain in accordance with the Patient Care Activities by Medical, Physician Assistant and Advanced Practice Registered Nurse Students Policy.
ARTICLE III - GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing, dated, timed, authenticated and legible. Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician or AHP giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and CRNA's may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the physician or AHP and indicate that the individual has confirmed the order. The physician or AHP who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate, time and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than thirty (30) days from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

Verbal orders will generally not be accepted for investigational drug, device or procedure protocols, orders to withhold (including Do Not Resuscitate orders) or withdraw life support. Verbal orders will not be accepted for chemotherapy drug orders. Withdrawing of life support will only be implemented with an order written and authenticated by the prescribing practitioner, AND in accordance with applicable hospital policies regarding advanced directives.

3.3 ILLEGIBLE TREATMENT ORDERS

The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

3.4 PREVIOUS ORDERS

All previous orders are cancelled when patients go to surgery.

3.5 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Formulary of the American Society of Hospital Pharmacists. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC.

The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

284 State law might require a different time period; Facility should always refer to state law to see the maximum time allowed for authenticating the verbal order (for example, Texas law requires 24 hours).
3.6 **ORDERING/DISPENSING OF DRUGS**

The practitioner must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. When the patient brings medication to the hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the practitioner and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Medications ordered to be “held” will be discontinued after twenty-four (24) hours in the absence of a “resume” order. The practitioner must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

3.7 **QUESTIONING OF CARE**

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall contact the Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the Chief of Staff. If the circumstances are such as to justify such action, the Chief of Staff may request a consultation.

3.8 **PATIENT CARE ROUNDS**

Hospitalized patients shall be seen at least daily and more frequently if their status warrants. Patients admitted to a swing bed shall be seen weekly, and more frequently if their status warrants, by the Attending Physician or his/her designated alternate. Patients admitted to Intensive Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than two (2) hours after admission or sooner if warranted by the patient’s condition.

3.9 **ATTENDING PHYSICIAN UNAVAILABILITY**

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.10 **PATIENT RESTRAINT ORDERS**

All practitioners shall abide by federal law, Joint Commission standards, and all hospital policies pertaining to restraints and seclusion.

3.11 **PRACTITIONERS ORDERING TREATMENT**

Licensure and Medicare/Medicaid eligibility will be verified for all practitioners ordering treatment (i.e. home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the practitioner’s Medical Staff status or lack thereof.
ARTICLE IV - GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

Excluding emergencies, prior to any surgical procedure, a history, physical and other appropriate information including the preoperative diagnosis and appropriate laboratory tests must be recorded on the patient's medical record. If not recorded, the operation shall be canceled. In all emergencies, the practitioner shall make a comprehensive note regarding the patient’s condition prior to induction of anesthesia and the start of surgery.

4.2 INFORMED CONSENT

A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high risk treatments (as provided by hospital policy and/or state law) except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient, or any person to whom the patient has properly delegated representative authority, only after the risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of care, and other information necessary to make a fully informed consent has been explained to the patient by the responsible physician or AHP. After informed consent has been obtained by the operating practitioner, the practitioner shall obtain the patient's signature on the consent form. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

Each consent form shall include the name of the hospital where the procedure is to take place; the name of the specific procedure for which consent is being given; the name of the responsible practitioner who is performing the procedure; a statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient’s legal representative; and the signature of the patient or the patient’s legal representative. The form must also comply with the requirements of applicable state law.

4.3 PATIENT REQUESTS AND REFUSAL OF TREATMENT

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient’s behalf, must be documented in the patient’s permanent hospital record. Patients have the right to request any treatment at any time, and such requests shall be documented in the patient’s permanent chart. However, such requests may be declined if determined to be medically unnecessary by the treating physician or his/her designated alternative.

4.4 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff, and documented in writing.

4.5 ELECTIVE SURGERY SCHEDULING
In order to reduce patient anxiety resulting from a long wait, reduce staff overtime for elective work and allow time for possible emergencies, the following guidelines will be used for scheduling elective surgeries. Emergency procedures shall take priority above all other cases.

4.5(a) **Starting Time:**

8:00 a.m. unless earlier starting times are requested by the surgeon and facilities, equipment and personnel are available to fulfill the request. Determination will be made by the Chief of Surgery and the Chief Surgical Nurse.

Starting time for all cases may be altered with the mutual agreement of BOTH the Chief of Surgery and the Chief Surgical Nurse, with approval of the Department of Surgery, to an earlier time for all cases should future circumstances, such as increased operating space, facilities, equipment and personnel allow.

4.5(b) **Priority Cases shall include:**

1. Cesarean section;
2. Age 12 and under;
3. Open bone work; and
4. Contaminated cases last, if possible.

4.5(c) **Scheduling of Cases:**

1. Chief of Surgery and the Chief Surgical Nurse, with approval of the Department of Surgery, shall formulate and implement a policy regarding scheduling of operative cases.

4.5(d) Preoperative workup is as deemed appropriate.

4.6 **POST-OPERATIVE EXAMINATION**

For all outpatient surgery patients discharged from recovery room to home, a post-operative examination will be conducted by the surgeon.

4.7 **ANESTHESIA**

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (MAC) including deep sedation, regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

4.79(a) Anesthesia services throughout the Hospital shall be organized into one anesthesia service under the direction of a qualified physician. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. The director of anesthesia services shall be an anesthesiologist member of the Active Medical Staff.

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285 On January 14, 2011, CMS published revised Interpretive Guidelines for the Hospital Conditions of Participation on anesthesia services. The revised Interpretive Guidelines make a number of changes to the applicable standards for hospital anesthesia services. Most notably, they likely require significant modifications to the hospital’s policies and procedures on anesthesia. We provide a number of recommended changes designed to facilitate compliance with these new Interpretive Guidelines.
Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services.

4.7(b) The Hospital shall maintain policies and procedures governing anesthesia services provided in all Hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

4.7(c) Only credentialed and qualified individuals as defined in the policies and procedures of the Hospital may provide anesthesia services. The Department of Surgery shall approve credentialing guidelines consistent with federal regulations and Joint Commission standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations and the policies and procedures of the Hospital. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care (MAC) must be supervised either by the operating practitioner who is performing the procedure or by an anesthesiologist who is immediately available. An anesthesiologist is considered “immediately available” only if he/she is physically located within the same area as the CRNA and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

When supervision of CRNA administered anesthesia services by a practitioner other than an anesthesiologist is required, doctors of medicine or osteopathy with clinical privileges to perform invasive procedures may supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care (MAC). Dentists, oral surgeons, and podiatrists who are qualified to administer anesthesia under state law may supervise the qualified CRNA in the administration of regional anesthesia and monitored anesthesia care (MAC).

4.7(d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the Hospital and shall be consistent with the requirements of applicable state law, the Joint Commission and the CMS Hospital Conditions of Participation. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care (MAC), this record shall include a pre-anesthesia evaluation, an intraoperative record, and a post anesthesia evaluation.

Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the Hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthetist or anesthesiologist will reevaluate and document the patient’s condition immediately before administering moderate or deep sedation or anesthesia, as such terms are defined by The Joint Commission.

