

# ***MEDICAL STAFF BYLAWS***

## ***APPENDIX “A”***

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### **FAIR HEARING PLAN**

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

### **DEFINITIONS**

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

1. "Appellate Review Body" means the group designated pursuant to this Plan to hear a request for Appellate Review that has been properly filed and pursued by the practitioner.
2. "Hospital" means PinnacleHealth Memorial Hospital and/or Memorial Hospital Outpatient Endoscopy Center and/or Memorial Hospital Outpatient Surgery Center and/or Memorial Hospital Breast Center and/or Greenbriar Medical Center.
3. "Hearing Committee" means the committee appointed pursuant to this Plan to hear a request for an evidentiary hearing that has been properly filed and pursued by a practitioner.
4. "Parties" means the practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.
5. "Practitioner", for purposes of this Plan, means a physician, dentist, or podiatrist who has been granted clinical privileges at the Hospital.
6. "Special Notice" means written notification sent by certified or registered mail, return receipt requested, or delivered by hand with a written acknowledgment of receipt.

**ARTICLE I**  
**INITIATION OF HEARING**

**1.1 RECOMMENDATION OR ACTIONS**

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

- (1) Denial of initial staff appointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;
- (2) Denial of reappointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;
- (3) Suspension of staff membership for fourteen (14) days or more, except automatic suspensions pursuant to Section 8.4 of the Medical Staff Bylaws;
- (4) Revocation of staff membership;
- (5) Denial of requested advancement of staff category, if such denial materially limits the physician's exercise of privileges;
- (6) Reduction of staff category due to an adverse determination as to a practitioner's competence or professional conduct;
- (7) Limitation of the right to admit patients, unless based upon a reduction of staff category not related to an adverse determination as to a practitioner's competence or professional conduct;
- (8) Denial of an initial request for particular clinical privileges, unless based upon failure to meet the basic objective criteria for the privileges requested;
- (9) Reduction of clinical privileges for a period of excess of thirty (30) days;
- (10) Permanent suspension of clinical privileges, except automatic suspensions pursuant to Section 8.4 of the Medical Staff Bylaws;
- (11) Permanent revocation of clinical privileges;
- (12) Terms of probation or consultation, if such terms of probation or consultation materially restrict the physician's exercise of privileges for more than thirty (30) days; and
- (13) Summary suspension of privileges or staff membership for a period in excess of fourteen (14) days.

**1.2 WHEN DEEMED ADVERSE**

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

- (1) Recommended by the MEC; or
- (2) Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

- (3) Taken by the Board on its own initiative without prior recommendation by the MEC.

### **1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION**

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

- (1) Advise the practitioner of the basis for the action and his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws of this Plan;
- (2) Specify that the practitioner has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;
- (3) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter;
- (4) State that upon receipt of this hearing request, the practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action;
- (5) Provide a summary of the practitioner's rights at the hearing; and
- (6) Inform the practitioner if the recommended action may be reportable to the National Practitioner Data Bank and appropriate licensing agencies.

### **1.4 REQUEST FOR HEARING**

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

### **1.5 WAIVER BY FAILURE TO REQUEST A HEARING**

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

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

**ARTICLE II**  
**HEARING PREREQUISITES**

**2.1 NOTICE OF TIME & PLACE FOR HEARING**

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

**2.2 STATEMENT OF ISSUES & EVENTS**

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

**2.3 PRACTITIONER'S RESPONSE**

Within ten (10) days of receipt of the notice of hearing under Section 2.1, the affected practitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the due process hearing.

**2.4 EXAMINATION OF DOCUMENTS**

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

**2.5 APPOINTMENT OF HEARING COMMITTEE**

**2.5(a) By Medical Staff**

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

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing

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

**2.5(b) By Board**

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

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

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

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

**ARTICLE III**  
**HEARING PROCEDURE**

**3.1 PERSONAL PRESENCE**

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

**3.2 PRESIDING OFFICER**

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

**3.3 REPRESENTATION**

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

**3.4 RIGHTS OF THE PARTIES**

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

- (1) Call and examine witnesses;
- (2) Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;
- (3) Cross-examine any witness on any matter relevant to the issues;
- (4) Impeach any witness;
- (5) Rebut any evidence;
- (6) Have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and
- (7) Submit a written statement at the close of the hearing.

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



### **3.5 PROCEDURE & EVIDENCE**

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

### **3.6 OFFICIAL NOTICE**

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

### **3.7 BURDEN OF PROOF**

- (1) When a hearing relates to initial appointment, advancement of staff category, or denial of an initial request for particular clinical privileges, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory.
- (2) For the other matters listed in Article I, Section 1.1, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

### **3.8 RECORD OF HEARING**

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

### **3.9 POSTPONEMENT**

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

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

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

### **3.11 RECESSES & ADJOURNMENT**

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

**ARTICLE IV**  
**HEARING COMMITTEE REPORT & FURTHER ACTION**

**4.1 HEARING COMMITTEE REPORT**

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

**4.2 ACTION ON HEARING COMMITTEE REPORT**

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

**4.3 NOTICE & EFFECT OF RESULT**

**4.3(a) Notice**

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

**4.3(b) Effect of Favorable Result**

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

Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed.

**4.3(c) Effect of Adverse Result**

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

**ARTICLE V**  
**INITIAL & PREREQUISITES OF APPELLATE REVIEW**

**5.1 REQUEST FOR APPELLATE REVIEW**

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

**5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW**

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

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

**5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW**

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

**5.4 APPELLATE REVIEW BODY**

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

**ARTICLE VI**  
**APPELLATE REVIEW PROCEDURE**

**6.1 NATURE OF PROCEEDINGS**

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

**6.2 WRITTEN STATEMENTS**

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

**6.3 PRESIDING OFFICER**

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

**6.4 ORAL STATEMENT**

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

**6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS**

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

**6.6 PRESENCE OF MEMBERS & VOTING**

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

**6.7 RECESSES & ADJOURNMENT**

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

**6.8 ACTIONS TAKEN**

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

**6.9 CONCLUSION**

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

**ARTICLE VII**  
**FINAL DECISION OF THE BOARD**

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



**ARTICLE VIII**  
**GENERAL PROVISIONS**

**8.1 HEARING OFFICER APPOINTED & DUTIES**

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

**8.2 ATTORNEYS**

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

**8.3 NUMBER OF HEARINGS & REVIEWS**

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

**8.4 RELEASE**

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

**8.5 WAIVER**

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

# ***MEDICAL STAFF BYLAWS***

## ***APPENDIX “B”***

### **HOSPITAL POLICY REGARDING PRACTITIONER WELLNESS**

It is the policy of this hospital to properly review and act upon concerns that a licensed independent practitioner, as defined in the Medical Staff Bylaws, is suffering from an illness or impairment. The hospital will conduct its review and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act. The purpose of this policy is to provide education about practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. The Practitioner Wellness Policy affords resources separate from the corrective action process to address physician health. This policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals. .

Impairment, as used in this policy, includes acute and ongoing physical, psychiatric, and emotional illness or injury, as well as health issues due to drugs or alcohol.

As part of the hospital’s commitment to the safe and effective delivery of care to patients, the Hospital and Medical Staff shall conduct education sessions concerning practitioner health and impairment issues, including illness and impairment recognition issues specific to practitioners (“at-risk” criteria). These sessions shall address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer from an illness or potentially impairing condition.

#### **Report & Review**

If any individual in the hospital has a reasonable suspicion that a licensed independent practitioner (hereinafter “LIP”) appointed to the Medical Staff is impaired, the following steps shall be taken:

1. An oral or, preferably, a written report shall be given to the President or the Chief of Staff. The reporting individual shall otherwise keep the report and the facts related thereto confidential. The report shall include a description of the incident(s) that led to the belief that the LIP may be impaired. The report must be factual. The individual making the report need not have proof of the impairment, but must state the facts leading to the suspicions. A LIP who feels that he/she may be suffering from impairment may also make a confidential self-report.

2. Notwithstanding the foregoing, in the event that any person observes a LIP who appears to be currently impaired by drugs or alcohol, that person shall report the events to the Chief of Staff and/or ~~CEO~~ President immediately. The Chief of Staff and/or ~~CEO~~ President may order an immediate drug or alcohol screen if, in their opinion, circumstances so warrant.

3. If, after discussing the incidents with the individual who filed the report, the President and Chief of Staff believe there is sufficient information to warrant further inquiry, the President and/or Chief of Staff may:

- (a) meet personally with the LIP or designate another appropriate person to do so; and/or
- (b) direct in writing that a review be instituted and a report thereof be rendered by an ad hoc committee to be appointed by the Chief of Staff for this purpose. The Chief of Staff shall appoint an ad hoc committee of three (3) physicians to convene within five (5) days of receipt of the request. In the alternative, if the Medical Staff Bylaws provide for a standing physician health or wellness committee, that committee will be convened within five (5) days. The ad hoc committee or standing physician wellness committee shall be referred to as “the committee” hereafter in this policy.

