
Mercy Regional Medical Center
MEDICAL STAFF BYLAWS

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MEDICAL STAFF BYLAWS¹²³⁴⁵

OF

Mercy Regional Medical Center

PREAMBLE

WHEREAS, Mercy Regional Medical Center, hereinafter referred to as "Hospital", is operated by Ville Platte Medical Center, LLC hereinafter referred to as "Corporation", a private corporation organized under the laws of the state of Louisiana and is lawfully doing business in Louisiana, 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.

NOW, THEREFORE, the practitioners practicing in Mercy Regional Medical Center hereby organize themselves into a Medical Staff conforming to these bylaws.

¹ Appendix A: Fair Hearing Plan – 42 USC 11101

² Appendix B: Medical Staff Rules and Regulations-MS 01.01.01 EP 15

³ Appendix C: Disruptive Practitioner Policy – 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: Focused Professional Practice Evaluation Policy

DEFINITIONS

1. "Active Staff" members shall be those physicians (D.O.'s and M.D.'s) licensed in the state of Louisiana that has the privilege of admitting patients, holding office and voting.
2. "Allied Health Professional" or "AHP" means an individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital. Such AHPs shall include, without limitation, Physician Assistants, Nurse Practitioners, CRNA, and other such professionals. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.
3. "Board" means the Board of Trustees of the Mercy Regional Medical Center.
4. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties or the American Board of Osteopathic Specialists.
5. "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.
6. "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.
7. "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.
8. "Corporation" means Ville Platte Medical Center, LLC.
9. "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.
10. "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.
11. "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.
12. "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 practitioner's clinical privileges are adversely affected by a determination based on the practitioner's professional conduct or competence. This procedure is incorporated into these Bylaws and is contained in Appendix "A" hereto.
13. "Hospital" means Mercy Regional Medical Center.
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 departmental 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 "E" hereto.
21. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Louisiana.
22. "Practitioner" means a physician who has been granted clinical privileges at the Hospital.
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.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Mercy Regional Medical Center.

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;⁶
- 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 performance improvement activities in accordance with the Hospital's performance improvement program;⁷
- 2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and AHPs 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;⁸
- 2.1(e) To promulgate, maintain and enforce bylaws and rules and regulations for the proper functioning of the Medical Staff;⁹
- 2.1(f) 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;¹⁰
- 2.1(g) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;¹¹
- 2.1(h) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO;¹²
- 2.1(i) To accomplish its goals through appropriate committees and departments; and

⁶ MS 01.01.01

⁷ MS 05.01.01; MS 05.01.03; LD 01.05.01 EP 5

⁸ [42 CFR 482.22](#); [LD 01.05.01 EP 5](#)

⁹ MS 01.01.01 EP 1.4

¹⁰ MS 01.01.01

¹¹ LD 01.05.01; LD 04.03.01

¹² LD 01.05.01; MS 01.01.01

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 and AHPs 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;¹³
- (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;¹⁴
- (3) Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the Hospital;¹⁵
- (4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan;¹⁶
- (5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPS;¹⁷
- (6) Initiate and pursue corrective action with respect to practitioners and AHPs, when warranted;¹⁸
- (7) Develop, administer and enforce these bylaws, the rules and regulations of the staff and other hospital policies related to medical care;¹⁹
- (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;²⁰
- (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 "B" hereto.²¹

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.²²

¹³ 42 CFR 482.24; 42 CFR 482.11

¹⁴ MS 03.01.03; MS06.01.01; MS 06.01.09

¹⁵ MS 12.01.01

¹⁶ MS 05.01.01; MS 05.01.03

¹⁷ MS 07.01.01; MS 03.01.01

¹⁸ MS 01.01.01 EP 12-15

¹⁹ MS 01.01.01 EP 1-4

²⁰ MS 09.01.01

²¹ MS 11.01.01

²² 45 CFR Parts 160, 162, 164 (HIPAA Administrative Simplification).

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT²³

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.

²³ 45 CFR 164.506

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.²⁴

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications²⁵

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

- (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;²⁶
- (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;²⁷
- (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;²⁸
- (4) Have professional liability insurance that meets the requirements of these Bylaws;
- (5) Are graduates of an approved educational institution holding appropriate degrees;²⁹
- (6) Show evidence of the following educational achievements: 12 hours every 2 years or show evidence of current Louisiana State Medical License. The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital;³⁰
- (7) Meet one of the following requirements, in addition to those listed above:
 - (i) Board certification; or

²⁴ MS 03.01.03

²⁵ 42 CFR 482.22

²⁶ MS 06.01.03

²⁷ MS 07.01.03

²⁸ MS 06.01.05 EP 9

²⁹ MS 06.01.03

³⁰ MS 06.01.03

- (ii) demonstration to the satisfaction of the MEC and the Board of Trustees, competency and training equal or equivalent to that required for Board certification.

The above requirement shall not apply to any practitioner already a member of the Medical Staff as of *January 1, 1999*.³¹

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.³²

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.³³

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.³⁴

3.2(e) Multiple Applications

Due to the administrative expense and inefficiencies created by multiple withdrawals of applications, any applicant who has withdrawn his/her application for Medical Staff membership three (3) times during any six (6) year period shall not be allowed to re-apply for an additional five (5) years from the most recent withdrawal.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP³⁵

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;³⁶
- 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;³⁷

³¹ 42 CFR 482.12(a)(7)

³² 42 CFR 482.22(c)(4)

³³ 42 USC 1981

³⁴ 42 CFR 482.12(a)(6)

³⁵ 42 CFR 482.22

³⁶ 42 CFR 482.12(a)(5)

³⁷ 42 CFR 482.30(f)

- 3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff;³⁸
- 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;³⁹
- 3.3(e) Cooperate with other members of the Medical Staff, management, the Board of Trustees and employees of the Hospital;⁴⁰
- 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;⁴¹
- 3.3(g) Attest that he/she suffers from no health problems which could effect 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;⁴²
- 3.3(h) Abide by the ethical principles of his/her profession and specialty;⁴³
- 3.3(i) Refuse to engage in improper inducements for patient referral;⁴⁴
- 3.3(j) Notify the CEO and Chief of Staff immediately if:⁴⁵
- (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; or
 - (4) He/She has been excluded from any federal or state health program, including Medicare and Medicaid.⁴⁶
- 3.3(k) 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.⁴⁷

³⁸ MS 01.01.01 EP 4

³⁹ MS 01.01.01 EP 4

⁴⁰ MS 01.01.01

⁴¹ 42 CFR 482.24

⁴² MS 06.01.05 EP 2 and 6

⁴³ 42 CFR 482.12(a)(6)

⁴⁴ 42 USC 1320a-7b

⁴⁵ 42 CFR 482.12(a)(6)

⁴⁶ MS 06.01.05 EP 9

⁴⁷ 45 CFR 160.103

3.4 HISTORY AND PHYSICAL EXAMINATIONS⁴⁸

Each qualified physician (or other licensed independent practitioner who has been credentialed and granted privileges to perform a history and physical examinations) shall complete an admission history and physical examination for every patient admitted for inpatient care within twenty-four (24) hours of admission, and immediately prior to any procedure(s) requiring anesthesia or sedation. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. 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. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered incomplete and the Chief of Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance, including but not limited to immediate suspension from scheduling and/or performing non-emergent elective procedures within the Hospital until completed. If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia/sedation, or other major high risk procedures.