The individual who administered the patient’s anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the Hospital, must also perform a post anesthesia evaluation of the patient and document the results of the evaluation no later than forty-eight (48) hours after the patient’s surgery or procedure requiring anesthesia services. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than forty-eight (48) hours, as addressed in Hospital policies and procedures. For those patients who are unable to participate in the post anesthesia evaluation, a post anesthesia evaluation should be
completed and documented within forty-eight (48) hours with notation that the patient was unable to participate, description of the reason(s) therefore, and expectations for recovery time, if applicable.

4.7(e) The anesthetist or anesthesiologist will be responsible to obtain and document informed consent for anesthesia in the medical record. In order to ascertain the patient’s wishes as they relate to the continuance of advanced directives, said advanced directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the attending physician prior to surgery. If the patient’s wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.

4.7(f) The Hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary.

4.8 ORGAN & TISSUE DONATIONS

The hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases (term birth to age 75) to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

No physician or AHP attending the patient prior to death or involved in the declaration of death shall participate in organ removal.286

The attending physician or AHP shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient’s medical record shall reflect the results of this notification.

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286 The Uniform Anatomical Gift Act that has been adopted in nearly all the states provides that the attending physician cannot participate in organ transplant.
ARTICLE V - GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

Only by those physicians who have training in high risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

5.1(a) All cesarean sections;
5.1(b) Premature infants’ less than thirty-five (35) weeks gestation, with or without complications;
5.1(c) Premature infants less than four (4) pounds eight (8) ounces, with or without complications;
5.1(d) All premature infants with complications; and
5.1(e) Full term infants with complications requiring invasive intervention.

5.2 LABOR AND DELIVERY

Physicians providing pediatric care for newborns delivered via cesarean section or other high risk newborns are required to arrive at the Emergency Department or Labor and Delivery Unit, as applicable, within thirty (30) minutes of initial contact regarding a cesarean delivery or other emergency condition which requires specialized pediatric or neonatal care.

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents to the Emergency Department, she will be assessed by the triage nurse (R.N.) to determine whether the presenting complaint is onset of labor or a general other complaint, not of onset of labor. Patients ≥20 weeks gestation, determined to be complaining of labor onset or a pregnancy related condition, will be stabilized and transported to the Labor and Delivery Unit with qualified medical personnel. All other pregnant females presenting to the Emergency Department <20 weeks gestation or complaining of complications unrelated to pregnancy, will be medically screened and treated as provided in Article VI of these Rules and Regulations. For those patients at term who are referred to the Labor and Delivery Unit, an R.N. trained in obstetrics will initiate the orders of the obstetrician of record, or in the case of a patient presenting with no prenatal care or care by a physician who is not a member of this Medical Staff, the orders of the physician on-call for obstetrics. For patients at term and without other complications, the medical screening examination required under Article VI may be performed by a qualified R.N. under the orders of and in telephone contact with the obstetrical physician where permitted under state law. In the case of a patient who is determined not to be in active labor, she may be discharged home by telephone order if the physician concurs with the assessment of the R.N. and the patient has had prenatal care under that physician, that physician’s practice or practice that on call physician is covering for. In cases where the patient has had no prenatal care and/or is unknown to the physician’s practice, the on-call physician shall examine the patient prior to a discharge decision and order. For patients determined to be in active labor after this screening process is completed, or in the event the nurse feels that the obstetrician’s physical presence is necessary to complete the medical screening, the provisions of Section 6.2 regarding consultations, referrals and emergency call shall apply. Where state law does not permit the performance of the medical screening examination by an R.N., such medical screening examination shall be performed by a physician.

287 We recommend these revisions in order to ensure compliance with applicable state law.
5.4 PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating practitioner or otherwise shall undergo the screening described in Section 5.2, above. The nurse shall contact the admitting physician upon any change in the patient’s condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital within thirty minutes upon being contacted by the nurse and requested to come to the Hospital due to a change in condition or deviation from the standard course of progress. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician or his/her designated alternate at any time that her condition warrants, but in any event no later than twelve (12) hours after admission.
ARTICLE VI - EMERGENCY MEDICAL SCREENING,
TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

(1) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an “emergency medical condition” is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

(2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual’s method of payment or insurance status, nor denied on account of the patient’s inability to pay.

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician or his/her designated alternate, or in the case of a woman in labor, a registered nurse trained in obstetric nursing, where permitted under state law and Hospital policy, who may determine true, false or no labor but may not make a medical diagnosis.

(4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

6.1(b) Stabilization

(1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.

(2) A patient is Stable for Discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or, the patient requires no further treatment and the treating practitioner or his/her designated alternate has provided written documentation of his/her findings.

(3) A patient Stable for Transfer if the treating practitioner has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating practitioner reasonably believes the receiving facility has the capability to manage the patient’s medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

(4) A patient does not have to be stabilized when:

(i) the patient, after being informed of the risks of transfer and of the hospital’s treatment obligations, requests the transfer and signs a transfer request form; or

(ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a

We recommend these revisions in order to ensure compliance with applicable state law.

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practitioner signs a certification which includes a summary of risks and benefits to this effect.

(5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician or his/her designated alternate, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual’s refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician or his/her designated alternate shall document the patient’s refusal in the patient’s chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a practitioner for outpatient follow-up care.

6.1(c) Transfer

(1) The Emergency Department Physician or his/her designated alternate shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.

(2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.

(3) Upon transfer, the Emergency Department shall provide a copy of appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call practitioner who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

(4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient’s representative) with respect to the transfer. The Emergency Department practitioner his/her designated alternate must inform the patient (or the patient’s representative) of the risks and benefits of the proposed transfer.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

6.2(a) When the Emergency Department Practitioner determines that a consultation or specialized treatment beyond the capability of the Emergency Department practitioner his/her designated alternate is needed, the patient shall be permitted to request the services of a specific private practitioner. This request will be documented in the patient’s medical record.

6.2(b) The practitioner whom the patient requests shall be contacted by a person designated by the practitioner in charge of the Emergency Department and that person will document the time of the contact in the patient’s medical record.

6.2(c) An appropriate attempt to contact the practitioner will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Attempted to reach the practitioner in the hospital;

(2) Called the practitioner at home;

(3) Called the practitioner at his/her office; and

(4) Called once on the practitioner’s pager.
Twenty minutes will be considered a reasonable time to carry out this procedure.

6.2(d) The rotation call list, containing the names and phone numbers of the on-call practitioners shall be posted in the Emergency Department. In the event that the patient does not have a private practitioner, the private practitioner refuses the patient’s request to come to the Emergency Department, or the practitioner cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private practitioner to provide the necessary consultation or treatment for the patient. A practitioner who has been called from the rotation list may not refuse to respond. The Emergency Department practitioner’s determination shall control whether the on-call practitioner is required to come in to personally assess the patient. Any such refusal shall be reported to the CEO for further action and may constitute grounds for revocation of the practitioner’s Medical Staff appointment and clinical privileges.

6.2(e) The practitioner called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient’s assignment to that practitioner is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the practitioner’s office. If, after examining the patient, the practitioner who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that practitioner’s responsibility to make the second referral. The first practitioner consulted retains responsibility for the patient until the second consultant accepts the patient.