4. In performing all functions hereunder, the President and Chief of Staff shall be deemed authorized agents of the MEC and the committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

5. Following a written request to review, the committee shall review the concerns raised and any and all incidents that led to the belief that the LIP may be impaired. The committee's review may include, but is not limited to, any of the following:

- (a) a review of any and all documents or other relevant materials;
- (b) interviews with any and all individuals involved in the incidents or who may have information relevant to the review, provided that any specific inquiries made regarding the LIP's health status are related to the performance of the LIP's clinical privileges and Medical Staff duties and are consistent with proper patient care or effective operation of the hospital;
- (c) a requirement that the LIP undergo a complete medical examination as directed by the committee, so long as the exam is related to the performance of the LIP's clinical privileges and Medical Staff duties and is consistent with proper patient care or the effective operation of the hospital; and/or
- (d) a requirement that the LIP take a drug test to determine if the LIP is currently using drugs illegally or abusing legal drugs.

6. The committee shall meet informally with the LIP as part of its review. This meeting does not constitute a hearing under the due process provisions of the hospital's Medical Staff Bylaws or pertinent credentialing policy and is not part of a disciplinary action. At this meeting, the committee may ask the LIP health-related questions so long as they are related to the performance of the LIP's clinical privileges and Medical Staff duties, and are consistent with proper patient care and the effective operation of the hospital. In addition, the Committee may discuss with the LIP whether a reasonable accommodation is needed or could be made so that the LIP could competently and safely exercise his or her clinical privileges and the duties and responsibilities of Medical Staff appointment.

7. Based on all of the information reviewed, the committee shall determine:

- (a) whether the LIP is impaired, or what other problem, if any, is affecting the LIP;
- (b) whether the LIP would benefit from professional resources, such as counseling, medical treatment or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and if so, what services would be appropriate;
- (c) if the LIP is impaired, the nature of the impairment and whether it is classified as a disability under the ADA;

- (d) if the LIP's impairment is a disability, whether a reasonable accommodation can be made for the LIP's impairment such that, with the reasonable accommodation, the LIP would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of Medical Staff appointment;
- (e) whether a reasonable accommodation would create an undue hardship upon the hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the hospital's operations or the provision of patient care; and/or
- (f) whether the impairment constitutes a "direct threat" to the health or safety of the LIP, patients, hospital employees, physicians or others within the hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the LIP appears to pose a direct threat because of a disability, the Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

8. If the review produces sufficient evidence that the LIP is impaired, the President shall meet personally with the LIP or designate another appropriate individual to do so. The LIP shall be told that the results of a review indicate that the LIP suffers from an impairment that affects his/her practice. The LIP should not be told who filed the report and does not need to be told the specific incidents contained in the report.

9. If the committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the LIP, so long as that arrangement would neither constitute an undue hardship upon the hospital or create a direct threat, also as described above. The President and Chief of Staff shall be kept informed of attempts to work out a voluntary agreement between the Committee and the LIP and shall approve any agreement before it becomes final and effective.

10. If the committee determines that there is no reasonable accommodation that can be made as described above, or if the committee cannot reach a voluntary agreement with the LIP, the committee shall make a recommendation and report to the MEC, through the Chief of Staff, for appropriate corrective action pursuant to the Bylaws. If the MEC's action would provide the LIP with a right to a hearing as described in the hospital's Medical Staff Bylaws or credentialing policy, all action shall be taken in accordance with the Fair Hearing Plan, and strict adherence to all state and federal reporting requirements will be required. The President shall promptly notify the LIP of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the hospital's Medical Staff Bylaws or credentialing policy.

11. The original report and a description of the actions taken by the committee shall be included in the LIP's confidential file. If the initial or follow-up review reveals that there is no merit to the report, the report shall be maintained in the LIP's confidential file but shall be accompanied by a notation, signed by the reviewing person or body, that indicates that the report is wholly without merit. If the initial or follow-up review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the LIP's file and the LIP's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

12. The President shall inform the individual who filed the report that follow-up action was taken, but shall not disclose confidential peer review information or specific actions implemented.

13. All parties shall maintain confidentiality of any LIP referred for assistance, except as limited by law, ethical obligation, or when safety of a patient is threatened. Throughout this process, all parties shall avoid

speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

14. In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the hospital or its Medical Staff, including the due process sections of those bylaws and policies, the provisions of this policy shall control.

15. Nothing herein shall preclude commencement of corrective action, including summary suspension under the Medical Staff Bylaws, or termination of any contractual agreements between the Hospital and the LIP, including any employment agreement, in the event that the LIP's continued practice constitutes a threat to the health or safety of patients or any person.

### **Rehabilitation & Reinstatement Guidelines**

#### **A. Substance Abuse**

If it is determined that the LIP suffers from a drug or alcohol related impairment that could be reasonably accommodated through rehabilitation, the following are guidelines for rehabilitation and reinstatement:

1. Hospital and Medical Staff leadership shall assist the LIP in locating a suitable rehabilitation program. A LIP who may benefit from counseling or rehabilitative services, but who is not believed to be impaired in his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the hospital. In cases where the LIP's ability is believed to be impaired, the LIP shall be allowed a leave of absence if necessary. A LIP who is determined to have an impairment which requires a leave of absence for rehabilitation shall not be reinstated until it is established, to the satisfaction of the committee, the MEC and the Board, that the LIP has successfully completed a program in which the hospital has confidence.

2. Upon sufficient proof that a LIP who has been found to be suffering from an impairment has successfully completed a rehabilitation program that LIP may be considered for reinstatement to the Medical Staff.

3. In considering an impaired LIP for reinstatement, the hospital and Medical Staff leadership must consider patient care interests paramount.

4. The committee must first obtain a letter from the physician director of the rehabilitation program where the LIP was treated. The LIP must authorize the release of this information. That letter shall state:

- (a) whether the LIP is participating in the program;
- (b) whether the LIP is in compliance with all of the terms of the program;
- (c) whether the LIP attends AA meetings or other appropriate meetings regularly (if appropriate);
- (d) to what extent the LIP's behavior and conduct are monitored;
- (e) whether, in the opinion of the director, the LIP is rehabilitated;
- (f) whether an after-care program has been recommended to the LIP and, if so, a description of the after-care program; and

- (g) whether, in the director's opinion, the LIP is capable of resuming medical practice and providing continuous, competent care to patients.

5. The LIP must inform the committee of the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.

6. From the primary care physician the committee needs to know the precise nature of the LIP's condition, and the course of treatment as well as the answers to the questions posed above in (4)(e) and (g).

7. Assuming all of the information received indicates that the LIP is rehabilitated and capable of resuming care of patients, the committee, MEC and the Board shall take the following additional precautions when restoring clinical privileges:

- (a) the LIP must identify another LIP who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and
- (b) the LIP shall be required to obtain periodic reports for the committee from his or her primary physician, for a period of time specified by the President, stating that the LIP is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

8. The LIP's exercise of clinical privileges in the hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of that monitoring shall be determined by the committee after its review of all of the circumstances.

9. The LIP must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the President or designee, the Chairperson of the committee or the pertinent department chair

10. All requests for information concerning the impaired LIP shall be forwarded to the President for response.

#### B. Physical, Psychiatric or Emotional Illness

If it is determined that the LIP suffers from an acute or ongoing physical, psychiatric, or emotional illness or injury that is not drug or alcohol related and could be reasonably accommodated through rehabilitation or treatment, the following are guidelines for rehabilitation or treatment and reinstatement:

1. If applicable, Hospital and Medical Staff leadership shall assist the LIP in locating a suitable rehabilitation program or treatment plan. A LIP who may benefit from counseling or rehabilitative services, but whose illness or injury is not believed to interfere with his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the hospital. In cases where the LIP's ability is believed to be undermined, the LIP shall be allowed a leave of absence if necessary. A LIP who is determined to have an illness or injury which requires a leave of absence for rehabilitation or treatment shall not be reinstated until it is established, to the satisfaction of the committee, the MEC and the Board, that the LIP has successfully completed any necessary rehabilitation or treatment in which the hospital has confidence.

2. Upon sufficient proof that a LIP who has been found to be suffering from an illness has successfully completed treatment or has been cleared for return to practice by his/her treating physician (as applicable), that LIP may be considered for reinstatement to the Medical Staff.

3. In considering an LIP for reinstatement, the hospital and Medical Staff leadership must consider patient care interests paramount.

4. If requested by the committee, the LIP must provide the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.

5. Assuming all of the information received indicates that the LIP is rehabilitated or recovered and capable of resuming care of patients, the committee, MEC and the Board may take the following additional precautions when restoring clinical privileges:

- (a) the LIP must identify another LIP who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and
- (b) the LIP may be required to obtain periodic reports for the committee from his or her primary physician, for a period of time specified by the Committee, stating that the LIP is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

6. The LIP's exercise of clinical privileges in the hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson<sup>1</sup> The nature of that monitoring shall be determined by the committee after its review of all of the circumstances.