A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed, and noting that "no change" has occurred or noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission, and immediately prior to any procedure(s) requiring anesthesia or sedation.

3.5 DURATION OF APPOINTMENT⁴⁹

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

⁴⁸ 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.

⁴⁹ 48 CFR 482.22(a)(1) (Interpretive Guidelines); MS 06.01.07 EP 8

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.

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.

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 the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC receives evidence of completion of such training and/or the MEC has satisfied itself as to the continuing competency of the returning staff member.

Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

- (3) Reinstatement will ordinarily be automatic if a leave of absence is an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, 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, to insure continuing competence.
- (4) If a member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.⁵⁰

⁵⁰ MS 06.01.05; MS 06.01.07

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF⁵¹

4.1 CATEGORIES

The staff shall include Active, Courtesy, Consulting and Honorary 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 45 minutes 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 24 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.

4.2(c) Responsibilities

Each member of the Active Staff shall:

- (1) Meet the basic responsibilities set forth in Section 3.3;⁵²

⁵¹ 42 CFR 482.22(c)(2)-(c)(3)

⁵² 42 CFR 482.22

- (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/critical care unit no later than 2 hours after admission or sooner if warranted by the patient's condition;⁵³
- (3) Actively participate:
 - (i) in the performance improvement 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;⁵⁴
 - (ii) in supervision of other appointees where appropriate;⁵⁵
 - (iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;⁵⁶
 - (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.

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) Have an office and/or residence located within 60 miles of the Hospital in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided;
- (3) Do not admit or participate in the care of more than 23 patients in a calendar year. Courtesy members who admit or are involved in the care of more than 23 patients in a calendar year must transfer to active staff. The requirement to transfer to active staff may be waived by the

⁵³ 42 CFR 482.12(a)(5)

⁵⁴ MS 05.01.01; MS 05.01.03

⁵⁵ MS 08.01.01; MS 03.01.01 EP 3

⁵⁶ 42 CFR 489.20(r)(2)

Board for practitioners who have their primary practice outside the community and provide services not otherwise available in the community; and

- (4) Are members of the Active Staff of another hospital where he/she actively participates in the performance improvement 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 Chairperson of any department and shall not 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; and⁵⁷
- (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.

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.

⁵⁷ 42 CFR 482.12(a)(5) (Interpretive Guidelines)

Consulting Staff members must have fewer than 12 encounters in which they manage direct patient care. Consulting Staff members whose primary practice is located in the community must transfer to Active Staff if they exceed the accepted number of encounters referenced above.

- (4) Are members of the Active Staff of another hospital where he/she actively participates in the performance improvement 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 EMERGENCY CONTRACT STAFF

4.6(a) Qualifications

Emergency contract 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 training.

Physicians currently in residency shall be considered upon complete review and approval by the Credentialing Committee (MEC) and the Board. Review will be based on but not limited to current year of residency and experience.

Emergency contract staff shall also be certified in Advance Cardiac Life Support

4.6(b) Responsibilities

Each member of the Emergency Contract Staff shall assume responsibility, as requested by an Active or Courtesy Staff member, for emergency and appropriate documentation thereof with regard to particular patients.

ARTICLE V
ALLIED HEALTH PROFESSIONALS (AHP)⁵⁸

5.1 CATEGORIES

Allied Health Professionals (“AHPs”) shall be identified as any person(s) other than practitioners who are granted privileges to practice in the Hospital and are directly involved in patient care. Such persons 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 and not exceed the limitations of practice set forth by their respective licensure.⁵⁹

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.⁶⁰

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;⁶¹
- (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;⁶²
- (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.⁶³

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;⁶⁴
- 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; and⁶⁵

⁵⁸ 42 CFR 482.22(c)(2)-(c)(3)

⁵⁹ MS 03.01.03 EP 4

⁶⁰ MS 06.01.05 EP 2

⁶¹ MS 06.01.03

⁶² MS 07.01.03

⁶³ MS 03.01.03 EP 4

⁶⁴ MS 03.01.03 EP 4

⁶⁵ MS 03.01.03 EP 4

- 5.3(c) To participate as appropriate in 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.⁶⁶

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 credentialing of practitioners. 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.⁶⁷
- 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.⁶⁸
- 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.⁶⁹
- 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.⁷⁰

⁶⁶ MS 05.01.01; MS 05.01.03

⁶⁷ MS 06.01.07 EP 4

⁶⁸ MS 01.01.01 EP 14-15; 42 USC 11101

⁶⁹ MS 01.01.01 EP 14-15; 42 USC 11101

⁷⁰ MS 01.01.01 EP 14-15; 42 USC 11101

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.

5.5 RESPONSIBILITIES

Each AHP shall:

- 5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;⁷¹
- 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;⁷²
- 5.5(c) Discharge any committee functions for which he/she is responsible;⁷³
- 5.5(d) Cooperate with members of the Medical Staff, administration, the Board of Trustees and employees of the Hospital;⁷⁴
- 5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;⁷⁵
- 5.5(f) Abide by the ethical principles of his/her profession and specialty; and⁷⁶
- 5.5(g) Notify the CEO and the Chief of Staff immediately if:⁷⁷
 - (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; or
 - (4) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privileges.⁷⁸

⁷¹ 42 CFR 482.12(a)(5)

⁷² MS 01.01.01 EP 3

⁷³ MS 01.01.01 EP 3

⁷⁴ MS 01.01.01

⁷⁵ 45 CFR 482.24

⁷⁶ 42 CFR 482.12(a)(6)

⁷⁷ 42 CFR 482.12(a)(6)

⁷⁸ MS 06.01.05

- 5.5(h) 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.⁷⁹

⁷⁹ 45 CFR Parts 160, 162, 164 (HIPAA Administrative Simplification).

ARTICLE VI
PROCEDURES FOR APPOINTMENT & REAPPOINTMENT⁸⁰

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.⁸¹

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. Applicants shall supply the Hospital with all information requested on the application.⁸²

The application form shall include, at a minimum, the following:⁸³

- (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:
 - (i) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and
 - (ii) 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
- (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;⁸⁴
- (c) 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;⁸⁵
- (d) 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 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;⁸⁶
- (e) Information on Malpractice Experience: All information concerning malpractice suits against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of

⁸⁰ 42 CFR 482.22

⁸¹ MS 06.01.07

⁸² MS 06.01.03

⁸³ MS 01.01.01 EP 4

⁸⁴ 42 USC 11101

⁸⁵ MS 06.01.05 EP 9

⁸⁶ MS 06.01.05 EP 2 and 6

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 suits against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions;⁸⁷

- (f) Education: Detailed information concerning the applicant's education and training.⁸⁸
- (g) 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;
- (h) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions;
- (i) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:⁸⁹
 - (i) membership/fellowship in local, state or national professional organizations;
 - (ii) specialty board certifications;
 - (iii) license to practice any profession in any jurisdiction;
 - (iv) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists);
 - (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 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.