6.2(f) All members of the Active Staff or his/her designated alternate shall participate in the on-call backup to the Emergency Department as required by the Board, upon recommendation of the MEC. The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital’s obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or Allied Health Professional is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital’s ability to fulfill its obligations as outlined above.

Practitioners called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in, they are required to do so within twenty (30) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within twenty (30) minutes of initial contact.

6.2(g) The system for providing on-call coverage shall be approved by the Board of Trustees and documented by written policy.
ARTICLE VII - ADOPTION & AMENDMENT OF RULES & REGULATIONS

7.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to bring before the Board formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

7.2 ADOPTION, AMENDMENT & REVIEWS

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular meeting of the medical staff at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

7.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

7.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel; or

7.3(b) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last restatement, which restated Rules & Regulations shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel.

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner.

7.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 7.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the wellbeing of patients, employees or staff.
MEDICAL STAFF RULES & REGULATIONS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: ________________________________
    Chief of Staff

By: ________________________________
    Date

BOARD OF TRUSTEES:

By: ________________________________
    Chairperson

By: ________________________________
    Date

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals:

By: ________________________________
    Chief Executive Officer

By: ________________________________
    Date

APPROVED AS TO FORM:

By: ________________________________
    Legal Counsel for DLP Harris Regional Hospital, LLC and DLP Swain Community Hospital, LLC

By: ________________________________
    Date

APPROVED:

By: ________________________________
    Division President

By: ________________________________
    Date
APPENDIX “C” – POLICY REGARDING BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

1.1 PURPOSE AND OBJECTIVE

It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy, and dignity, and to conduct ourselves in a professional, cooperative manner, and in compliance with the Code of Conduct of LifePoint Hospitals. This policy, which replaces the Disruptive Practitioner Policy, sets forth the requirement that all physicians and allied health professionals who work in the Hospital will act in a professional and respectful manner at all times. Further, this policy defines behavior or behaviors that undermine a culture of safety, and outlines how to report and address it.

The objectives of this policy are to ensure quality patient care by promoting a safe, cooperative, and professional health care environment, and to provide Hospital employees with a work environment based on respect and one that encourages personal and professional growth.

This policy is applicable to all medical staff members and all allied health professionals (collectively referred to in this policy as “Practitioners”).

Conduct of a criminal nature by a Practitioner, including but not limited to assault, battery, rape, or theft shall be handled through local law enforcement officials in accordance with local and State laws, in addition to application of this policy to address Practitioner’s medical staff or allied health membership.

Any employee who engages in behavior or behaviors that undermine a culture of safety, including employed Practitioners, may be dealt with in accordance with the Hospital’s human resource policies. Practitioners or Hospital employees who observe undermining behavior on the part of a Hospital employee shall follow the reporting mechanisms set forth in the human resource policies.

2.1 BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

For purposes of this policy, behavior that undermines the culture of safety (herein referred to as "Undermining Behavior") is any behavior that substantially intimidates others; affects morale or staff turnover; disrupts the smooth operation of the Hospital; adversely affects the ability of others to perform their jobs appropriately; poses a threat or potential threat to safe quality patient care; or exposes the Hospital or Medical Staff to potential liability. Behavior that does not substantially impact a culture of safety is behavior that is outside the scope of this policy. Behavior which may rise to the level of Undermining Behavior may include, but is not limited to, behavior such as:

2.1(a) Rude, abusive or intimidating behavior or comments to Hospital personnel, other Practitioners, Hospital visitors, patients or their families, or other behavior that negatively affects the ability of others to do their jobs. Such behavior can include the failure to cooperate, the refusal to return calls, or other passive activities when such substantially impacts the culture of safety.

2.1(b) Attacks, verbal or physical, directed at other Practitioners, Hospital personnel, patients or visitors, that are personal, inappropriate, irrelevant, or beyond the bounds of fair professional conduct.

2.1(c) Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the Hospital, or attacking particular Practitioners, nurses, other Hospital employees, or Hospital policies.

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2.1(d) Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

2.1(e) Refusal to accept, or causing a disturbance of, medical staff assignments or participation in committee or departmental affairs.

2.1(f) Interference with Hospital operations, Hospital or Medical Staff committees, or departmental affairs, or placing quality care at the Hospital in jeopardy.

2.1(g) Knowingly making false accusations or falsifying any patient medical records or Hospital documents.

2.1(h) Verbal or physical maltreatment of another individual, including physical or sexual assault or battery, or retaliation of any kind for making a report under this policy.

2.1(i) Sexual, racial, or other harassment, including words, gestures and actions, verbal or physical, that interferes with a person’s ability to perform his or her job.

2.1(j) Behavior that adversely affects or impacts the community’s confidence in the Hospital’s ability to provide quality patient care.

3.1 REPORTING OF UNDERMINING BEHAVIOR

3.1(a) Hospital employees who observe, or are subjected to, Undermining Behavior by a Practitioner shall notify their supervisor about the incident. If the supervisor’s behavior is at issue, the employee shall notify the Chief Executive Officer (or his or her designee) or the Hospital Human Resources Director. Any Practitioner who observes Undermining Behavior of another Practitioner shall notify the Chief Executive Officer directly. Supervisors who have received a report of Undermining Behavior shall report the same to the Chief Executive Officer.

3.1(b) If a reporting individual is uncomfortable with reporting Undermining Behavior directly, then a report of the incident must be made to the Hospital’s Ethics & Compliance Officer or the LifePoint Ethics Line at 1-877-508-LIFE (5433).

4.1 DOCUMENTATION

4.1(a) Documentation of Undermining Behavior is critical since it is ordinarily a pattern of conduct, rather than one incident, which justifies disciplinary action. Practitioners, nurses and other Hospital employees who observe and report Undermining Behavior by a Practitioner must document the behavior or in the alternative, the supervisor/Chief Executive Officer shall document the incident as reported. That documentation shall include:

(1) The date and time of the questionable behavior;

(2) A statement of whether the behavior affected or involved a patient in any way; and if so, the medical record number of the patient;

(3) Known circumstances which precipitated the situation;

(4) A description of the questionable behavior limited to factual, objective language;

(5) Known consequences, if any, of the Undermining Behavior as it relates to patient care or Hospital operations;

(6) The names of other witnesses to the incident; and
A record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

4.1(b) The report shall be submitted to the Chief Executive Officer, who shall provide the report to the Chief of Staff. In performing all functions hereunder, the Chief Executive Officer and Chief of Staff, and their designees, shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

4.1(c) After a report of Undermining Behavior, the Chief Executive Officer or his or her designee shall ensure those making the report are aware of the Hospital’s standards of behavior and process for assuring professional and appropriate behavior in the Hospital. Individuals that reported the potentially undermining behavior will be advised of policies preventing retaliation and will be requested to report any perceived acts of retaliation to the CEO or his or her designee. This follow-up discussion with individuals that made a report will occur as soon as practical after each report of Undermining Behavior.