7. All requests for information concerning the impaired LIP shall be forwarded to the President for response.

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<sup>1</sup> For non-departmental hospitals, this sentence would be revised to the following: "The LIP's exercise of clinical privileges in the hospital shall be monitored by Chief of Staff or his/her designee."

# ***MEDICAL STAFF BYLAWS***

## ***APPENDIX “C”***

### **HOSPITAL POLICY REGARDING**

### **BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY**

*For purposes of this policy, "behavior that undermines a culture of safety" is any conduct that intimidates others, affects morale or staff turnover, disrupts the smooth operation of the Hospital, poses a threat to patient care or exposes the Hospital and/or Medical Staff to liability. Such conduct may include, but is not limited to, behavior such as:*

1. Attacks, verbal or physical, leveled at other appointees to the medical staff, hospital personnel, patients or visitors, that are personal, irrelevant, or beyond the bounds of fair professional conduct.
2. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the hospital, or attacking particular physicians, nurses, other employees, or hospital policies.
3. Nonconstructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.
4. Refusal to accept or causing a disturbance of medical staff assignments or participation in committee or departmental affairs in a disruptive or non-constructive manner.
5. Discrimination, harassment and/or retaliation.
6. Passive activities such as quietly exhibiting uncooperative attitudes during routine activities, reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation and impatience with questions.

#### **Objective**

The objective of this policy is to provide a mechanism for timely reporting and addressing of behavior that undermines a culture of safety, and to ensure quality patient care by promoting a safe, cooperative, and professional health care environment, and to prevent or eliminate, to the extent possible, conduct that:

1. Disrupts the operation of the hospital;
2. Affects the ability of others to do their jobs;
3. Creates a “hostile work environment” for hospital employees or other medical staff members;
4. Interferes with an individual’s ability to practice competently; or
5. Adversely affects or impacts the community’s confidence in the hospital’s ability to provide quality patient care.



## **Documentation of Behavior That Undermines a Culture of Safety**

1. Documentation of behavior that undermines a culture of safety is critical. Physicians, nurses and other hospital employees who observe or are otherwise made aware of<sup>1</sup> undermining behavior by a practitioner must document the behavior. Whenever possible, the behavior shall be documented on the attached Practitioner Behavior that Undermines a Culture of Safety Report Form (the "Report") (attached hereto as "Exhibit A"). Such documentation shall be provided to the hospital's President as soon as practicably possible.<sup>2</sup>

The documentation shall include:

- (a) the name of the practitioner(s) involved in the questionable behavior;
- (b) the date and time of questionable behavior;
- (c) a statement of whether the behavior affected or involved a patient in any way, and if so, the chart number of the patient;
- (d) the circumstances that precipitated the situation, if known;
- (e) a description of the questionable behavior limited to factual, objective language as much as possible;
- (f) the consequences, if any, of the behavior as it relates to patient care or hospital operations;
- (g) a record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

2. Once the Report is received by the President, the President shall provide a copy of the Report to the Chief of Staff. In performing all functions hereunder, the President and Chief of Staff shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

## **Investigation**

1. Once received, a report will be investigated by the President and the Chief of Staff. As part of the investigation, the President will interview the employee or other person completing the report as soon as reasonably practical, usually within three (3) business days of having received the Report, in order to gather additional, more complete information. If the President is unable to complete the Report within this time period, the documentation of the investigation will indicate why the interview could not occur within three (3) business days. The President will document the time, date and substance of this meeting, and such documentation will be made part of the investigative file.

2. In general, investigations of behavior that undermines a culture of safety should be completed within five (5) business days after the initial interview of the complaining party, whenever practical. Once an investigation is completed, the President will follow-up with the reporting employee or other individual to inform them (in general terms and without disclosing peer review information or other confidential or sensitive

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<sup>1</sup> Physicians, nurses or other staff who receive a complaint from a patient, family member or community member shall encourage those individuals to document their complaint. Should the individual refuse to do so, the physician, nurse or staff member receiving the complaint shall document the information.

<sup>2</sup> The President will strongly encourage any employee or physician reporting such conduct to document the conduct as outlined above. Should the individual refuse to do so, the President shall document the conduct as described to him/her, and shall note on the form that the conduct was not personally observed by him/her and that the reporting individual refused to document the conduct. The President shall nonetheless have a duty to investigate any credible verbal complaint that describes conduct that may create a risk to the well being of any person, a hostile working environment, or expose the hospital to liability.

information), of the conclusions of the investigation, and that appropriate actions will be taken. The employee or person reporting should be encouraged to report any further behavior that undermines a culture of safety. In addition, the employee or other reporting individual shall be advised that retaliatory action will not be tolerated, and will be encouraged to report any action which appears to have been taken in retaliation for making a report pursuant to this policy.

3. Reports which are determined to be credible, based on the facts and information gathered during the investigation, will be addressed through the procedure set out below and will become a part of the physician's quality file. If the report is determined to be credible, the practitioner who is the subject of the report shall be interviewed prior to conclusion of the investigation.

4. If at any time it appears to the Chief of Staff, the President or any committee charged with implementation of this policy that a practitioner's behavior may result from an impairment, the procedure set forth in the Practitioner Wellness Policy shall be followed.

### **Progressive Corrective Action**

1. A single confirmed incident warrants a formal discussion with the offending practitioner. This meeting will be held in conjunction with the interview described in Paragraph 3 above. The Chief of Staff and President **shall** initiate a meeting with the practitioner. The President shall create a record of the meeting, and shall document that the practitioner was informed that the conduct in question was inappropriate. The President will also, during that meeting, review the substance of this policy with the practitioner, and explain to the practitioner the possible results of continued behavior that undermines a culture of safety. A follow-up letter to the practitioner shall state that the practitioner is required to behave professionally and cooperatively.

2. If there is a second incident of behavior that undermines a culture of safety, the President and Chief of Staff shall follow the same process as described above. However, this second meeting with the practitioner shall constitute the practitioner's final warning. A letter shall be sent to the practitioner following the meeting informing the practitioner that if there is a third incident of behavior, the matter will be referred to the hospital's Medical Executive Committee for appropriate corrective action, which may include a referral to the Board of Trustees for suspension from the medical staff, or termination of the practitioner's medical staff privileges.

3. If there is a pattern of behavior that undermines a culture of safety (defined as three or more incidents of behavior), the President and/or Chief of Staff shall refer the matter to the Medical Executive Committee for recommendation and to the Board of Trustees for final action and resolution of the matter. Any action, recommendation or communication by the MEC becomes a part of the practitioner's permanent file. More formal corrective action may be pursued at this juncture if deemed warranted by the Chief of Staff and/or President.

4. Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident, or at any time during the investigative or corrective action process, should the Chief of Staff and/or President determine that the seriousness of the incident justifies such action.

5. If at any time during the process any participant has reason to believe that the practitioner's behavior may result from an impairment, the procedures set forth in the Practitioner Wellness Policy should be followed.

6. Summary suspension may be appropriate pending the completion of this process, depending on the substance and seriousness of the reported offense. Any summary suspension pursuant to this policy must meet the requirements for summary suspension as outlined in the Medical Staff Bylaws.

### **Disciplinary Action Pursuant to Medical Staff Bylaws**

1. The President and Chief of Staff shall be responsible for presenting the history of conduct to the Medical Executive Committee.
2. The Medical Executive Committee shall be fully apprised of any reports of behavior that undermines a culture of safety, and any meetings and warnings, so that it may pursue whatever action is necessary to terminate the unacceptable conduct.
3. The Medical Executive Committee may refer the matter to the Board of Trustees with or without recommendation as to action. If the Medical Executive Committee makes a recommendation, it shall be processed as provided in the corrective action section of the Medical Staff Bylaws.
4. Should the Medical Executive Committee forward the matter without a recommendation, any further action, including hearing and appeal, shall then be initiated by the Board of Trustees and shall be processed as provided in the corrective action section of the Medical Staff Bylaws.

*Although this policy is intended to outline a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, or damaging hospital property may result in immediate corrective action.*

### **Documentation and Document Retention**

1. All meetings with the practitioner and/or relating to the reported behavior that undermines a culture of safety shall be documented and maintained in the practitioner's quality file.
2. After each meeting with the practitioner, a letter summarizing the substance of the meeting shall be sent to the practitioner.
3. A copy of all original Reports shall be maintained in the practitioner's quality file with all of the documents and notes on the matter. The practitioner may also submit a written response to be placed in the file if he/she so desires.