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 of the above actions against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions.⁹⁰

- (j) 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;⁹¹
- (k) References: The names of at least three (3) practitioners (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, experience, clinical ability and

⁸⁷ 42 CFR 482.12(a)(6)

⁸⁸ MS 06.01.05 EP 2

⁸⁹ 42 CFR 482.12(a)(6)

⁹⁰ MS 06.01.05 EP 9

⁹¹ MS 06.01.05 EP 2

current competence, ethical character and ability to exercise the privileges requested and to work with others;⁹²

- (l) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;⁹³
- (m) Request: Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;⁹⁴
- (n) Photograph: A recent, wallet sized government issued photograph of the applicant;
- (o) Citizenship Status: Proof of United States citizenship or legal residency; and⁹⁵
- (p) 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 current privilege the applicant.⁹⁶

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.

6.3(b) Applicant's Burden⁹⁷

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, shall be grounds for immediate rejection of his/her application; and
- (5) Pledges to provide continuous care for his/her patients treated in the Hospital.⁹⁸

⁹² MS 07.01.03

⁹³ MS 06.01.05 EP 2

⁹⁴ MS 06.01.03-06.01.07

⁹⁵ 42 CFR 482.12(a)(6)

⁹⁶ MS 06.01.05 EP 2

⁹⁷ MS 06.01.03; MS 06.01.05; MS 06.01.07

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 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.

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;

⁹⁸ 42 CFR 482.12(a)(5)

- (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 Information⁹⁹

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; or¹⁰⁰
- (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
- (3) Exclusive Contract. The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital; or¹⁰¹
- (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; or¹⁰²
- (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); or¹⁰³
- (7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy 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 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 at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer

⁹⁹ MS 06.01.03

¹⁰⁰ MS 06.01.05 EP 2

¹⁰¹ MS 06.01.01

¹⁰² MS 06.01.05 EP 9

¹⁰³ MS 06.01.05 EP 9

printout obtained from the appropriate licensing board. Verification of current licensure through 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.¹⁰⁴

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.¹⁰⁵

6.3(f) Recommendation of Department Chairperson

The Chairperson 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.¹⁰⁶

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 Chairperson 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.¹⁰⁷

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(1). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff

¹⁰⁴ MS 06.01.03; MS 06.01.05 EP 7; MS 06.01.07

¹⁰⁵ MS 06.01.05; MS 06.01.07

¹⁰⁶ MS 06.01.07

¹⁰⁷ MS 06.01.07

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.¹⁰⁸

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.¹⁰⁹

- (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 Chairperson. 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.¹¹⁰
- (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. 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.¹¹¹

6.3(j) Board Action

- (1) Decision; Deadline. The Board of Trustees may accept, reject or modify the MEC recommendation. 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 Secretary of the Board shall reduce the decision to writing and shall set forth therein the reasons for the decision. 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.¹¹²
- (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

¹⁰⁸ MS 06.01.03; MS 06.01.05

¹⁰⁹ MS 06.01.05; MS 06.01.03

¹¹⁰ MS 06.01.05; MS 06.01.03

¹¹¹ MS 06.01.09; MS 01.01.01 EP 15; 42 USC 11101

¹¹² MS 06.01.03; MS 06.01.05; LD 01.03.01; MS 06.01.07 EP 7

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 performance improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.¹¹³

- (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. 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.

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.¹¹⁴

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.

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.

6.3(m) Time Periods for Processing¹¹⁵

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 Chairperson 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.¹¹⁶

¹¹³ MS 06.01.07 EP 7; MS 06.01.09

¹¹⁴ MS 06.01.09; MS 01.01.01 EP 15; 42 USC 11101

¹¹⁵ Please consult State Law regarding time periods for processing applications

¹¹⁶ MS 06.01.07 EP 3

6.3(n) Denial for Hospital's Inability to Accommodate Applicant¹¹⁷

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.

6.3(o) Appointment Considerations¹¹⁸

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.

¹¹⁷ 42 USC 11101; MS 06.01.01; MS 01.01.01 EP 15

¹¹⁸ MS 06.01.01; MS 06.01.03

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.¹¹⁹

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

The Reapplication Form must be accompanied by a \$60 processing fee (applies to Courtesy and Consulting reapplications) and 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;¹²⁰
- (2) **License**: Current licensure;¹²¹
- (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;¹²²
- (4) **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;¹²³
- (5) **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:¹²⁴
 - (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

¹¹⁹ MS 01.01.01 EP 12-15

¹²⁰ MS 06.01.05 EP 2

¹²¹ MS 06.01.03

¹²² 06.01.05 EP 2 and 6

¹²³ MS 06.01.05 EP 2

¹²⁴ 42 CFR 482.12(a)(6)

- (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.¹²⁵
- (6) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period,¹²⁶
 - (7) 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;
 - (8) 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 Chairperson 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 performance improvement 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.¹²⁷

Practitioners 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 shall have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist must complete the Physician Reappointment Profile Hospitalist Addendum. The Hospitalist shall 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 shall 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;¹²⁸

- (9) 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;¹²⁹

¹²⁵ MS 06.01.05 EP 9

¹²⁶ 42 CFR 482.12(a)(6)

¹²⁷ 42 CFR 482.12(a)(6)

¹²⁸ MS 06.01.05

¹²⁹ MS 06.01.05 EP 9

- (10) Notification of Release & Immunity Provisions: The acknowledgments and statement of release;
- (11) 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; and¹³⁰
- (12) 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 two (2) practitioners (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.¹³¹

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.¹³²

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.¹³³

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 Performance Improvement activities which

¹³⁰ MS 06.01.05 EP 2 and 9

¹³¹ MS 07.01.03

¹³² MS 06.01.03

¹³³ MS 06.01.05; MS 06.01.07

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.¹³⁴

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.¹³⁵

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.¹³⁶

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. The Fair Hearing does not apply in this case.¹³⁷

¹³⁴ MS 06.01.03

¹³⁵ MS 06.01.05; MS 06.01.07

¹³⁶ 42 CFR 482.11

¹³⁷ MS 01.01.01 EP 12-14

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES¹³⁸

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 7.5, 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.¹³⁹

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.¹⁴⁰

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 performance improvement 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.¹⁴¹

¹³⁸ 42 CFR 482.22

¹³⁹ MS 06.01.05

¹⁴⁰ MS 07.01.03; MS 06.01.05

¹⁴¹ MS 06.01.05

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.¹⁴²

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.¹⁴³

7.2(e) Initial and Additional Grants of Privileges¹⁴⁴

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 evaluation for a period of not less than six (6) months. 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 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS¹⁴⁵

7.3(a) Temporary Privileges

The CEO or his/her designee, upon recommendation of the Chief of Staff or Chairperson 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: After receipt of a completed application for staff appointment, including a request for specific temporary privileges, for a period not to exceed the pendency of the application. Prior to any award of temporary privileges pursuant to this Section, the applicant must submit, in addition to the completed application, a photograph, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine and DEA certificate. In exercising temporary privileges, the applicant shall act under the supervision of the Chairperson of the applicable department.
- (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

¹⁴² MS 06.01.05; MS 06.01.07

¹⁴³ MS 07.01.01

¹⁴⁴ MS 08.01.01

¹⁴⁵ MS 06.01.03

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.

- (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.

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.

7.3(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.