5.1 INVESTIGATION

Once received, a report will be investigated by the Chief Executive Officer and/or the Chief of Staff. The Chief Executive Officer may delegate this investigation to the Hospital’s Human Resources Director, Chief Nursing Officer, or other individual who may have applicable expertise or skill. This investigation may include meeting with the individual who reported the behavior and any other witnesses to the incident. If the Chief Executive Officer and Chief of Staff determine after investigation that the report lacks merit, this conclusion shall be documented and no further action is necessary. Those reports considered accurate will be addressed through the procedure set out below. This documentation shall be placed in the Practitioner’s confidential peer review file. If at any time it appears to the Chief of Staff, the Chief Executive Officer, or any committee charged with implementation of this policy that a practitioner’s behavior may result from impairment, the procedure set forth in the Impaired Practitioner Policy shall be followed.

6.1 MEETING WITH THE PRACTITIONER

6.1(a) A first confirmed incident requires a discussion with the offending Practitioner. The Chief of Staff and Chief Executive Officer shall initiate a meeting with the Practitioner and emphasize that such behavior is inappropriate and violates Hospital policy and the Medical Staff bylaws.

6.1(b) These individuals shall discuss the matter informally with the Practitioner, emphasizing that if the behavior continues, more formal action will be taken to stop it. The identity of the individual who made the report of Undermining Behavior shall not be disclosed at this time, unless the Chief Executive Officer and Chief of Staff agree in advance that it is appropriate to do so. The following guidelines shall be followed regarding the meeting:

(1) The initial approach should be collegial and designed to be helpful to the practitioner;

(2) The parties should emphasize that if the behavior continues, more formal action will be taken to stop it;

(3) Informal meetings shall be documented with a written summary of the meeting. This documentation shall be maintained in a confidential peer review file of the Practitioner;

(4) A follow-up letter to the practitioner shall state that the practitioner is required to behave professionally and cooperatively, along with a copy of this Hospital policy on Undermining Behavior; and
Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident should the Chief of Staff and/or the Chief Executive Officer determine that the seriousness of the incident justifies such action.

6.1(c) If an additional incident of Undermining Behavior occurs, or if the Chief of Staff or the Chief Executive Officer determines it to be necessary, the Chief Executive Officer and the Chief of Staff, shall meet with and advise the practitioner that such behavior is intolerable and must stop. This meeting constitutes the practitioner's final warning. It shall be followed with a letter reiterating the warning and summarizing the meeting. The Practitioner may prepare a written response to the letter. This documentation shall be maintained in the Practitioner's confidential peer review file. More formal corrective action may be pursued at this juncture if deemed warranted by the Chief of Staff and/or Chief Executive Officer.

6.1(d) Every meeting with the Practitioner shall include a review of the Hospital’s policy against retaliation. Such discussions shall be explicitly documented.

6.1(e) All meetings with the Practitioner shall be documented.

6.1(f) After each meeting with the Practitioner, a letter shall be sent to the Practitioner confirming the Hospital's and medical staff leadership's position - that the Practitioner is required to behave professionally and cooperatively, and which also shall include the potential consequences of continued non-compliance or retaliation against individuals the Practitioner believes to have reported the behavior in question.

7.1 DISCIPLINARY ACTION PURSUANT TO BYLAWS

7.1(a) A single additional incident of behavior that undermines a culture of safety, after the above process has been completed, shall result in initiation of formal disciplinary action pursuant to the medical staff bylaws. The Chief Executive Officer and Chief of Staff shall be responsible for presenting the history of behavior to the Medical Executive Committee.

7.1(b) Summary suspension may be appropriate pending this process, depending upon the seriousness of the offense, and after consultation with operations counsel.

7.1(c) The Medical Executive Committee must be fully advised of all of the previous meetings and warnings, if any, and must take them into account, so that it may pursue whatever action is necessary to cease the Undermining Behavior.

7.1(d) The Medical Executive Committee must take action or refer the matter to the Board with a recommendation as to action. This recommendation shall be processed as provided in the administrative corrective action section of the Medical Staff Bylaws. The Board will review and may initiate action if the Medical Executive Committee fails to take action, refer the matter or make a recommendation as to action regarding the matter.

7.1(e) Although the above outline is a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual’s behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, damaging Hospital property or jeopardizing patient care may result in immediate corrective action. As such, if they deem it appropriate based upon the circumstances, the Hospital’s Chief Executive Officer, Chief of Staff or Board Chairperson may initiate formal disciplinary action under the Bylaws for a single incident of Undermining Behavior without first resorting to the progressive disciplinary approach set forth herein.
7.1(f) In the minutes of the deliberative meetings of any peer review committee addressing Undermining Behavior of a Practitioner, the Hospital’s Human Resource Director shall be formally included as an ex-officio member of the committee without vote, and to the extent possible, the Hospital’s Human Resource Director shall be advised of the action taken against a Practitioner resulting from a report of Undermining Behavior by a Hospital employee.
BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY POLICY
ADOPTED & APPROVED:

MEDICAL STAFF:

By: ____________________________  __________________________
    Chief of Staff                      Date

BOARD OF TRUSTEES:

By: ____________________________  __________________________
    Chairperson                      Date

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals:

By: ____________________________  __________________________
    Chief Executive Officer          Date
APPENDIX “D” – IMPAIRED PRACTITIONER POLICY

It is the policy of this hospital to properly investigate and act upon concerns that a licensed independent practitioner, as defined in the Medical Staff Bylaws, is suffering from an impairment. The hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans With Disabilities Act.

As part of the hospital’s commitment to the safe and effective delivery of care to patients, the Hospital and Medical Staff shall conduct education sessions concerning practitioner health and impairment issues, including illness and impairment recognition issues specific to practitioners (“at-risk” criteria).

1.1 Report & Investigation

If any individual in the hospital has a reasonable suspicion that a licensed independent practitioner (hereinafter “LIP”) appointed to the Medical Staff is impaired, the following steps shall be taken:

1.1(a) An oral or, preferably, a written report shall be given to the Chief Executive Officer or the Chief of Staff. The reporting individual shall otherwise keep the report and the facts related thereto confidential. The report shall include a description of the incident(s) that led to the belief that the LIP may be impaired. The report must be factual. The individual making the report need not have proof of the impairment, but must state the facts leading to the suspicions. A LIP who feels that he/she may be suffering from impairment may also make a confidential self-report. Impairment, as used in this policy, includes both physical and mental impairment, as well as impairment due to drugs or alcohol.

1.1(b) Notwithstanding the foregoing, in the event that any person observes a LIP who appears to be currently impaired by drugs or alcohol, that person shall report the events to the Chief of Staff and/or CEO immediately. The Chief of Staff and CEO may order an immediate drug or alcohol screen if, in their opinion, circumstances so warrant.

1.1(c) If, after discussing the incidents with the individual who filed the report, the Chief Executive Officer and Chief of Staff believe there is sufficient information to warrant further investigation, the Chief Executive Officer and Chief of Staff may:

   (1) Meet personally with the LIP or designate another appropriate person to do so; and/or

   (2) Direct in writing that an investigation be instituted and a report thereof be rendered by an ad hoc committee to be appointed by the MEC for this purpose. The MEC shall appoint an ad hoc committee of three (3) physicians to investigate the issue within five (5) days of receipt of the request.