Date Form Completed: \_\_\_\_\_  
Completed by: \_\_\_\_\_

**Section 1: General Information**

Practitioner Involved: \_\_\_\_\_ Date of undermining behavior: \_\_\_\_\_

Time of undermining behavior: \_\_\_\_\_ am / pm

Location of incident: \_\_\_\_\_

Were any patients involved in the incident? If yes, please provide patient chart number:

\_\_\_\_\_

**Section 2: Description of Behavior that Undermines a Culture of Safety**

Describe the circumstances which precipitated the situation, if known: \_\_\_\_\_

\_\_\_\_\_

Describe the questionable behavior in objective, fact-based terms: \_\_\_\_\_

\_\_\_\_\_

Describe the results, if any, of the undermining behavior as it relates to patient care or hospital operations:

\_\_\_\_\_

\_\_\_\_\_

What actions, if any, were taken to remedy the situation? Include the names of other individuals that may have intervened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section 3: Confidentiality and Non-retaliation**

Your report of behavior that undermines a culture of safety will be treated as confidentially as possible consistent with Hospital and Medical Staff policy and applicable law. We cannot assure you that the practitioner in question will never become aware of your identity, however, we can assure you that retaliation against any person for making a complaint of undermining conduct will not be tolerated. Retaliation is taken very seriously and retaliation against any individual will be a basis for corrective action. We encourage you to report any behavior which you believe to be retaliatory in nature.

**Section 4: Verification of Report**

Please sign below verifying that the contents of this report are true and accurate, to the best of your knowledge, and based on personal knowledge of the reported behavior that undermines a culture of safety. Once completed, this report should be delivered to the Hospital President.

Name of Person Reporting: \_\_\_\_\_ Signature: \_\_\_\_\_

**PRACTITIONER BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY REPORT FORM**

Privileged and Confidential for use by Legal Counsel

Not Part of the Medical Record

DO NOT PHOTOCOPY

# *MEDICAL STAFF BYLAWS*

## *APPENDIX "D"*

### **MEDICAL STAFF POLICY REGARDING PEER REVIEW, ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) & FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**

This Policy is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the policy and procedures described herein.

#### **SCOPE**

Applies to all credentialed members of the Medical Staff and Allied Health Practitioners.

#### ***EXCEPTION:***

*No volume providers with medical staff membership and without clinical privileges per Joint Commission clarification are exempt from the Ongoing Professional Performance Evaluation and Focused Professional Practice Evaluation requirements contained within this document.*

#### **I. PURPOSE:**

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competence, practice, and the quality and safety of patient care;

To define those circumstances in which an external review or focused review may be necessary;

To address identified issues in an effective and consistent manner.

"Professional Practice Evaluation" is considered an element of the peer review process and the records and proceedings relating to this policy are confidential and privileged to the fullest extent permitted by applicable law.

#### **II. DEFINITIONS**

##### **Peer:**

For purposes of this policy, the term "Peer" refers to any practitioner who possesses the same or similar knowledge and training in a medical specialty as the practitioner whose care is the subject of review.

##### **Examples include:**

- Emergency Medicine / Internal Medicine / Family Practice / Pulmonology
- Pediatrics / Family Practice
- General Surgery / Gynecology / ENT / Urology

- Obstetrics / General Surgery / Family Practice with OB privileges (larger facilities Obstetrics may be reviewed by same specialty)
- Podiatry – reviewed by the same specialty
- Orthopedics – reviewed by same specialty
- Radiology – reviewed by same specialty
- Pathology – reviewed by same specialty
- Anesthesiology – reviewed by the same specialty
- Dentist (oral surgeon) – reviewed by same specialty
- Cardiology / Internal Medicine
- Interventional Cardiology – reviewed by same specialty
- Nurse Practitioner/PA – reviewed by same specialty or physician of same specialty
- CRNA – reviewed by same specialty or physician of same specialty

### **Individual Case Review:**

The process outlined for peer review of a particular case identified with a potential quality of care issue.

### **Ongoing Professional Practice Evaluation:**

The ongoing process of data collection for the purpose of assessing a practitioner's clinical competence and professional behavior. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the two-year membership and privilege renewal cycle.

### **Focused Professional Practice Evaluation:**

The time-limited evaluation of practitioner competence in performing a specific privilege. The process is consistently implemented as a means to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality care.

FPPE affects only the privileges for which a relevant concern has been raised and related privileges for which the same concern would apply. Other existing privileges in good standing should not be affected by the decision to initiate FPPE.

### **Peer Review**

Peer Review is the process by which a practitioner, or committee of practitioners, examines the work of a peer and determines whether the practitioner under review has met accepted standards of care in rendering medical services. The professional or personal conduct of a physician or other healthcare professional may also be investigated. Individual Case Review, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation are components of peer review.

### **Practitioner Proctoring:**

The personal presence of an assigned practitioner who does not have a treatment relationship with the patient, who is designated to provide clinical teaching or to monitor the clinical performance of another practitioner to facilitate quality of care to patients, as required for purposes of credentialing, reappointment, quality improvement, FPPE, or corrective action.

## Focused Professional Practice Evaluation (FPPE)

### A. Initiation of FPPE

FPPE will be initiated in the following instances:

- Upon initial appointment;
- When a new privilege is requested by an existing practitioner;
- When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner's ability to provide safe, high-quality patient care. For example, when a trigger is exceeded and preliminary review indicates a need for further evaluation.

A recommendation of FPPE may be made by:

- The Credentials Committee;
- A Department of the Medical Staff;
- The Chief of the Department;
- The Chief of Staff;
- A special committee of the medical staff;
- The MEC

The FPPE monitoring plan for a new practitioner, or newly requested privilege(s) will be specific to the requested privileges or group of privileges.

FPPE is not considered corrective action as defined in the Medical Staff Bylaws and is not subject to the Bylaws provisions related to the corrective action process.

### B. Timeframe for Collection and Reporting

The period of FPPE must be time-limited. Time-limited may be defined by:

- A specific period of time; or
- A specific volume (number of procedures/admissions/encounters)

The duration of FPPE may be tiered for different levels of documented training and experience:

1. Practitioners coming directly from an outside residency program (unknown data)
2. Practitioners coming directly from the organization's residency program (have data)
3. Practitioners coming with a documented record of performance of the privilege and its associated outcomes versus those with no record

FPPE shall begin with the applicant's first admission(s), encounter(s), or performance of the newly requested privilege. FPPE should optimally be completed within three months, or a suitable period based upon volume. The period of FPPE may be extended as necessary at the discretion of the medical staff but may not extend beyond the first biennial reappointment.

### C. Methods for Conducting FPPE/Communication to the Practitioner

FPPE may be accomplished by:

1. Chart reviews, both concurrent and/or retrospective
2. Simulation
3. Discussion with the involved practitioner and/or other individuals involved in the care of the practitioner's patients, for example, consulting physicians, surgical assistants, nursing staff or administrative personnel
4. Direct observation/proctoring
5. For dependent AHPs, FPPE methods may include review or proctoring by the sponsoring physician
6. Internal or external peer review

FPPE completed via medical record review may be delegated to quality management staff for screening, utilizing medical staff approved criteria, so long as said staff has access to physician peer for input if needed.

The terms of all FPPE shall be communicated in writing to the affected practitioner or AHP, including the following:

- The cause for the focused monitoring
- The anticipated duration
- The specific mechanism by which monitoring will occur (i.e. chart reviews, proctoring, peer observation, etc.)

#### **D. Performance Monitoring Criteria and Triggers**

Monitoring criteria, including specific performance elements to be monitored, as well as thresholds or triggers, are developed and approved by the medical staff or responsible medical staff departments/committees and Board. Triggers are defined as potentially unacceptable levels of performance. Triggers to consider include, but are not limited to:

- A single egregious case or evidence of a practice trend
- Unacceptable number of individual peer reviews with adverse determinations
- Sentinel events/Serious Safety Events
- Increasing lengths of stay as compared to others
- Increasing number of returns to surgery
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Behavior that undermines a culture of safety

If the results for a practitioner or AHP exceed thresholds established by the Medical Staff, outliers may be forwarded for peer review after initial screening by the Quality Management Department.

#### **E. Conclusion of FPPE**

At the conclusion of the initial FPPE, findings will be reviewed by the Medical Executive Committee or responsible Department, for decision and recommendation. Decisions may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending to limit or suspend the privilege. Such



recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to the Medical Staff Bylaws Appendix A (Fair Hearing Plan) will apply.

Each practitioner or AHP will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member or AHP including, but not limited to, the following:

- An overall summary of the findings and outcome of FPPE
- Specific actions, if any, that need to be taken by the practitioner or AHP to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed
- If the focused review is complete or will continue (duration will be specific if the focused review will continue)
- The period of initial FPPE is completed and the practitioner or AHP will move into OPPE
- The period of FPPE for a specific privilege is completed and the practitioner or AHP will continue with OPPE

At the end of the period of focused evaluation, in the event that the practitioner or AHP's activity/volume has not been sufficient to meet the requirements of FPPE:

- The practitioner or AHP may voluntarily resign the relevant privilege(s), or
- The practitioner or AHP may submit a written request for an extension of the period of focused evaluation, or
- If the practitioner or AHP has sufficient volume of the privileges in question at another local facility, external peer references specific to the privilege/procedure may be obtained.
- FPPE may be extended at the discretion of the responsible medical staff department or committee.