7.3(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.¹⁴⁶

7.3(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.¹⁴⁷

7.3(e) Term

No term of temporary or locum tenens privileges shall exceed a total of one hundred and twenty (120) days.¹⁴⁸

7.4 EMERGENCY & DISASTER PRIVILEGES¹⁴⁹

For the purpose of this section, an “emergency” is defined as a condition in which serious or permanent harm to a patient is likely to occur, or in which the life of a patient is in immediate danger, and delay in administering treatment would add to that danger. 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 7.4(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.

¹⁴⁷ 42 USC 11101; MS 01.01.01 EP 14

¹⁴⁸ MS 06.01.13 EP 6

¹⁴⁹ EM 02.02.11; EM 02.02.13-EM 02.02.15

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.

7.5 TELEMEDICINE¹⁵⁰

7.5(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.

7.5(b) Telemedicine Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the "telemedicine physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. If the telemedicine physician's site is also accredited by JOINT COMMISSION, and the telemedicine physician is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telemedicine physician's credentialing information from that site may be relied upon to credential the telemedicine physician 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. This Hospital shall further conduct the verification procedures for all hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated.

¹⁵⁰ 42 CFR 482.11(c); MS 13.01.01; MS 13.01.03

ARTICLE VIII
CORRECTIVE ACTION¹⁵¹

8.1 ROUTINE CORRECTIVE ACTION

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 to 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 Chairperson 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 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 constitutes the grounds for the request. 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;
- (5) Recommending reduction, suspension or revocation of clinical privileges;
- (6) Recommending reduction of staff category or limitation of any staff prerogatives; or

¹⁵¹ 42 USC 11101; MS 10.01.01

(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) or (6) (where such action materially restricts a practitioner's exercise of privileges) or any combination of such actions, shall entitle the practitioner 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 SUSPENSION¹⁵²

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.

¹⁵² MS 01.01.01 EP 12-13

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 practitioner's clinical privileges, the practitioner 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 SUSPENSION¹⁵³

8.3(a) License

A staff member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in Louisiana 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 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 8.4(c)(1), any staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.4(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 physician 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.

8.3(e) Exclusions/Suspension from Medicare

Any physician who is excluded from the Medicare program or any state government payor program will be automatically suspended.

¹⁵³ MS 01.01.01 EP 12-13

8.3(f) Automatic Suspension - Fair Hearing Plan Not Applicable

No staff member, whose privileges are automatically suspended under this Section 8.4, 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(g) 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 8.4.

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 6.3(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, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such 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.

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 practitioner 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.¹⁵⁴

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 practitioner's exercise of clinical privileges, shall give rise to any right to a hearing.¹⁵⁵

9.3 ADVERSE ACTION AFFECTING AHPs

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

¹⁵⁴ MS 10.01.01; MS 01.01.01 EP 15

¹⁵⁵ 42 USC 11101

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE STAFF¹⁵⁶

10.1(a) Identification

The officers of the staff shall be:

- (1) Chief of Staff;
- (2) Chief of Staff Elect;
- (3) Secretary/Treasurer; and
- (4) Immediate Past Chief of Staff.

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. The Nominating Committee shall use its best efforts to nominate candidates from each campus of the Hospital to ensure both campuses have appropriate representation as Officers of the Staff.
- (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 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

¹⁵⁶ MS 01.01.01 EP 9

10.1(e) 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. At the end of the Chief of Staff's term, the Vice Chief of Staff shall automatically assume the Chief of Staff's office and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.

10.1(f) 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(g) 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;¹⁵⁷
 - (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;¹⁵⁸
 - (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;¹⁵⁹
 - (iv) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and hospital management committees;¹⁶⁰
 - (v) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;¹⁶¹
 - (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;¹⁶²
 - (vii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

¹⁵⁷ MS 02.01.01 EP 12

¹⁵⁸ MS 01.01.01; LD 01.05.01

¹⁵⁹ MS 12.01.01; MS 05.01.01; MS 05.01.03; MS 02.01.01 EP 10

¹⁶⁰ MS 02.01.01 EP 12

¹⁶¹ MS .01.01.01

¹⁶² MS .01.01.01 EP 3-4

- (viii) serve as a voting member of the MEC and an ex-officio member of all other staff committees or functions;¹⁶³
 - (ix) assist in coordinating the educational activities of the Medical Staff;¹⁶⁴
 - (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; and¹⁶⁵
 - (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.¹⁶⁶
- (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 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(h) Conflict of Interest of Medical Staff Leaders¹⁶⁷

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.

¹⁶³ MS .01.01.01 EP 9

¹⁶⁴ MS 12.01.01

¹⁶⁵ MS 06.01.01

¹⁶⁶ MS 08.01.01

¹⁶⁷ 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 December 31st, 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:¹⁶⁸

- 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;¹⁶⁹
- 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;¹⁷⁰
- 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;¹⁷¹
- 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;¹⁷²
- 11.2(e) Monitor on an ongoing basis the compliance of its department members with applicable professional standards;¹⁷³
- 11.2(f) Coordinate the patient care provided by the department's members with nursing, administrative, and other non-Medical Staff services;¹⁷⁴
- 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; and¹⁷⁵

¹⁶⁸ MS 01.01.01 EP 8

¹⁶⁹ MS 08.01.03

¹⁷⁰ MS 06.01.07 EP 2

¹⁷¹ MS 12.01.01

¹⁷² MS 01.01.01 EP 4

¹⁷³ MS 08.01.03

¹⁷⁴ MS 03.01.03

¹⁷⁵ PI 01.01.01; PI 02.01.01

- 11.2(i) Submit written reports or minutes of department meetings to the MEC on a regular basis concerning:
- (1) Findings of the department's review and evaluation activities, actions taken thereon, and the results thereof;¹⁷⁶
 - (2) Recommendations for maintaining and improving the quality of care provided in the department and in the Hospital; and¹⁷⁷
 - (3) Such other matters as may be requested from time to time by the MEC.¹⁷⁸
- 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.¹⁷⁹

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 CHAIRPERSONS¹⁸⁰

11.4(a) Each Department shall have a Chairperson, 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. Department Chairpersons 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 Chairperson include:

- (1) Accountability to the MEC for all professional and Medical Staff administrative activities within the department;¹⁸¹
- (2) Continuing review of the professional performance qualifications and competence of the Medical Staff members and AHPs who exercises privileges in the department;¹⁸²
- (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;¹⁸³

¹⁷⁶ MS 02.01.01 EP 12

¹⁷⁷ MS 02.01.01 EP 12

¹⁷⁸ MS 02.01.01 EP 12

¹⁷⁹ MS 08.01.03 EP 2

¹⁸⁰ MS 01.01.01 EP 8

¹⁸¹ MS 01.01.01 EP 8

¹⁸² MS 01.01.01 EP 8

¹⁸³ MS 01.01.01 EP 8; 42 CFR 482.21

- (4) Assuring the participation of department members in department orientation, continuing education programs and required meetings;¹⁸⁴
- (3) Assuring participation in risk management activities related to the clinical aspects of patient care and safety;¹⁸⁵
- (6) Assuring that required performance improvement 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;¹⁸⁶
- (7) Recommending criteria for clinical privileges and specific clinical privileges for each member of the department;¹⁸⁷
- (8) Implementing within the Department any actions or programs designated by the MEC;¹⁸⁸
- (9) Assisting in the preparation of reports as may be required by the MEC, the CEO or the Board;¹⁸⁹
- (10) Developing, implementing and enforcing the Medical Staff Bylaws, Rules & Regulations, and policies and procedures that guide and support the provision of services;¹⁹⁰
- (11) Participating in every phase of administration with other departments or services, in cooperation with nursing, hospital administration and the Board;¹⁹¹
- (12) Assessing and recommending to the CEO any off-site sources for needed patient care services not provided by the department or organization; and¹⁹²
- (13) Making recommendations for a sufficient number of qualified and competent persons to provide care or services within the department.¹⁹³

11.4(c) Department Chairpersons shall be elected annually and serve for a term of one (1) year.