1.1(d) In performing all functions hereunder, the Chief Executive Officer and Chief of Staff shall be deemed authorized agents of the MEC and the ad hoc committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

1.1(e) Following a written request to investigate, the ad hoc committee shall investigate the concerns raised and any and all incidents that led to the belief that the LIP may be impaired. The ad hoc committee’s investigation may include, but is not limited to, any of the following:

   (1) A review of any and all documents or other materials relevant to the investigation;
(2) Interviews with any and all individuals involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the LIP's health status are related to the performance of the LIP's clinical privileges and Medical Staff duties and are consistent with proper patient care or effective operation of the hospital;

(3) A requirement that the LIP undergo a complete medical examination as directed by the ad hoc committee, so long as the exam is related to the performance of the LIP’s clinical privileges and Medical Staff duties and is consistent with proper patient care or the effective operation of the hospital; and

(4) A requirement that the LIP take a drug test to determine if the LIP is currently using drugs illegally or abusing legal drugs.

1.1(f) The ad hoc committee shall meet informally with the LIP as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the hospital's Medical Staff Bylaws or pertinent credentialing policy and is not part of a disciplinary action. At this meeting, the ad hoc committee may ask the LIP health-related questions so long as they are related to the performance of the LIP’s clinical privileges and Medical Staff duties, and are consistent with proper patient care and the effective operation of the hospital. In addition, the Committee may discuss with the LIP whether a reasonable accommodation is needed or could be made so that the LIP could competently and safely exercise his or her clinical privileges and the duties and responsibilities of Medical Staff appointment.

1.1(g) Based on all of the information it reviews as part of its investigation, the ad hoc committee shall determine:

(1) Whether the LIP is impaired, or what other problem, if any, is affecting the LIP;

(2) Whether the LIP would benefit from professional resources, such as counseling, medical treatment or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and if so, what services would be appropriate;

(3) If the LIP is impaired, the nature of the impairment and whether it is classified as a disability under the ADA;

(4) If the LIP's impairment is a disability, whether a reasonable accommodation can be made for the LIP's impairment such that, with the reasonable accommodation, the LIP would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of Medical Staff appointment;

(5) Whether a reasonable accommodation would create an undue hardship upon the hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the hospital's operations or the provision of patient care; and

(6) Whether the impairment constitutes a "direct threat" to the health or safety of the LIP, patients, hospital employees, physicians or others within the hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the LIP appears to pose a direct threat because of a disability, the Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

1.1(h) If the investigation produces sufficient evidence that the LIP is impaired, the CEO shall meet personally with the LIP or designate another appropriate individual to do so. The LIP shall be told that the results of an investigation indicate that the LIP suffers from an impairment that affects his/her
practice. The LIP should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

1.1(i) If the ad hoc committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the LIP, so long as that arrangement would neither constitute an undue hardship upon the hospital nor create a direct threat, also as described above. The Chief Executive Officer and Chief of Staff shall be kept informed of attempts to work out a voluntary agreement between the Committee and the LIP, and shall approve any agreement before it becomes final and effective.

1.1(j) If the ad hoc committee determines that there is no reasonable accommodation that can be made as described above, or if the ad hoc committee cannot reach a voluntary agreement with the LIP, the ad hoc committee shall make a recommendation and report to the MEC, through the Chief of Staff, for appropriate corrective action pursuant to the Bylaws. If the MEC’s action would provide the LIP with a right to a hearing as described in the hospital's Medical Staff Bylaws or credentialing policy, all action shall be taken in accordance with the Fair Hearing Plan, and strict adherence to all state and federal reporting requirements will be required. The Chief Executive Officer shall promptly notify the LIP of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the hospital's Medical Staff Bylaws or credentialing policy.

1.1(k) The original report and a description of the actions taken by the ad hoc committee shall be included in the LIP's confidential file. If the initial or follow-up investigation reveals that there is no merit to the report, the same shall be noted on the report and no further action shall be taken. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the LIP's file and the LIP's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

1.1(l) The Chief Executive Officer shall inform the individual who filed the report that follow-up action was taken, but shall not disclose confidential peer review information or specific actions implemented.

1.1(m) All parties shall maintain confidentiality of any LIP referred for assistance, except as limited by law, ethical obligation, or when safety of a patient is threatened. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

1.1(n) In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the hospital or its Medical Staff, including the due process sections of those bylaws and policies, the provisions of this policy shall control.

1.1(o) Nothing herein shall preclude commencement of corrective action, including summary suspension under the Medical Staff Bylaws, or termination of any contractual agreements between the Hospital and the LIP, including any employment agreement, in the event that the LIP’s continued practice constitutes a threat to the health or safety of patients or any person.

2.1 Rehabilitation & Reinstatement Guidelines

If it is determined that the LIP suffers from an impairment that could be reasonably accommodated through rehabilitation, the following are guidelines for rehabilitation and reinstatement:

2.1(a) Hospital and Medical Staff leadership shall assist the LIP in locating a suitable rehabilitation program. A LIP who may benefit from counseling or rehabilitative services, but who is not believed...
to be impaired in his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the hospital. In cases where the LIP’s ability is believed to be impaired, the LIP shall be allowed a leave of absence if necessary. A LIP who is determined to have an impairment which requires a leave of absence for rehabilitation shall not be reinstated until it is established, to the satisfaction of the ad hoc committee, the MEC and the Board, that the LIP has successfully completed a program in which the hospital has confidence.

2.1(b) Upon sufficient proof that a LIP who has been found to be suffering from an impairment has successfully completed a rehabilitation program that LIP may be considered for reinstatement to the Medical Staff.

2.1(c) In considering an impaired LIP for reinstatement, the hospital and Medical Staff leadership must consider patient care interests paramount.

2.1(d) The ad hoc committee must first obtain a letter from the physician director of the rehabilitation program where the LIP was treated. The LIP must authorize the release of this information. That letter shall state:

(1) Whether the LIP is participating in the program;

(2) Whether the LIP is in compliance with all of the terms of the program;

(3) Whether the LIP attends AA meetings or other appropriate meetings regularly (if appropriate);

(4) To what extent the LIP's behavior and conduct are monitored;

(5) Whether, in the opinion of the director, the LIP is rehabilitated;

(6) Whether an after-care program has been recommended to the LIP and, if so, a description of the after-care program; and

(7) Whether, in the director's opinion, the LIP is capable of resuming medical practice and providing continuous, competent care to patients.

2.1(e) The LIP must inform the ad hoc committee of the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The ad hoc committee has the right to require an opinion from other physician consultants of its choice.

2.1(f) From the primary care physician the ad hoc committee needs to know the precise nature of the LIP's condition, and the course of treatment as well as the answers to the questions posed above in (4)(e) and (g).

2.1(g) Assuming all of the information received indicates that the LIP is rehabilitated and capable of resuming care of patients, the ad hoc committee, MEC and the Board shall take the following additional precautions when restoring clinical privileges:

(1) The LIP must identify another LIP that is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and

(2) The LIP shall be required to obtain periodic reports for the ad hoc committee from his or her primary physician—for a period of time specified by the Chief Executive Officer—stating that
the LIP is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

2.1(h) The LIP’s exercise of clinical privileges in the hospital shall be monitored by the department Chief or by a physician appointed by the department Chief. The nature of that monitoring shall be determined by the ad hoc committee after its review of all of the circumstances.

2.1(i) The LIP must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chairperson of the ad hoc committee or the pertinent department chair.