The practitioner or AHP is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished. Note that even in the absence of entitlement to hearing rights, a report to the National Practitioner Data Bank may still be triggered.

FPPE practitioner-specific data reports are maintained in the Practitioner or AHP's Confidential Quality File. A summary document/report shall be maintained in the Credentials File. For purposes of this provision, the summary document/report shall mean general communication letter that was sent to the practitioner following the review informing him/her whether he/she successfully met the established expectation for FPPE during the review period. The summary document/report shall not include quality screens, reviews, data reports, etc., which shall all be maintained in the confidential quality file.

## **F. Performance Improvement Plan**

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff department, committee or chair. The written improvement plan and supporting FPPE outcomes should be presented to the Medical Executive Committee for approval. The involved Practitioner or AHP should also be offered the opportunity to address the MEC and respond to the findings before the improvement plan is finalized and implemented.

Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

- Necessary education
- Proctoring and/or mentoring
- Counseling
- Practitioner Assistance Program
- Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or Chief of Staff will meet with the Practitioner or AHP to communicate the improvement plan. If the Practitioner or AHP agrees with the plan, the written document should be signed by the Practitioner or AHP and forwarded to the Quality Department. If the Practitioner or AHP does not agree with the plan and/or refuses to implement the improvement plan, the outcome will be reported to the responsible department chief and/or Medical Executive Committee for resolution.

## **ONGOING PROFESSIONAL PRACTICE EVALUATION**

### **A. Timeframe for Collection and Reporting**

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/or action as specified in this Policy.

### **B. Indicators for Review**

1. The type of data to be collected and related thresholds or triggers is determined by individual medical staff committees/departments and approved by the Medical Staff. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/outlier trending data. Good performance data should also be considered.
  - a. Each Medical Staff department will select three to five *specialty-specific* indicators based upon their clinical service. These indicators may be evidence-based, such as post-op infection rate, mortality data, blood utilization, etc.
  - b. The Medical Staff will select two or three *general* indicators that apply to all credentialed practitioners and AHPs.
  - c. The Medical Staff may consider the six areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME). These include:
    - i. Patient care
    - ii. Medical/clinical knowledge
    - iii. Practice-based learning and improvement
    - iv. Interpersonal and communication skills
    - v. Professionalism
    - vi. Systems-based practice

Information used in the ongoing professional practice evaluation may be acquired through:

- Periodic chart review
- Direct observation

- Monitoring of diagnostic and treatment techniques
  - Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel.
2. Thresholds/triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable levels of performance within the established defined criteria and are used to identify those performance outcomes that could trigger FPPE. Triggers to consider include, but are not limited to:

Defined number of events occurring  
Defined number of individual peer reviews with adverse determinations  
Elevated infection, mortality, and/or complication rates  
Sentinel events  
Small number of admissions/procedures over an extended period of time  
Increasing lengths of stay in comparison to peers  
Increasing number of returns to surgery  
Frequent unanticipated readmission for the same issue  
Patterns of unnecessary diagnostic testing/treatments  
Failure to follow approved clinical practice guidelines

### **C. Oversight and Reporting**

The organized Medical Staff delegates the collection of the selected performance indicators to the appropriate hospital department. The overall process, data compilation and reporting is coordinated by the Quality Management Department.

The review of performance data and any recommendation(s) for action, if necessary, may be the responsibility of one of the following:

- The Medical Executive Committee;
- The specific Medical Staff Department;
- The Chief of the Department;
- A standing or special committee of the medical staff.

### **D. Results and Reporting of Data Analysis**

Data are analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized practitioner or AHP report are referenced in the MEC meeting minutes, maintained in the quality file and incorporated into the two-year reappointment process.

A summary document/report of OPPE shall be maintained in the Credentials File. For purposes of this provision, the summary document/report shall mean the general communication letter that was sent to the practitioner following the review informing him/her whether he/she successfully met the established expectation for OPPE during the review period. Physician-specific OPPE data reports, quality screens, data reports, etc. are all maintained in the confidential quality file and not the Credentials File and shall not be included with the summary document/report.

During the course of OPPE, FPPE may be triggered by the following special circumstances:

- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Behavior that undermines a culture of safety

If unprofessional behavior or disruptive conduct is identified as a possible concern, the Behavior that Undermines a Culture of Safety Policy (Appendix C) will be initiated as a component of the OPPE.

At the completion of the review period, an overall summary of the results of OPPE will be communicated to the individual practitioner or AHP. For purposes of this provision, an “overall summary” means a general communication letter indicating to the practitioner whether he/she successfully met the established expectation for OPPE. The actual report itself shall not be forwarded to the practitioner or AHP with this communication. The original report will be maintained in the practitioner or AHP quality file.

### **RESPONSIBILITIES OF THE QUALITY MANAGEMENT DEPARTMENT:**

1. The Quality Management Department will be responsible for compiling and reporting results of FPPE and OPPE to the Medical Staff Committee(s).
2. In order to facilitate FPPE for Allied Health Professionals, and/or those practitioners requesting a new privilege, the practitioner or AHP must notify the Quality Management Department of the first scheduled procedure or encounter. The practitioner or AHP must also provide the Quality Management Department with a patient listing or log until the specified patient volume or FPPE requirement is met.
3. A OPPE practitioner or AHP-specific profile that illustrates performance over the two-year reappointment cycle will be utilized at the time of reappointment.
4. The Quality Management Department will be responsible for collaborating with each Medical Staff Committee/Department on an annual basis to review the continued relevance of the selected indicators and triggers.

### **Individual Case Review Process**

Cases identified with potential quality of care issues are referred to the appropriate Medical Staff Department or Committee for review. The Quality Management Department is responsible for coordinating the Peer Review Process.

Cases may be identified through OPPE, FPPE, case management, risk management, audits, sentinel events/serious safety events, clinician referrals, allegations of suspected substance abuse or disruptive behavior and other sources. All cases should be initially screened by the Quality Management department utilizing medical staff approved screening criteria, prior to forwarding for physician review. If there are no potential quality of care issues identified following the quality management screening, the case is closed, the findings are documented and trending is performed in the Quality Department.

If potential quality of care issues are identified through Quality Management screening, the following process for peer review shall be implemented:

**A. Reviewer Selection & Duties**

Reviews are completed by the designated Medical Staff Practitioner, Department or Committee (based upon the particular medical staff structure).

The designated reviewer may not review a case where he/she participated in the care.

**B. Reviewer Disqualification & Replacement**

If a reviewer does not feel he/she can adequately review a medical record due to a conflict of interest or believes he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee, Department Chief or Chief of Staff. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer. If a member has reviewed a record that needs to be presented but is unable to attend the meeting, the member shall report to the Chair so that the presentation may be reassigned to another Committee member or presented by the Chairperson. If the chairperson is the practitioner subject to review, the record review will be assigned to another Active Staff member by the Chief of Staff or to an external reviewer if circumstances are as described in Section D, below.

**C. Communication to Involved Practitioner**

Any Practitioner or AHP who is the subject of a review receiving an assigned peer review score of 3 or greater, shall be notified in writing at least two weeks prior to the medical staff meeting where the outcome of review is reported. Communication shall include the case medical record number, admission/discharge date, reason and outcome of the review. Comments and/or opinions made by the reviewer may be included, however, the identity of the reviewer should be redacted.

The involved Practitioner or AHP is provided the opportunity to respond to the results of the review in writing in advance of the meeting where the outcome is reported. At the request of the Department Chief, or Chief of Staff, the Practitioner or AHP may be invited to attend the meeting and discuss the case.

**D. Circumstances Requiring External Peer Review**

The MEC, Chief of Staff, Department Chair, Peer Review Committee/Chair or the Board of Trustees may request external peer review by a practitioner who is Board certified within the same specialty in circumstances, including, but not limited to, the following:

- The pool of eligible reviewers is unable to serve
- There is no qualified practitioner on staff to conduct the review
- Litigation risk
- The facility has only a single practitioner in a particular specialty and no other practitioner has similar background, training or experience
- The procedure is new to the organization
- Other reasons as deemed by the MEC and Board.

No practitioner or AHP may require the Hospital to obtain external peer review if it is not deemed necessary by the Chief of Staff, MEC, Department Chair, Peer Review Committee or the Board of Trustees.<sup>1</sup>

**E. Review Form Summary**

Reviewing practitioners must complete the Peer Review Form, Attachment One, clearly and concisely. The reviewing practitioner must sign his/her name on the review form which shall grade the care and outcome based on the following schedule:

- 1 = Treatment appropriate, outcome good, and any patient impact was minimal
- 2 = Treatment appropriate but patient sustained significant adverse outcome
- 3 = Treatment inappropriate but adverse impact on patient was minor or minimal, temporary or permanent harm
- 4 = Treatment inappropriate and patient sustained moderate to severe, temporary or permanent harm.