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 Chairperson.¹⁹⁴
- 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 monthly to present educational programs and

¹⁸⁴ MS 01.01.01 EP 8

¹⁸⁵ MS 01.01.01 EP 8

¹⁸⁶ MS 01.01.01 EP 8; 42 CFR 482.21

¹⁸⁷ MS 01.01.01 EP 8

¹⁸⁸ MS 01.01.01 EP 8

¹⁸⁹ MS 02.01.01 EP 12

¹⁹⁰ MS 01.01.01 EP 4

¹⁹¹ MS 01.01.01 EP 8

¹⁹² MS 01.01.01 EP 8

¹⁹³ MS 01.01.01 EP 8

¹⁹⁴ MS 01.01.01

conduct clinical review of practice within their department. Written minutes must be maintained and furnished to the MEC.¹⁹⁵

- 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 Chairperson 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 CHIEF

11.6(a) Chiefs of Service shall be selected by the Board in consultation with the Chief of Staff. The chief of each service shall have the following duties with respect to his/her service:

- (1) Account to the appropriate department chairperson and to the MEC for all professional activities within the service;¹⁹⁶
- (2) Develop and implement service programs in cooperation with the department chairperson;
- (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 chairperson;¹⁹⁷
- (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 chairperson, 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;¹⁹⁸
- (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; and¹⁹⁹
- (8) Perform such other duties as may reasonably be requested by the Chief of Staff, the MEC, the Department Chairperson or the Board of Trustees.

¹⁹⁵ MS 12.01.01

¹⁹⁶ MS 03.01.01

¹⁹⁷ 42 CFR 482.21

¹⁹⁸ MS 02.01.01 EP 12

¹⁹⁹ 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.²⁰⁰
- 12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.²⁰¹
- 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.
- 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.²⁰²

12.2 MEDICAL EXECUTIVE COMMITTEE²⁰³

12.2(a) Composition

Members of the committee shall include the following:

- (1) The Chief of Staff, who shall act as Chairperson;
- (2) The Chief of Staff Elect;
- (3) The Immediate Past Chief of Staff;
- (4) The Chiefs of Departments;
- (5) Secretary to the Medical Staff;
- (6) Emergency Department Medical Director;
- (7) 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 functions and responsibilities of the MEC shall include, at least the following:²⁰⁴

- (1) Receiving and acting upon department and committee reports;²⁰⁵
- (2) Implementing the approved policies of the Medical Staff;²⁰⁶

²⁰⁰ MS 02.01.01 EP 12

²⁰¹ MS 02.01.01 EP 12

²⁰² MS 02.01.01 EP 3

²⁰³ 42 CFR 482.22(6); MS 01.01.01; MS 02.01.01

²⁰⁴ MS 01.01.01 EP 11; MS 02.01.01

²⁰⁵ MS 02.01.01 EP 12

²⁰⁶ MS 02.01.01

- (3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action;²⁰⁷
- (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;²⁰⁸
- (5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;²⁰⁹
- (6) Assuring regular reporting of performance improvement 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;²¹⁰
- (7) Assuring an annual evaluation of the effectiveness of the Hospital's performance improvement program is conducted;²¹¹
- (8) Developing and monitoring compliance with these bylaws, the rules and regulations, policies and other Hospital standards;²¹²
- (9) Recommending action to the CEO on matters of a medico-administrative nature;²¹³
- (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;²¹⁴
- (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 a 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; and²¹⁵
- (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.²¹⁶

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.²¹⁷

²⁰⁷ MS 02.01.01 EP 8

²⁰⁸ MS 02.01.01

²⁰⁹ MS 02.01.01 EP 6

²¹⁰ MS 02.01.01 EP 6

²¹¹ MS 02.01.01 EP 6

²¹² MS 01.01.01 EP 1-4

²¹³ MS 02.01.01

²¹⁴ MS 11.01.01 EP 1

²¹⁵ MS 06.01.05 EP 6

²¹⁶ MS 01.01.01 EP 15; MS 10.01.01; MS 06.01.07 EP2

²¹⁷ MS 02.01.01

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.²¹⁸

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.²¹⁹

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;²²⁰
- (2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record, core measures and other appropriate reviews;²²¹
- (3) Conduct or coordinate utilization review activities;²²²
- (4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital's professional library services;²²³
- (5) Develop and maintain surveillance over drug utilization policies and practices;²²⁴
- (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;²²⁵
- (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;²²⁶
- (8) Investigate and control nosocomial infections and monitor the Hospital's infection control program;²²⁷

²¹⁸ MS 02.01.01

²¹⁹ MS 02.01.01

²²⁰ MS 03.03.01

²²¹ MS 05.01.01

²²² MS 05.01.01; MS 05.01.03

²²³ MS 12.01.01

²²⁴ MM 07.01.01-07.01.03; MS 01.01.01 EP 5

²²⁵ 42 CFR 482.13(b); MS 03.01.06 EP 6

²²⁶ MS 08.01.03

²²⁷ 42 CFR 482.42

- (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;²²⁸
- (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;²²⁹
- (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;²³⁰
- (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.²³¹
- (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;
 - (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.²³²
- (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.²³³
- (15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;²³⁴

²²⁸ EC 01.01.01; EC 02.01.01

²²⁹ MS 01.01.01

²³⁰ MS 11.01.01

²³¹ MS 05.01.01 EP 2-9

²³² MS 05.01.01 EP 10-11

²³³ MS 08.01.01; LD 01.05.01

²³⁴ MS 01.01.01

- (16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;²³⁵
- (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;²³⁶
- (18) Investigate any breach of ethics that is reported to it;²³⁷
- (19) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and²³⁸
- (20) To prepare and recommend a slate of nominees for the officers of the Medical Staff.²³⁹

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.

12.4 CONFLICT RESOLUTION COMMITTEE²⁴⁰

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.

12.5 CREDENTIALS COMMITTEE

12.5 (a) Composition

The committee shall be chaired by the Vice Chief of Staff of the Medical Staff. There shall be four (4) members appointed by the Chief of Staff from the Active Staff that will generally serve two (2) year terms. Members of the Medical Executive Committee (other than the Vice Chief of Staff) and Board of Trustee members shall not be members of this committee. Initially, two (2) of the four (4) members appointed by the Chief of Staff shall serve an initial three (3) year term so that the appointments will be staggered so as to insure that only half of the committee turns over in any one medical staff year.

12.5(b) Meetings

This committee shall meet monthly, and shall report their recommendations and activities to the Medical Executive Committee.