2.1(j) All requests for information concerning the impaired LIP shall be forwarded to the Chief Executive Officer for response.
IMPAIRED PHYSICIAN POLICY
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _______________________________ _______________________________
    Chief of Staff                          Date

BOARD OF TRUSTEES:

By: _______________________________ _______________________________
    Chairperson                          Date

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals:

By: _______________________________ _______________________________
    Chief Executive Officer              Date

APPROVED AS TO FORM:

By: _______________________________
    Legal Counsel for DLP Harris Regional Hospital, LLC and DLP Swain Community Hospital, LLC
    Date

APPROVED:

By: _______________________________ _______________________________
    Division President                   Date
APPENDIX “E” – PEER POLICY

DLP- Harris Regional Hospital/ DLP- Swain Community Hospital

Medical Staff Peer Review Policy & Procedure

Adopted: 10/13/2009
Revision Adopted by the Medical Management Committee: 5/27/2014
Revision Adopted by the Medical Staff: 10/02/2014
PURPOSE

The Medical Staff establishes these policies and procedures for the purposes of:

- assuring the hospital, through the activities of its Medical Staff, has an effective On-Going Professional Practice Evaluation process (OPPE) to assess and monitor the ongoing competence and performance of its Medical Staff, departments and delivery system.

- defining the Focused Professional Practice Evaluation (FPPE) and its use to complement the ongoing evaluation.

- establishing the process by which medical staff quality of care reviews such as peer review and unresolved complaints may be resolved in a non-punitive atmosphere that promotes education, performance improvement, and favorable clinical outcomes.

- maintaining confidentiality of the information generated during the process to allow complete, candid and honest assessment.

DLP- Harris Regional Hospital/ DLP- Swain Community Hospital supports the Medical Staff in addressing all quality of care concerns regarding practitioners through a non-biased and non-punitive process by which all provider-related occurrences are reviewed, documented, and appropriate action taken.

POLICY

1. The delivery of health care services by Practitioners will be continually monitored and evaluated by the Medical Management Committee through established processes.

2. The proceedings of a meeting of the Medical Management Committee, the Medical Executive Committee and any other standing or ad hoc committee acting in the capacity of a Medical Review Committee as that term is defined in N.C. Gen. Stat. 131E-76 (5) (the "Medical Review Committee"), the records and materials a Medical Review Committee produces and the materials it considers or information originated with or at the instance of a Medical Review Committee or a member of a Medical Review Committee acting in his/her capacity as a member shall be confidential.

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and NC General Statutes. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled accordingly.

3. All reviewers will sign a “Medical Management Committee Physician Attestation Statement of Confidentiality” prior to participating in peer review activities. MMC members will sign the statement on appointment. Reviewers who are not committee members will sign a statement for each requested review. Invited guests will sign a statement at the first meeting attended for that year.

“Statement of Confidentiality”

Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, not public records, shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena.
4. When acting in the capacity of a Medical Review Committee, only members of the committee and those persons involved directly or indirectly in the matter before the committee shall be present.

5. The Chairman of the Medical Management Committee (the "Chairman") shall for all intents and purposes be considered a member of the Medical Management Committee for purposes of these policies and procedures.

GOALS

1. Evaluate the ongoing professional practice of individual practitioners with clinical privileges which deviate from acceptable targets for the Medical staff indicators

2. Create a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities

3. Perform focused professional practice evaluation when potential practitioner improvement opportunities are identified and upon appointment of new privileges

4. Promote efficient use of practitioner and quality staff resources

5. Provide accurate and timely performance data for practitioner feedback, Ongoing and Focused Professional Practice Evaluation and reappointment

6. Support medical staff educational goals to improve patient care

7. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the medical staff

8. Assure that the process for peer review is clearly defined, fair, defensible, timely and useful.
DEFINITIONS

Peer Review

Peer review is the process by which a professional review body considers whether a practitioner’s clinical privileges or membership in a professional society will be adversely affected by a physician’s or AHP’s competence or professional conduct. The foremost objective of the medical peer review process is the promotion of the highest quality of medical care as well as patient safety (American Medical Association).

During this process, the practitioner is not considered to be “under investigation” for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

The data sources may include case reviews and aggregate data based on review, rule and rate indicators in comparison with generally recognized standards, benchmarks or norms. The data may be objective or perception-based as appropriate for the competency under evaluation.

Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the General Competencies framework described in “Medical Staff Expectations for General Competencies”.

Peer

An individual practicing in the same profession who has the expertise to evaluate the subject matter that is under review. The level of subject matter expertise required will determine what “practicing in the same profession” means on a case-by-case basis.

Practitioner

All persons who have been credentialed and granted privileges.

Rate Indicators

This type of indicator generates a record which is maintained for statistical analysis by the appropriate committee or administrative function. A target range is generally established for each rate indicator. This may be based on best practice from benchmark data or statistical variation from average or internal targets.

Reviewer

Physicians on the Medical Management Committee or MEC or Members of the Medical Staff or other Physicians conducting a case review on behalf of the MMC or MEC.

Rule Indicator

This type of indicator represents a general rule, standards or recognized professional guidelines of accepted practice of medicine. Individual variation does not directly cause adverse patient outcomes but there should be compliance.

Conflict of Interest

A member of the Medical Staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the practitioner is the provider under review or a first degree relative or spouse. Potential conflicts of interest would result if the practitioner was: 1) directly involved in the patient’s care but not related to the issues
under review or 2) a direct competitor, partner or key referral source, or 3) involved in a perceived personal conflict with the practitioner under review.

**Patient Encounter**

Shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

**Low volume Practitioner**

Any Practitioner who has had <12 patient encounters within a one (1) year timeframe.

**Ongoing Professional Practice Evaluation (OPPE)**

The routine monitoring and evaluation of current competency for practitioners with granted privileges. Ongoing professional practice evaluation (OPPE) allows the organization to identify professional practice trends that impact the quality of care and patient safety.

**Focused Professional Practice Evaluation (FPPE)**

Focused professional practice evaluation is a predefined process in which a hospital evaluates the privilege specific competence of a single provider. (Standard MS.08.01.01) This process is designed to complement the OPPE process.
PROCEDURES

► Peer Review Information Management

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and nondisclosurability.

2. The involved practitioner will receive provider-specific feedback on a routine basis.

3. The Medical Staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

4. Any written documents that the medical staff determines should be retained related to practitioner-specific peer review information will be kept by the hospital in a secure, locked file. Practitioner-specific peer review information may include

   ▪ individual case review findings,
   ▪ aggregate performance data for all of the general competencies measured for that practitioner
   ▪ any written correspondence with the practitioner deemed necessary regarding recommendations, improvement opportunities, or corrective action.

5. Only the final determinations, any subsequent actions or recommendations and correspondences between the committee and the practitioner are considered part of an individual practitioner’s quality file. Documents relating to peer review will be maintained in accordance with state and federal regulations as well as hospital policies. Peer review information in a practitioner’s quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Medical Management Committee Chair will assure that only authorized individuals have access to individual practitioner quality files and that the files are reviewed under the supervision of the Medical Staff Services Coordinator or designee for the following individuals:

   • The specific practitioner;
   • Members of the MEC and/or service chiefs, Credentialing Committee
   • Medical Staff Services professionals, Quality Management Director and quality staff supporting the peer review process;
   • Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. The Joint Commission or state/federal regulatory bodies;
   • Individuals with a legitimate purpose for access as determined by the hospital Board of Trustees;
   • The organization’s CEO for purposes of any potential professional review action as defined by the medical staff bylaws.
6. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, the Board or by mutual agreement between the Chief of Staff and the Medical Management Committee Chair.