**DOCUMENTATION OF PEER REVIEW ACTIVITIES:**

Reports of OPPE, FPPE and individual case review findings and recommendations shall be presented to the MEC. The MEC may adopt the recommendations of the Medical Staff Department/Committee and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.

All recommendations of the MEC other than for further investigation or Corrective Action shall be delivered to the Board. The Board shall make a final determination concerning any actions warranted based on the findings and recommendations of the MEC.

Results of OPPE, FPPE and Peer Review outcomes shall be documented and maintained in the practitioner's quality file and referenced at reappointment. A summary of OPPE and FPPE shall be provided to the MEC and Board no greater than every nine (9) months or as determined by the organization. A summary of Peer Review outcomes shall be reported to the Board on at least a quarterly basis.

**Practitioner Review of Confidential Quality File**

A practitioner or AHP may review his quality file by making an appointment with the Director of Quality Management and Regulatory Compliance (QMRC)/Chief Quality Officer, and the Chief of Staff. No copies of the quality file may be made, nor may the practitioner or AHP remove any portion of the quality file from the Hospital. In the discretion of the President, in consultation with the Chief of Staff, personal information, such as the identity of external or internal peer reviewers, or the identity of patients or employees reporting quality issues, may be redacted before the practitioner or AHP may review the file.

*\*Refer to policy "Guidelines for Confidential Quality Files*

# ***MEDICAL STAFF BYLAWS***

## ***APPENDIX “E”***

### **MEDICAL STAFF POLICY REGARDING PHYSICIAN OWNERSHIP DISCLOSURE TO PATIENTS**

1. Physicians who have ownership interest in any business that provides anything to patients should disclose their interest to the patient before any good or service is provided to a patient.
  - a. Goods and/or services include any items provided to the Hospital used for direct patient care, such as orthopedic implants, sentinel lymph node detection services, intra-operative surgical monitoring, ophthalmic implants, etc.
2. Physicians are not permitted to condition treatment of a patient on the use of anything provided by a physician owned company.
3. Physicians are required to disclose any financial interest they (or their family members) hold in any company that sells any product and/or service to the Hospital and patients before ordering such a product or service for any patient.
4. The failure of physicians on the Medical Staff to disclose an ownership interest to patients may violate the Stark law and state conflicts of interest laws, and is not in the best interest of the patient-physician relationship.

**MEDICAL STAFF BYLAWS**  
**APPENDIX F**  
**DEPARTMENTAL STANDARDS**  
**FOR**  
**MEMORIAL HOSPITAL OUTPATIENT ENDOSCOPY CENTER**

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**PREAMBLE**

The Department is an outpatient endoscopy center licensed by the State of Pennsylvania and is operated as an outpatient department of Memorial Hospital. The purpose of the Department is to provide safe, high quality endoscopy services to its patients. All capitalized terms in this Appendix shall have the meanings set forth in the Medical Staff Bylaws unless otherwise defined herein. Unless otherwise specified in this Appendix, the Medical Staff Bylaws and the Medical Staff Rules & Regulations shall equally apply to all Department Practitioners. A separate copy of this Appendix, all Department policies, the Medical Staff Bylaws, and the Medical Staff Rules & Regulations shall be maintained within the Department. In the event of a conflict between the provisions of this Appendix and the Medical Staff Bylaws, Rules & Regulations or any applicable policy, the provisions of this Appendix will apply to Department Practitioners and Department operations.

**DEFINITIONS**

1. "Administrator" means the President of the Department who has overall administrative responsibility of the Department. The Hospital's President shall serve as the Administrator of the Department.
2. "Board" means the Board of Trustees of PinnacleHealth Memorial Hospital, which shall assume full legal authority and responsibility for the Department.
3. "Department" means the PinnacleHealth Memorial Hospital Outpatient Endoscopy Center, an outpatient endoscopy center, which is operated as an outpatient department of PinnacleHealth Memorial Hospital.
4. "Department Clinical Privileges" means the Board's recognition of a practitioner's competence and qualifications to render outpatient endoscopy services within the Department.
5. "Department Practitioners" means practitioners who have been granted privileges by the Board to provide patient care services in the Department.



6. "Departmental Standards" or "Appendix" means these standards of the Department. The Departmental Standards are adopted in connection with the Medical Staff Bylaws of PinnacleHealth Memorial Hospital and made a part thereof. A copy of the Departmental Standards along with the Medical Staff Bylaws shall be maintained in the Department.
7. "Hospital" means PinnacleHealth Memorial Hospital.
8. "Medical Director" means the individual appointed by the Board to oversee the overall medical care provided in the Department.
9. "Medical Staff" means the formal organization of practitioners who have been granted medical staff membership by the Board to attend patients in the Hospital, including the Department.
10. "Medical Staff Bylaws" means the PinnacleHealth Memorial Hospital Medical Staff Bylaws and all ancillary documents, including but not limited to, the Medical Staff Credentials Manual, the Allied Health Professionals Manual, the Medical Staff Committee Manual, the Medical Staff Policies and Procedures Manual, general Medical Staff policies and Hospital policies.
11. "Services" means outpatient endoscopy services and procedures approved by the Board as services that can be safely performed in the Department.

## **ARTICLE I**

### **PURPOSES**

With regard to the Department, the primary purpose of the Medical Staff is to provide for the collegial organization and thereby to:

- a) Permit all Department patients to receive quality medical, surgical and procedural care according to accepted standards relating to the provision of endoscopy services.
- b) Participate in and promote Department activities designed to improve and protect the general health of those patients to whom the Department may from time to time provide services.
- c) Provide a means whereby the Medical Staff is assured of an effective means of communication with the Medical Director and Board, particularly with regard to the quality of care offered by the Department, and provide an effective organization for the observation and evaluation of professional practice and professional conduct in the Department.
- d) Permit an acceptable level of professional performance of Department Practitioners through the appropriate delineation of the clinical privileges which each Department Practitioner may exercise and through a continuing review and evaluation of each Department Practitioner's performance in the Department.

- e) Assist the Medical Director and the Board in evaluating the quality of care and ethical conduct of Department Practitioners.

## **ARTICLE II**

### **MEDICAL STAFF MEMBERSHIP**

All practitioners seeking to provide Services in the Department and who are included in the Medical Staff Bylaws definition of Medical Staff must successfully obtain and maintain Medical Staff membership and Department Clinical Privileges pursuant to the requirements and procedures delineated in the Medical Staff Bylaws. Medical Staff membership shall be extended only to the practitioners who continuously meet the qualifications, standards, obligations and requirements set forth in the Medical Staff Bylaws. A copy of the credentials file for Medical Staff members with Department Clinical Privileges shall be maintained within the Department.

#### **Section 1.      **Qualifications and Standards for Membership****

Medical Staff membership and clinical privileges shall be requested and granted pursuant to the procedures and requirements set forth in the Medical Staff Bylaws.

#### **Section 2.      **Conditions and Duration of Appointment****

The duration of all appointments to the Medical Staff and the procedures associated with requests for a leave of absence and modification of appointments shall be governed by the requirements outlined in the Medical Staff Bylaws.

#### **Section 3.      **Staff Category****

All practitioners that apply for Medical Staff membership with Department Clinical Privileges, shall request and be assigned to the appropriate category of the Medical Staff pursuant to the Medical Staff Bylaws. All Medical Staff members providing patient care services in the Department shall continuously fulfill the basic obligations of Medical Staff membership and the obligations of the appropriate Staff category as outlined in the Medical Staff Bylaws.

## **ARTICLE III**

### **PROCEDURE FOR MEDICAL STAFF APPOINTMENT**

#### **AND REAPPOINTMENT**

#### **Section 1.      **Appointment Process****

All practitioners seeking to provide Services in the Department and who are included in the Medical Staff Bylaws definition of Medical Staff shall be members of the Medical Staff, and shall be initially appointed to the Medical Staff pursuant to the procedures for Medical Staff appointment set forth in the Medical Staff Bylaws. All initial applications shall be processed in the same manner as outlined in the Medical Staff Bylaws.

## **Section 2. Reappointment Process**

All practitioners providing Services in the Department and who are included in the Medical Staff Bylaws definition of Medical Staff shall be members of the Medical Staff, and shall be reappointed to the Medical Staff pursuant to the procedures for Medical Staff reappointment set forth in the Medical Staff Bylaws. All applications for reappointment shall be processed in the same manner as outlined in the Medical Staff Bylaws.

## **ARTICLE IV**

### **ALLIED HEALTH PROFESSIONALS**

#### **Section 1. Qualification and Standards for Privileges**

Allied Health Professionals seeking to provide patient care services in the Department shall continuously meet the basic qualifications and conditions for Allied Health Professionals outlined in the Medical Staff Bylaws. Allied Health Professionals providing patient care services in the Department shall obtain and maintain Department Clinical Privileges pursuant to the requirements and procedures for privileging Allied Health Professionals in the Medical Staff Bylaws. A copy of the credentials file for Allied Health Professionals with Department Clinical Privileges shall be maintained within the Department.