²³⁵ MS 06.01.01; LD 01.05.01

²³⁶ MS 08.01.03; LD 01.05.01

²³⁷ MS 09.01.01

²³⁸ MS 01.01.01 EP 14-15

²³⁹ MS 01.01.01 EP 9

²⁴⁰ LD 02.02.01

12.5(c) Functions

The functions of the Credentials Committee shall be to:

- (1) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;
- (2) Make a report to the MEC on each applicant for Medical Staff membership and clinical privileges;
- (3) Review, on a periodic basis, 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; and
- (4) Investigate any breach of ethics that is reported to it.

ARTICLE XIII
MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

The annual Medical Staff meeting shall be held in January, 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 Chairperson;
- (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 quarterly each year. 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 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.

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 MINUTES²⁴¹

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 fifty percent (50%) of meetings of the Medical Staff. Absence from two (2) of the regular meetings for the year without acceptable excuse may be considered as a resignation from the Active Staff. Members must also attend fifty percent (50%) of committee and departmental meetings in which they are a member.

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. Unless excused for a good cause, failure to meet the attendance requirements of these bylaws shall be grounds for corrective action.

Reinstatement of a staff member whose membership has been revoked because of absence from meetings shall be made only on application, and such application shall be processed in the same manner as an application for initial appointment.

²⁴¹ MS 02.01.01 EP 12

13.7(c) Special Appearance

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, 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.²⁴²

²⁴² MS 01.01.01 EP 12-13

ARTICLE XIV
GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations 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. Such 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.²⁴³

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 claim 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.

14.3 FORMS

Application forms and any other prescribed forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO or his/her designee, subject to adoption by the Board after considering the advice of the MEC. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

14.4 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.

14.5 TRANSMITTAL OF REPORTS

Reports and other information which these bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO or his/her designee

²⁴³ 42 CFR 482.22; MS 01.01.01 EP 5

14.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.6(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.

14.6(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.

14.6(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 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.²⁴⁴

²⁴⁴ 42 USC 11101; Refer to State Peer Review Statute

ARTICLE XV
ADOPTION & AMENDMENT OF BYLAWS²⁴⁵

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 SUPPLEMENTARY DOCUMENTS

The bylaws shall contain supplementary documents such as rules and regulations and appendices. The rules and regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each hospital credentialed person. The appendices shall consist of Medical Staff Policies and Procedures.

These rules and regulations and appendices shall be periodically reviewed, updated, and approved by the Medical Executive Committee. The bylaws shall be periodically reviewed, updated, and approved by the Medical Staff.

15.3 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.

15.3(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.

15.3(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.²⁴⁶

²⁴⁵ MS 01.01.01; MS 01.01.03

²⁴⁶ 42 CFR 482.12

15.4 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

- 15.(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
- 15.4(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.

**MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____
Chairperson

Date

Mercy Regional Medical Center:

By: _____
Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for Ville Platte Medical Center, LLC

Date

APPROVED:

By: _____
Division President

Date

APPENDIX A
FAIR HEARING PLAN

APPENDIX B
**MEDICAL STAFF RULES
AND REGULATIONS**

APPENDIX C
DISRUPTIVE PRACTITIONER POLICY

APPENDIX D
IMPAIRED PRACTITIONER POLICY

APPENDIX E
PEER REVIEW POLICY

Mercy Regional Medical Center

MEDICAL STAFF

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 only by an attending member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership.
- 1.1(c) Physicians 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(d) Emergency Department Physicians, and physicians providing care in the Intensive Care Unit (ICU), shall be required to maintain documentation regarding current ACLS certification. Physicians admitting to ICU without ACLS certification will be required to co-manage the case with an ACLS certified physician.
- 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, 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 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 Inpatient Rehabilitation Unit;
- (5) From any department to Skilled Nursing Facility;
- (6) From obstetric patient care area (unit) to general care area when medically indicated; and
- (7) 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.
- 1.3(c) If the critical care unit is full and a patient requires ICU care; all physicians 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 patient's 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) The hospital social worker 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. Should a patient leave the hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. 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 Physician Advisor for assistance.
- 1.5(c) The Attending Physician 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 or other committee responsible for case management, the Attending Physician 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 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 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 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 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 Treatment Outcomes.

ARTICLE II
MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Physician 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.

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician (or other licensed independent practitioner who has been credentialed and granted privileges to perform a history and physical examination) within twenty-four (24) hours of admission. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. 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. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered delinquent and the Chief of Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance. If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission.

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 Physician 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 as pertinent chronological report on the patient's course in the hospital and reflects any changes in condition at a minimum of every two (2) days 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.

2.5 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. An operative progress note must be entered immediately after surgery to provide pertinent information to be used by all individuals who attend the patient to the next level of care. 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 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through written order of the Attending Physician. 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 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 dated, timed and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or electronic signature. The use of rubber stamp signature is not acceptable. Electronic signature shall be used in the place of written signature for documents dictated and/or transcribed. Those utilizing electronic signature will be given logons and passwords that they are responsible for safe guarding and are solely responsible. A statement to the effect placed in the administrative offices. Faxed signature shall be accepted provided that a signed statement regarding the validity of the signature is in the administrative offices.

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, in documentation of an operative procedure, or if they are included on the "DO NOT USE" list.

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. 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.

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 by the physician and the Utilization Management Committee. 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 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 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 physician's privileges. When a staff member is notified of suspension, the staff member 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 physician may not cover Emergency Room call, may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the Chief of Staff and the CEO.

2.16(b) The suspended staff member is obligated to provide to the hospital CEO and the Chief of Staff the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations and any other services that physician 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 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 not be written by Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician.

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.

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. The patient business office should notify the Attending Physician whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing, dated, timed and authenticated. 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 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 and indicate that the individual has confirmed the order. The physician 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 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 ten (10) 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 chemotherapy drug orders, investigational drug, device or procedure protocols, orders to withhold (including Do Not Resuscitate orders) or withdraw life support. 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 canceled 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.

3.6 ORDERING/DISPENSING OF DRUGS

The physician 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 physician 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 physician 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 in the Skilled Nursing Facility 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 Medical Staff members 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 ADMISSION OF DENTAL CARE PATIENT

A patient admitted for dental care is a dual responsibility involving the dentist and a physician member of the Medical Staff.

4.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

- (1) To provide a detailed dental history justifying hospital admission;
- (2) To provide a detailed description of the examination of the oral cavity and preoperative diagnosis;
- (3) To complete an operative report describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the hospital pathologist for examination;
- (4) To provide progress notes as are pertinent to the oral condition; and
- (5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

- (1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery;
- (2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
- (3) To supervise the patient's general health status while hospitalized.

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and the Attending Physician.

4.3 ADMISSION OF PODIATRIC PATIENTS

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist.

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

- (1) To provide a detailed podiatric history justifying hospital admission;
- (2) To provide a detailed description of the podiatric findings and a preoperative diagnosis;
- (3) To complete an operative report describing the findings and technique. A tissue shall be sent to the hospital pathologist for examination;
- (4) To provide progress notes as are pertinent to the podiatric condition; and
- (5) To provide a clinical summary.

4.3(b) Physician's Responsibilities

The responsibilities of the physician are:

- (1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;
- (2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
- (3) To supervise the patient's general health status while hospitalized.

4.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and Physician.