**Ongoing Professional Practice Evaluation (OPPE)**

OPPE is used to assess the competence of those practitioners privileged through the medical staff process. Data is collected and analyzed for review every 8 months. This evaluation is accomplished through a review of various data sources as specified by MEC.

The written results of OPPE will become part of the practitioner’s quality file and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke an existing privilege prior to or at the time of renewal.

Results of the ongoing professional practice evaluations are communicated to the practitioner. The ongoing professional practice evaluation form will also act as the physician or AHP practice profile and will be distributed every eight (8) months for each active physician or AHP who has patient encounters at DLP- Harris Regional Hospital/ DLP- Swain Community Hospital.

The Medical Staff is responsible for ensuring that OPPE is consistently implemented and that clearly defined indications are uniformly applied.

**Individual Case Review / Internal Peer Review (IPR)**

- Quality concerns regarding patient care are to be addressed as they arise to provide continuous quality patient care and safety and to ensure favorable clinical outcomes. A quality concern regarding any practitioner may be raised by medical staff or midlevel professionals, hospital staff, and patients/families/visitors or through the performance improvement process. The concerned party will file a report with the Quality Management Department.

The MMC will review and act upon situations involving questions of clinical competence, patient care and treatment, case management, or inappropriate behavior of any practitioner. A targeted chart review is warranted whenever the Chief of Staff, chief of a clinical service, or Administration:

- Has cause to question the demonstrated clinical competence of any practitioner
- Has cause to question the care or treatment of a patient or management of a case by any practitioner
- Knows of or has reason to suspect violation by any practitioner of applicable ethical standards of the medical staff bylaws, rules and regulations, policies, corporate bylaws, or the corporate responsibility program or standards of conduct

Quality of care issues may be reported electronically (e-mail, current reporting web site), verbally (using an occurrence reporting form), and via the organization’s Hotline. All reports are processed in accordance with DLP- Harris Regional Hospital/ DLP- Swain Community Hospital policies and procedures and Medical Staff bylaws, Rules & Regulations and policies and procedures.

Any evaluation referencing peer review or quality concern issues shall be submitted to the MEC during its next meeting; however, the Chief of Staff or his or her designee shall, at any time, immediately act upon
any reported concern regarding a privileged practitioner’s clinical practice or competence in accordance with Article VIII, Corrective Action section of the Medical Staff bylaws.

Peer review will be conducted in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality Management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability. The timelines for this process are described in the Case Review Process Chart.

• Rating/Evaluation System:
  The rating/evaluation system for determining results of individual case reviews is described as follows:

  RA: Reviewed, determined to be appropriate
  01A: Complication that is expected, anticipated, and managed appropriately
  01B: Complication that is NOT expected and anticipated, but managed appropriately
  02: Documentation Concern
  03: Opportunity for Improvement
  04: Opportunity for improvement with referral to MEC for Focused Professional Plan Evaluation (FPPE) consideration
  R: Referred to another Committee for care issue
  P: Referred for process issue

•Reviewer:

  o If the specialty is not represented on the MMC, the Medical Management Committee Chair may appoint a Medical Staff Member who specializes in the non-represented medical field or specialty to conduct the evaluation for and on behalf of the MMC. Any appointment of a reviewer shall be in writing, dated and signed by the MMC Chair.

  o If the initial reviewer determines a case has a technical issue outside of their expertise, they will inform QM.

  o If either QM or the initial reviewer feels the case needs specialty review, QM will contact the MMC Chair for confirmation and to determine the appropriate specialty reviewer(s).

  o It is the obligation of the reviewer to disclose to the MMC any potential conflict. It is the responsibility of the MMC to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating.

    • When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during peer review discussions or decisions other than to provide specific information requested as described in the Case Review Process.

• Review Process (See Case Review Process / for details.)

  o The reviewer may use all available data including, but not limited to, chart analysis and interviews with Hospital staff and Practitioners involved in the case that will assist the reviewer and the MMC in the evaluation and assessment.
The reviewer or the MMC may request staff to assist in the investigation.

In the event the final determination of the case is reveals an opportunity for improvement, the MMC will notify the Practitioner and refer the case to the MEC in a timely manner.

- At least 14 calendar days before the date that the MEC will receive the information regarding the case, the MMC will notify the Practitioner in writing that the information will be presented to the MEC.

- The person delivering such notification shall record the date and time the notice was delivered.

- The Practitioner may appear before the MEC and present his/her analysis of the results upon written request executed by the Practitioner. Such written request must be delivered to the Chairman of the MEC or his designee on or before five (5) days after the Practitioner is given notification that such information will be referred to the MEC, otherwise the Practitioner shall not be entitled to appear before the MEC.

The MEC upon receipt of information from the MMC will take whatever action it deems necessary to reasonably address the issues including, without limitation, direct that the MMC conduct a more detailed review, take corrective action as set forth in the bylaws, require that one or more Practitioners or Hospital staff pursue further training, or issue a letter to one or more Practitioners that details the concerns of the MEC.

The MEC upon receipt of information from the MMC will take whatever action it deems necessary to reasonably address the issues including, without limitation, direct that the MMC conduct a more detailed review, take corrective action as set forth in the bylaws, require that one or more Practitioners or Hospital staff pursue further training, or issue a letter to one or more Practitioners that details the concerns of the MEC.

After the MEC has completed its final assessment, the Practitioner may see a summary of the review and the MEC's action in the Medical Staff Services Department. The summary of the review shall not include the identification of the Reviewer.

External Peer Review (EPR):

Administration or the MMC may request the MEC to authorize an EPR. No practitioner can require the hospital to obtain EPR if it is not deemed appropriate by the MMC and/or the MEC.

Circumstances for EPR may include but are not limited to the following:

- Lack of internal expertise: when no one on the medical staff has adequate expertise in the specialty under review; including new procedures or technology or the only practitioners on the medical staff with that expertise are determined to have a significant conflict of interest.

- Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees.

- Legal concerns: when the medical staff needs confirmation of internal findings or an expert witness for potential litigation or fair hearing

- Credibility: when or if the medical staff or board needs to verify the overall credibility of the IPR process typically as an audit of IPR findings.

- Benchmarking: when an organization is concerned about the care provided by its physicians or AHP’s relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.
• Lack of internal resources: when the medical staff has the expertise but lacks sufficient time to perform EPR.

• In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

An external reviewer is appointed to the committee as an ad hoc member for the purpose of completing a case review.

The authorizing body will define whether the results will be considered definitive regarding the quality and appropriateness of care once the report is received. This will be based on the nature of the review, the expertise of the reviewer, and the issues under review.

Once the results of EPR are obtained, unless the reason for EPR was due to legal concerns or credibility, the report will first be reviewed by the MMC at its next regularly scheduled meeting unless an expedited process is requested by the MEC, Administration or the Board. The MMC will determine if any improvement opportunities are present. If improvement opportunities exist, they will be handled through the same mechanism as IPR unless the issue is already being addressed in the corrective action process. If EPR is authorized for legal concerns or credibility, the requesting body will determine which body should perform the initial review of the report.