#### **Section 2. Prerogatives and Responsibilities**

Allied Health Professionals providing patient care services in the Department shall have the same prerogatives and responsibilities as those set forth in the Medical Staff Bylaws for Allied Health Professionals. Allied Health Professionals providing patient care services in the Department shall provide Services within the limits established in the Medical Staff Bylaws and by Pennsylvania law.

## **ARTICLE V**

### **PRIVILEGES**

#### **Section 1. Department Privileges**

- a) Department Clinical Privileges shall be specific to the Department and to outpatient endoscopy and individual outpatient endoscopy procedures. The Board shall, upon recommendation from the Medical Staff, establish the specific Department Clinical

Privileges. Procedures performed in the Department are limited to procedures that are approved by the Board, upon the recommendation of the Medical Staff and congruent with state law.

- b) Every Department Practitioner providing direct clinical services in the Department shall be entitled to exercise only those Department Clinical Privileges specifically granted to him/her by the Board. Said Department Clinical Privileges must be within the scope of the license authorizing the Department Practitioner to practice in Pennsylvania and consistent with any restrictions thereon. The Board shall approve the list of specific Department Clinical privileges and limitations for each category of Department Practitioner, and each Department Practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.
- c) All Department Clinical Privileges shall be requested and granted pursuant to the requirements and procedures concerning clinical privileges outlined in the Medical Staff Bylaws. Department Clinical Privileges granted shall reflect the results of peer review and utilization review programs specific to the Department. The delineation of Department Clinical Privileges shall address the administration of anesthesia/sedation as applicable.

## **Section 2. Temporary Privileges**

Temporary Department Clinical Privileges shall be requested and granted pursuant to the requirements and procedures concerning temporary clinical privileges as outlined in the Medical Staff Bylaws.

## **Section 3. Emergency, Disaster and Telemedicine Privileges**

Emergency, disaster and telemedicine Department Clinical Privileges shall be requested and granted pursuant to the requirements and procedures concerning emergency, disaster, and telemedicine clinical privileges outlined in the Medical Staff Bylaws.

# **ARTICLE VI**

## **CORRECTIVE ACTION**

### **Section 1. Routine Corrective Action**

Any request for corrective action or a performance improvement plan regarding a Department Practitioner shall be made and processed pursuant to the procedures associated with routine correction action delineated in the Medical Staff Bylaws and Rules & Regulations.

### **Section 2. Summary/Precautionary Suspension**

Any summary/precautionary suspension imposed against a Department Practitioner shall be imposed and processed pursuant to the requirements and procedures related to summary suspensions outlined in the Medical Staff Bylaws and Rules & Regulations.

**Section 3. Automatic Suspension/Relinquishment.**

The provisions concerning automatic suspensions/relinquishments in the Medical Staff Bylaws and Rules & Regulations shall equally apply to all Department Practitioners.

**Section 4. Interviews and Fair Hearings**

The provisions concerning interviews and fair hearings in the Medical Staff Bylaws and Rules & Regulations shall equally apply to all Department Practitioners. Any adverse action affecting an Allied Health Professional who provides Services in the Department shall be accomplished in accordance with the requirements and procedures for Allied Health Professional adverse actions in the Medical Staff Bylaws.

**ARTICLE VII**

**DEPARTMENT MEDICAL DIRECTOR**

**Section 1. Medical Director**

The Medical Director shall oversee the overall medical care provided in the Department.

**Section 2. Qualifications of Medical Director**

The Medical Director shall be a Physician who is able to demonstrate qualifications acceptable to the Board, who maintains Department Clinical Privileges and who is board certified by an American Board of Medical Specialties recognized board or the osteopathic equivalent.

**Section 3. Appointment of Medical Director**

The Medical Director is appointed by the Board, upon the recommendation of the Administrator. The Medical Director shall hold that position until such time as he/she is relieved of the position by the Board.

**Section 4. Removal of Medical Director**

Except as otherwise provided herein, the Board may remove and replace the Medical Director with or without cause.

## **Section 5. Vacancy in Office**

If there is a vacancy in the office of Medical Director, the Board or its designee shall appoint a new Medical Director.

## **Section 6. Duties of Medical Director**

The Medical Director shall:

- a) Oversee all Services within the Department and report directly to the Administrator;
- b) Act in coordination with the Administrator and Board in all matters of concern within the Department, and carry out all of the duties and responsibilities of a Medical Director as required under applicable Pennsylvania rules and regulations governing endoscopy facilities;
- c) Be physically present in the Department as necessary to carry out the duties set forth in this Appendix and as required from time to time by the Board;
- d) Ensure Department compliance with any applicable federal regulations, state statutes/rules, and local municipality and accrediting body standards;
- e) Implement, review and enforce all Departmental Standards, policies and procedures;
- f) Supervise the provision of anesthesia/sedation services or appoint another Physician who shall be approved by the Board to supervise the provision of anesthesia/sedation services in the Department;
- g) Develop and implement policies and procedures with respect to the evaluation of patients who have received anesthesia/sedation in the Department. Such policies and procedures shall be approved by the Medical Staff and Board;
- h) Assure that post operative monitoring of anesthesia/sedation is conducted in accordance with the criteria set forth in this Appendix, the Medical Staff Bylaws and Medical Staff Rules and Regulations;
- i) Assure that all procedures performed in the Department are limited to those procedures that are approved by the Board and make recommendations to the Board regarding which procedures should be approved to be performed in the Department;
- j) Assure that appropriate personnel provide adequate supervision of Services provided in the Department and make recommendations to the Board regarding the supervision of Services;

- k) Provide medical supervision of the Department (directly or by a credentialed designee) on a twenty-four (24) hour basis;
- l) Review infection control activities in the Department and validate compliance with state, federal and Hospital programs;
- m) Be familiar with and oversee Department compliance with state and federal patient confidentiality and state advanced directive requirements;
- n) Review all Department quality indicators; cooperate and participate in the Department education and in-service programs; review at least quarterly all deaths of Department patients; and generally oversee quality of care in the Department;
- o) Counsel, as necessary, any Department Practitioner not meeting the performance standards set forth in this Appendix, the Medical Staff Bylaws or the Rules & Regulations;
- p) Supervise the planning of the quality assessment and performance improvement program as related to the Department;
- q) Review and support all reasonable, clearly defined, vendor activities in the Department as approved by the Board;
- r) Report to the Board of any emergency, such as a strike, fire or natural disaster which significantly interrupts or alters Department services and threatens the health and safety of patients pursuant to state law; and
- s) Organize an annual safety program for all Department personnel and oversee a Department specific disaster and fire plan.

## **ARTICLE VIII**

### **COMMITTEES**

#### **Section 1. General Provisions**

The Hospital Medical Executive Committee may appoint special or ad hoc committees to perform Medical Staff functions with regard to the Department. Each Department committee shall keep a permanent record of its proceedings and actions. All Department committee actions shall be reported to the Hospital Medical Executive Committee. All information pertaining to activities performed by the Medical Staff and its committees shall be privileged and confidential to the full extent provided by law. The Administrator or his/her designee shall

serve as an ex-officio member, without vote, of each standing and special Department committee.

## **Section 2. Medical Executive Committee Representation**

The Hospital Medical Executive Committee shall include the Medical Director of the Department. In addition to the Medical Executive Committee functions delineated in the Medical Staff Bylaws, the Medical Executive Committee shall ensure that the Medical Staff performs the functions delineated in this Appendix.

## **Section 3. Quality Management Committee Representation**

The Hospital Quality Management Committee, or the committee performing the quality management function of the Medical Staff, shall include one (1) member of the Medical Staff who maintains Department Clinical Privileges and who is responsible for the quality assurance and improvement activities within the Department. The Department shall routinely present quality assurance and improvement reports to the Hospital Quality Management Committee or equivalent committee. Committee minutes shall specifically address the Department in all activities affecting the Department, and copies of such minutes shall be maintained on file in the Department. The Committee shall make regular reports to the Hospital Medical Executive Committee and Board. In addition to the Hospital Quality Management Committee functions delineated in Hospital policies, the Committee shall:

- a) Evaluate data submitted by the Department as part of the quality assurance program; and review Department tissue examination reports;
- b) Review Department infection control procedures; and
- c) Review the standard of practice in all specific areas of the Department.

## **Section 4. Quality Assessment and Performance Improvement Activities**

The Hospital quality assessment and performance improvement program shall describe the program's objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluating and problem solving activities with regard to the Department. The Hospital quality assessment and performance improvement program shall be endorsed by the Medical Staff, Board and Medical Director. The program shall emphasize the ongoing nature of the quality assurance program and the comprehensive scope of the program with regard to the Department. The program, including all processes delineated in this Appendix, shall be reviewed and approved annually by the Hospital Quality Management Committee (or equivalent committee), Medical Executive Committee and Board.