4.4 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 and has continuing force and effect until (1) the patient revokes it, or (2) the patient's condition changes materially such that either the scope of the procedure or the risks change.. 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. In those emergencies involving a minor or unconscious patient in whom 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.

The following list of procedures has been designated by the Hospital as procedures requiring an informed consent but should not be considered all-inclusive and does not negate the need for obtaining consent for procedures meeting the above criteria.

Administration of blood and/or blood products
Anesthesia and/or deep sedation
Autopsy Consent
Biopsies (including those done outside of the surgical suite, e.g. uterine, liver, muscle, bone marrow core, pleural, lung-transbronchial and percutaneous, lymph node, skin, nerve, eyelids, external eye, transrectal or perineal prostate biopsy)
Bronchoscopy
Cardiac (all invasive procedures)
Cardioversion (elective)
Cesarean Section
Chemotherapy for cancer treatment
Closed reduction of fracture and dislocations
Cutdown
Cystoscopy (Retrograde Pyelography)
Dilatation of Urethral Stricture
Endoscopies requiring conscious sedation
ENT Procedure
 Myringotomy and Tympanostomy
 Tonsillectomy and Adenoidectomy
 FESS-IGS
 Parotidectomy
 Thyroidectomy
Experimental Drugs
Fetal Blood Sampling
Gastrointestinal Procedures:
 Colonoscopy
 Esophageal Dilatation
 Esophageal Motility
 Gastric Tamponade
 Polypectomy
 Small Bowel Biopsy
Laparoscopy
Hemodialysis (Shunt)
HIV Testing
Hysterectomy
Induction of Labor (elective)
Intra Uterine Device (IUD) insertion or removal
Laser Procedures
Line Insertions:
 Elective Central Vein Catheterization
 Arterial Pressure Line
 Swan-Ganz
 Umbilical Artery & Vein Catheterization
Lumbar Puncture/Spinal Tap
Ophthalmic Procedure
 Cataract Extraction

Trabeculectomy
Eye Muscle Surgery
Laser
Peritoneal Dialysis (Shunt)
Radiographic Procedures
 Angiography (all) CTA, MRA
 Cholangiography (transhepatic)
Sterilization
Surgical Procedures:
 General Anesthesia
 Local Anesthesia
 Major Surgery¹
 Minor Surgery²
 Paracentesis
 Thoracentesis
Vaginal Deliver
Vitreous Fluorophotometry (VFP)

4.5 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 designee.

4.6 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.

4.7 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. The surgeon with an *emergency situation* will notify the Surgery Supervisor or designee and the emergency will be accommodated in the first available room. Any questions regarding urgency of the procedure will be referred to the physician involved. (*The surgeon being bumped will be notified by the surgeon requiring the room*). In the case of a disagreement, the Chief of Surgery or Chief of Staff will be notified to assist with the decision.

¹ Major surgery usually involves the use of general anesthesia. Major surgery often involves opening one of the major body cavities – the abdomen (laparotomy), the chest (thoracotomy), or the skull (craniotomy) – and can stress vital organs. The surgery is usually performed in an operating room by a team of doctors. A stay of at least one night in the hospital is usually needed after major surgery. – Surgery: Special Subjects: Online Merck Manual

² Minor surgery can involve the use of local, regional, or general anesthesia. Major body cavities are not opened". Minor surgery may be performed in an emergency department, and ambulatory surgical center, or a doctor's office. Vital organs usually are not stressed, and surgery can be performed by a single doctor, who may or may not be a surgeon. Usually, the person can return home on the same day that minor surgery is performed. - Surgery: Special Subjects: Online Merck Manual

4.7(a) Standing Time:

7:00 a.m.

4.7(b) Priority Cases shall include:

- (1) Cesarean section;
- (2) Age 12 and under;
- (3) Open bone work;
- (4) Latex allergic patients; and
- (5) Contaminated cases last, if possible.

4.7(c) Scheduling of Cases:

- (1) Elective surgery should be scheduled by 3:00 p.m the previous day;
- (2) All cases must be scheduled with Operating Room Staff;
- (3) All cases must be taken in the order they are scheduled, whether general or local, inpatient or outpatient, except for pre-existing priority cases;
- (4) If a scheduled case is canceled, the schedule will be moved up to fill the vacancy. New cases will not replace the canceled case. Any other case scheduled by the same surgeon will be added to the end of the schedule.
- (5) If a surgeon desires to change the order of his/her scheduled cases, any other surgeon who will be affected by the change must be notified and consent to the change; and
- (6) The start time for a surgery shall be deemed to be the time of incision or invasion. If a surgeon is more than thirty (30) minutes late for a scheduled procedure, the case will then follow other scheduled cases. If the surgeon is more than fifteen (15) minutes late, the OR Supervisor will attempt to contact the surgeon and ascertain when he/she will be available. If the surgeon will not be available within a reasonable period of time, the next scheduled surgery shall commence and the case will be moved to the end of the schedule.

4.7(d) Preoperative workup is as deemed appropriate.

4.8 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a post operative examination will be conducted by the surgeon.

4.9 ANESTHESIA

Responsibility for the overall management of sedation or anesthesia lies with the physician or licensed independent practitioner responsible for the anesthesia service.

Only qualified individuals as defined in the policies and procedures of the hospital may provide moderate or deep sedation or anesthesia. The Department of Surgery shall approve credentialing guidelines consistent with Joint Commission standards for individuals providing moderate or deep sedation or anesthesia.

The anesthetist or anesthesiologist shall maintain a complete sedation or anesthesia record to including evidence of pre-sedation or pre-anesthesia evaluation used to determine whether the patient is an appropriate candidate for the planned sedation or anesthesia. Also included in the record shall be a pre-sedation or pre-induction evaluation. The individual who administered the patient's sedation, or another individual credentialed and qualified to administer anesthesia must perform a postanesthesia evaluation of the patient prior to the patient's discharge and document the results of the evaluation within forty-eight (48) hours of the patient's discharge. Patients staying overnight shall have another post-sedation or post-anesthesia visit prior to discharge. The post-sedation or anesthesia follow-up shall include documentation of the patient's response to care.

The anesthetist 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.

The anesthetist or anesthesiologist will review and document the patient's condition immediately prior to induction.

The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary. Thus, the response time for arrival of the CRNA and/or anesthesiologist must not exceed twenty (20) minutes.

4.10 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 attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

The attending physician 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.

ARTICLE V
GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK OBSTETRICAL/INFANT CARE

Care will be provided for obstetrical and infants at high risk by providers who have been trained in high risk infant resuscitation and care as deemed appropriate for the patient and for the hospital

5.1(a) Cesarean Sections with fetal distress will have Pediatrician present;

5.1(b) Any obstetrical patients less than 35 weeks will be transferred unless a higher risk for both patients would occur in the transfer; and

5.1(c) 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

All patients presenting to be seen in the Emergency Department with pregnancy or suspected pregnancy will be triaged in the following manner:

5.3 (a) Greater than 20 weeks gestation presenting with a non-obstetrical complaint, will be seen in the Emergency Department by the ED physician. The ED physician will examine and treat the non-obstetrical complaint as appropriate. A medical screening examination will then be performed by the Women's Center staff to assess the obstetrical condition.

5.3 (b) Greater than 20 weeks presenting with an obstetrical complaint, a medical screening examinations will be performed by the Women's Center staff for the obstetrical condition.