The MEC will prospectively determine the nature of the involvement for the practitioner under review. If issues are identified, the practitioner will be allowed to review the report and will be given an opportunity to provide input regarding its findings in the same timeframes as for IPR prior to the committee’s final decision. The identity of the EPR reviewer will be blinded from the practitioner.

If the MEC does not authorize an EPR, then it will select a Member as a reviewer.

Selection of Practitioner Performance Measures

Measures of practitioner performance will be selected to reflect the six General Competencies and will utilize multiple sources of data described in the Medical Staff Indicator List in.

► Focused Professional Practice Evaluation (FPPE) (Standard MS.08.01.01)

A process designed to complement the OPPE process. The process is time-limited and requires the medical staff to evaluate the privilege-specific competence of a practitioner who either has had an expansion or new privileges added at the healthcare facility or to evaluate the clinical competence of a practitioner, when a question has arisen regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care. FPPE is not considered an investigation as defined by the Medical Staff Bylaws. If a FPPE results in action plan requiring an investigation, the process outlined in the Medical Staff Bylaws would apply.

Upon the granting of privileges, each practitioner shall have his or her performance monitored, evaluated, documented, and reported to the Medical Management Committee (MMC) on an ongoing basis. Focused professional practice evaluations shall be performed and documented for each practitioner without documented current privilege-specific performance at the organization, whenever a question arises regarding a practitioner’s ability to provide safe and high quality patient care, or as otherwise indicated within the medical staff bylaws and policies.
The evaluation process:

Providers are evaluated on the six (6) General Competencies:

a) Patient Care
b) Medical/Clinical Knowledge
c) Practice-Based Learning
d) Interpersonal Communication Skills
e) Professionalism
f) Systems –Based Practice

(See “Medical Staff Expectations for General Competencies”)

Information used for evaluation may be obtained through, but is not limited to:

a) Concurrent or targeted medical record review
b) Direct observation
c) Monitoring clinical practice patterns
d) Proctoring via direct observation
e) Discussion with other individuals involved in the care of specific patients
f) Data collected and assessed for the organization’s quality improvement indicators
g) Occurance Screening Reviews
h) Any applicable peer review data

All reviews shall be considered a part of the confidential peer review activity of the medical staff and are intended to enhance the quality and safety of patient care, and as such is entitled to peer review protection and privilege.

FPPE Process for Initial privileges:

a) The MSS shall provide each proctor with the approved proctoring evaluation form. Evaluations shall be performed by the clinical service chief or an appointed member of the medical staff. Evaluations shall be submitted to Medical Staff Services (MSS) with their results being presented to the MMC. Concerns regarding a practitioner’s clinical practice or competence shall be acted upon immediately.

b) Monitoring/proctoring of specific procedures shall be performed as required by the clinical service, or upon request of the clinical service chief. The medical director or clinical service chief of each involved service shall assign a proctor from the medical staff. If a proctor cannot be chosen from the medical staff due to an obvious or perceived potential conflict of interest, the Chief of Staff and CEO shall agree upon a proctor who may or may not be a current member of another organization’s medical staff.
Due to the nature of the hospital, proctoring may occur at another organization, with the approval of the Chief of Staff and CEO, if the same circumstances (equipment/supplies/support) are available at this organization for future performance of the specified procedure. Completion and submission of this organization’s approved proctoring form is required.

If there is insufficient activity available for assessment, the timeframe may be extended with alternative methods utilized.

If practitioner is terminated or resigns for any reason prior to the completion of the FPPE process the assigned peer reviewer will conduct a review of the cases performed by clinician (if any) and attach a letter to the FPPE form stating that the physician’s or AHP’s employment was terminated. (MS.01.01.01 EP 1)

Process for Performance issues resulting in FPPE:

In the case that a potential issue with a practitioner’s performance is identified, the MMC may initiate a FPPE.

The thresholds for FPPE are described in the acceptable targets for the medical staff indicators. However, a single egregious case may initiate a focused review by the MMC.

The MMC Committee will notify the Practitioner and send the information to the MEC if the results of the FPPE reflect a significant change or deviation in the Practitioner’s behavior from standards, guidelines, monitoring criteria and/or policies and procedures established by the organization and or the medical staff.

- At least 14 calendar days before the date that the MEC will receive the information regarding the FPPE, the MMC will notify the Practitioner in writing that the information will be presented to the MEC.
- The person delivering such notification shall record the date and time such notice was delivered.
- The Practitioner may appear before the MEC and present his/her analysis of the results upon written request executed by the Practitioner. Such written request must be delivered to the Chairman of the MEC or his written designee on or before five (5) days after the Practitioner is given notification that such information will be referred to the MEC, otherwise the Practitioner shall not be entitled to appear before the MEC.
- The MEC, upon receipt of information from the MMC, will take whatever action it deems necessary to reasonably address the issues including, without limitation, direct that the MMC conduct a more detailed review, take corrective action as set forth in the bylaws, require that one or more Practitioners or Hospital staff pursue further training, or issue a letter to one or more Practitioners that details the concerns of the MEC.

- If the information regarding the FPPE indicates the need for a performance improvement plan, the plan will be drafted by the MMC or the responsible department, committee, or chair and will be presented to the MEC for approval. Improvement methods may include education, proctoring, mentoring, counseling, enrollment in a practitioner behavior or wellness program, or suspension or revocation of privileges, subject to the provisions of the Medical Staff Bylaws. If the practitioner agrees with the plan, it should be signed and placed in the practitioner’s file. If the practitioner does not agree or refuses to implement the plan, this will be reported to the department chair, MMC, and/or MEC for resolution.
- After the MEC has completed its final assessment, the Practitioner may see a summary of the review and the MEC's action in the Medical Staff Services Department. The summary of the review shall not include the identification of the Reviewer.

**OPPE as Performance Feedback**

The best approach to improve practitioner performance is to provide practitioners their own data on the general competencies on a regular basis which can also be used by medical staff leaders for systematic evaluation and follow-up for OPPE. The use of the OPPE for the Performance Feedback procedures are as follows:

- The OPPE form will be distributed every 8 months to practitioners with patient encounters at DLP-Harris Regional Hospital/ DLP- Swain Community Hospitals. The OPPE data will be confidential to the individual practitioner and appropriate medical staff leaders (i.e. Service Chiefs, Credentialing Committee, Medical Management Committee, Medical Executive Committee and Medical Staff Officers).
PEER REVIEW POLICY
ADOPTED & APPROVED:

MEDICAL STAFF:

By: ________________________________  ________________________________
    Chief of Staff                              Date

BOARD OF TRUSTEES:

By: ________________________________  ________________________________
    Chairperson                              Date

Harris Regional Hospital & Swain Community Hospital, Duke Lifepoint Hospitals:

By: ________________________________  ________________________________
    Chief Executive Officer                  Date

APPROVED AS TO FORM:

By: ________________________________
    Legal Counsel for DLP Harris Regional Hospital, LLC
    and DLP Swain Community Hospital, LLC
                      Date

APPROVED:

By: ________________________________
    Division President                  Date