5.3 (c) Under 20 weeks gestation will be seen in the ED by the ED physician and will be medically screened and treated as provided in Article VI of these Rules and Regulations.

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 will be initiated. 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 or physician's practice. 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.

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 physician 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 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 trained in emergency medicine, or in the case of a woman in labor, a registered nurse trained in obstetric nursing pursuant to hospital policy, Medicare and other applicable federal regulations.
- (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 physician has provided written documentation of his/her findings.
- (3) A patient Stable for Transfer if the treating physician 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 physician 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 physician 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, 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 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 physician for outpatient follow-up care.

6.1(c) Transfer

- (1) The Emergency Department Physician 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 physician 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 Physician 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 Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient's medical record.
- 6.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician 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 physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:
- (1) Attempted to reach the physician in the hospital;
 - (2) Called the physician at home;
 - (3) Called the physician at his/her office; and
 - (4) Called once on the physician'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 physicians shall be posted in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient's request to come to the Emergency Department, or the physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the rotation list may not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician 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 physician's Medical Staff appointment and clinical privileges.
- 6.2(e) The physician 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 physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the physician's office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.
- 6.2(f) All members of the Active Staff shall participate in the on-call backup to the Emergency Department.

Physicians called are required to respond to Emergency Department call by telephone within fifteen (15) minutes. If requested to come in, they are required to do so within thirty (30) minutes after responding by telephone. Obstetricians, Anesthesiologists and CRNAs are required to arrive within twenty (20) 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. Active Staff members shall accept assignment of up to ten (10) days of on-call coverage per month, except in situations where a specialty has more than three (3) Active Staff members (in such situations the on-call coverage shall be distributed equitably on a pro-rata basis). A Primary Care physician who is unavailable to the emergency department because of call obligations at another facility cannot count that day as one of the mandatory 10 days of call. Surgeons and Specialists may overlap call at another facility. If the Surgeon is in surgery when called, the patient will be transferred unless another Surgeon not on call is available. Specialist and Sub-Specialist may also overlap call, and should be able to respond when called unless extraordinary situations which would have to be explained and approved by the Emergency Department physician. The ED physician would then make the determination regarding need for transfer. Active Staff members with 30

years of consecutive service and age 55 are not required to participate in the on-call rotation; so long as his/her specialty is fully covered on the on-call rotation

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 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 8.2 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 well being of patients, employees or staff.

**MEDICAL STAFF RULES & REGULATIONS
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____
Chairperson

Date

Mercy Regional Medical Center:

By: _____
Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for **Ville Platte Medical Center, LLC**

Date

APPROVED:

By: _____
Division President

Date



Ville Platte—Eunice

REQUEST FOR CLINICAL PRIVILEGES & RECORD OF PRIVILEGES GRANTED

1. NAME _____

2. Areas of Practice

Attached is my request(s) for those clinical privileges in the following areas of practice for which by training and experience I have current competence and which I wish to exercise at Mercy Regional Medical Center and /or Acadian Medical Center (A campus of Mercy Regional Medical Center).

- ___Anesthesiology ___Dermatology ___Orthopedic/Traumatic
___Emergency Medicine ___Dental ___Otolaryngological/Neck
___Medicine ___Neurology ___Plastic/Maxillofacial/Oral
___Surgery ___Abdominal ___Rectal
___Nuclear Medicine ___Breast ___Thoracic
___Obstetrics ___Gynecological ___Urological
___Pathology ___Neurosurgical ___Vascular
___Pediatrics ___Ophthalmic ___Other
___Psychiatry ___Family/General Practice ___Podiatry
___Radiology ___Optometry ___Physician Assistant

___Special Procedures – Non-Specialty Specific (K-6)

3. Subject to Consultation Requirements and Other Policies

I understand that in exercising any clinical privileges granted, I am constrained by relevant Hospital and Medical Staff policies requiring consultations for difficult diagnoses, conditions of extreme severity, and procedures/conditions which are beyond my area of specialization and expertise, by Hospital policies concerning the types of patients for whom it does not have appropriate resources (facilities, equipment or personnel) to treat except on an emergency basis, and by such special policies as may from time to time be adopted.

4. Emergency Situations

I also understand that it is not necessary to request emergency clinical privileges; that an emergency is deemed to exist whenever serious permanent harm or aggravation of injury or disease is imminent; or the life of the patient is in immediate danger, and any delay in administering treatment could add to that danger; that in such emergency I am authorized and will be assisted to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by my license but regardless of department affiliation, staff category or level of privileges; and that if I provide services to a patient in an emergency, I am obligated to utilize appropriate consultative assistance when available and to arrange for appropriate follow-up care.

5. Signature _____ Date _____

6. Conditions/Exceptions

The following clinical privileges have been approved by the Board of Trustees with the following conditions or exceptions:

PRIVILEGE	CONDITION/EXCEPTION

7. APPROVALS:

SERVICE CHIEF _____ **DATE** _____

MEC _____ **DATE** _____

BOARD _____ **DATE** _____



Ville Platte/Eunice

PHYSICIAN NAME

LICENSE NUMBER

MEDICARE

“Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds, maybe subject to fine, imprisonment, or civil penalty under applicable Federal Laws.”

I, _____, certify that I have received the above statement.

Signature

Date

CHAMPUS

“Notice to Physicians: Champus payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds, maybe subject to fine, imprisonment, or civil penalty under applicable Federal Laws.”

I, _____, certify that I have received the above statement.

Signature

Date



Ville Platte/Eunice

Reappointment Activity/Quality Verification Form

I, (print) _____, understand that to qualify for reappointment to the Medical Staff of Mercy Regional Medical Center/Acadian Medical Center (A campus of Mercy Regional Medical Center, I must provide evidence of a minimum of 24 patient activities (i.e., admissions/consultations/surgeries/procedures) during the past 2 year period to be able to demonstrate current clinical competence.

If I have not met the minimum case requirement at Mercy Regional Medical Center, I understand it is my responsibility to obtain appropriate verification from the hospital where I more actively practice and can provide evidence of a minimum of 24 patient activities (i.e., admissions/consultations/ surgeries/procedures) during the past 2 year period for the purpose of demonstrating current clinical competence. I hereby consent to the release of the requested information below for purposes of appointment/reappointment to the Medical Staff of Mercy Regional Medical Center.

Appropriate verification is:

- Completion of the lower section of this form by a hospital’s representative which must be returned directly from the Facility completing the information via mail or facsimile 505-346-0829 or 337-580-7729.

Physician Signature

Date

I, (print) _____, verify that the above named physician has had the following patient activities at this facility during the past two (2) year period.

- Upon request of the above named practitioner, the following information is provided for the past 2 year period:

Number of admissions _____ Number of consultations _____ Number of procedures _____
Number of deaths _____ Infection rate _____ Weeks/Days suspended for delinquent charts _____

- Provide information on actions taken as a result of peer review activities. These include:

____ Surgery Case Review ____ Utilization Review ____ Medical Record Review ____ Drug Utilization
____ Blood Utilization ____ Risk Management ____ Case Management Monitoring

Explain if any are checked (attach additional paper as needed):

Signature: _____ Title: _____

Facility: _____ Date: _____