The activities shall include monitoring and evaluation of data collected from the Department, based on defined criteria that reflect current knowledge and clinical experience and that relate to the care provided in the Department. Sources of data include medical records, incident reports, infection control records and patient complaints. In the event the Department treats pediatric patients, the Hospital Quality Management Committee, or



equivalent committee, shall segregate data regarding these patients. The program shall also provide for the identification of problems, actions on said problems and continued monitoring of actions taken which improve the quality and appropriateness of patient care within the Department.

The frequency, severity and source of suspected Department problems and concerns are evaluated by Department Practitioners and staff. Measures shall be implemented to resolve important Department problems or concerns identified in accordance with 28 Pa. Code 557.3. The results of these corrective measures shall be monitored to assure that the problem has been satisfactorily resolved.

In addition to any other requirements mandated by the Medical Staff Bylaws and Hospital policies, the Hospital quality assessment and performance improvement program shall address the following matters:

- a) Peer-based review of clinical performance of Department Practitioners;
- b) Department case and tissue review;
- c) Department anesthesia/sedation services;
- d) Department nursing services;
- e) Department pharmaceutical services;
- f) Department pathology and radiology services;
- g) Department infection control procedures;
- h) Procedures performed within the Department and their necessity; and
- i) Reports of accidents, injuries and safety hazards within the Department.

#### **Section 5. Infection Committee Representation**

The Hospital Infection Committee, or the committee performing the infection control function of the Medical Staff, shall include one (1) member of the Medical Staff who maintains Department Clinical Privileges and who is responsible for the infection control and prevention activities within the Department. The Department shall routinely present infection control and prevention reports to the Hospital Infection Committee. Committee minutes shall specifically address the Department in all activities affecting the Department, and copies of such minutes shall be maintained on file in the Department. The Committee shall make regular reports to the Hospital Medical Executive Committee and Board. In addition to any other requirements mandated by the Medical Staff Bylaws and Hospital policies, the Hospital Infection Committee, or equivalent committee, shall be responsible for:

- a) The prevention, control and investigation of infection in the Department and for assuring the effectiveness of current procedural techniques;
- b) Maintaining written standards for Department sanitation and asepsis;

- c) Maintaining isolation procedures within the Department; and
- d) Maintaining records of infections which originate in the Department among patients and personnel to trace the sources of infection and to identify epidemic situations;

#### **Section 6. Functions of the Medical Staff**

The Medical Staff shall perform the functions delineated in this Appendix and the Medical Staff Bylaws and Rules & Regulations. The Medical Staff shall meet and conduct all business in accordance with the Medical Staff Bylaws and Rules & Regulations. In addition to the functions of the Medical Staff delineated in the Medical Staff Bylaws and Rules & Regulations, the Medical Staff shall perform the following functions with regard to the Department:

- a) Ensure compliance with applicable state and federal laws related to the Department;
- b) Ensure that all Services meet the state law criteria for endoscopy services and procedures on pediatric patients as outlined in 28 Pa. Code § 551.21-22;
- c) Ensure that a copy of a Department specific patient bill of rights is generally made available to Department patients;
- d) Maintain and enforce written policies for the admission, discharge, transfer and proper referral of Department patients, minor patients and incompetent patients;
- e) Establish and maintain a Department specific disaster and fire plan;
- f) Establish policies and procedures related to Department sterilization control, preventative equipment and physical plant maintenance, and waste services;
- g) Appoint a qualified individual with Department Clinical Privileges to supervise the radiology services in the Department, and maintain policies addressing radiology services in the Department;
- h) Maintain policies addressing routine and emergency laboratory services in the Department, to include a requirement that tests be performed in a timely manner and that test results be furnished within twenty four (24) hours after completion of a test;
- i) Appoint a qualified individual with Department Clinical Privileges to supervise the pharmaceutical services in the Department, and maintain policies addressing pharmaceutical services in the Department;
- j) Ensure that the Department shall be prepared to initiate immediate onsite resuscitation or other appropriate response to an emergency which may be associated with Services performed in the Department;
- k) Ensure that the Department has an effective procedure for the immediate transfer to the Hospital of patients requiring emergency medical care beyond the capabilities of the Department in accordance with state law;
- l) Recommend to the Board the appropriate anesthesia/sedation techniques to be utilized within the Department; and

- m) Maintain policies addressing Department anesthesia/sedation services in accordance with state law and federal law.

## **ARTICLE IX**

### **RULES AND REGULATIONS**

#### **Section 1. General Provisions**

The Medical Staff Rules and Regulations and Hospital policies shall apply equally to Department Practitioners, unless otherwise provided in this Appendix. In the event of a conflict between the provisions of this Appendix and the Medical Staff Rules & Regulations and Hospital policies, the provisions of this Appendix will apply to Department Practitioners.

#### **Section 2. Medical Records**

The Hospital and Medical Staff will assume responsibility for all medical record functions of the Department. Medical records for services provided in the Department shall be processed by the Hospital medical records department and integrated into the Hospital's medical records storage system in accordance with the requirements of 28 Pa. Code § 563.1. Medical records for patients of the Department will be easily retrievable through a unified retrieval system and identified as Department records. The Hospital shall provide full time staff members to provide medical records services to the Department. The Hospital's Director of Medical Records, or equivalent position, shall assume administrative responsibility for the Department's medical records functions. For Department patients, all information, including but not limited to, medical history, physical examination, preoperative diagnosis, appropriate laboratory tests and informed consents shall be documented in the medical record pursuant to the Medical Staff Rules and Regulations and Hospital policy on the day of surgery/the procedure prior to induction of anesthesia/sedation and the start of surgery/the procedure.

#### **Section 3. Pharmaceutical Services**

The Hospital Pharmacy, which shall be supervised by a licensed pharmacist, shall assume responsibility for the Department's pharmaceutical services. The Department's pharmaceutical services shall be supervised by a member of the Medical Staff who maintains Department Clinical Privileges and who is responsible for the pharmaceutical services within the Department.

#### **Section 4. Nursing Services**

The Hospital's organized nursing department shall assume responsibility for the Department's nursing services. The Department's nursing services shall be supervised by a registered nurse who maintains Department Clinical Privileges and who is responsible for the following nursing services within the Department:

- a) The delivery of Department nursing services;

- b) The development and maintenance of Department nursing service goals and objectives, standards of nursing practice, nursing policy and procedure manuals and written job descriptions for each level of personnel;
- c) The coordination of Department nursing services with other patient services;
- d) The establishment of a means of assessing the nursing care needs of patients in the Department and staffing to meet those needs;
- e) Department staff development;
- f) Ensuring that at least one registered nurse shall be in attendance during the hours patients are present in the Department;

**Section 5. Anesthesia/Sedation Services**

The Hospital Director of Anesthesia Services shall be responsible for the Department's anesthesia/sedation services and shall appoint a member of the Medical Staff who maintains Department Clinical Privileges to supervise anesthesia/sedation services within the Department. Anesthesia/sedation services provided in the Department shall be limited to those techniques that are permitted by Pennsylvania law, or an applicable exception granted by the State Department of Health, and approved by the Board upon the recommendation of the Medical Staff.

**ARTICLE X**

**ADOPTION AND AMENDMENT**

This Appendix is adopted in connection with the Medical Staff Bylaws and made a part thereof. This Appendix shall be amended and reviewed in accordance with the procedures set forth in the Medical Staff Bylaws. The amendment and review process delineated in the Credentials Manual and other Medical Staff manuals and policies shall not apply to the adoption, amendment and review of this Appendix.

**MEDICAL STAFF BYLAWS APPENDIX A**

**ADOPTED & APPROVED:**

**MEDICAL STAFF:**

By: \_\_\_\_\_  
President of the Medical Staff

\_\_\_\_\_  
Date

**BOARD OF TRUSTEES:**

By: \_\_\_\_\_  
Chairperson

\_\_\_\_\_  
Date

**MEMORIAL HOSPITAL:**

By: \_\_\_\_\_  
President

\_\_\_\_\_  
Date

**MEDICAL STAFF BYLAWS**  
**APPENDIX G**  
**DEPARTMENTAL STANDARDS**  
**FOR**  
**MEMORIAL HOSPITAL OUTPATIENT SURGERY CENTER**

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**PREAMBLE**

The Department is an outpatient ambulatory surgery center licensed by the State of Pennsylvania and is operated as an outpatient department of Memorial Hospital. The purpose of the Department is to provide safe, high quality ambulatory surgery services to its patients. All capitalized terms in this Appendix shall have the meanings set forth in the Medical Staff Bylaws unless otherwise defined herein. Unless otherwise specified in this Appendix, the Medical Staff Bylaws and the Medical Staff Rules & Regulations shall equally apply to all Department Practitioners. A separate copy of this Appendix, all Department policies, the Medical Staff Bylaws and the Medical Staff Rules & Regulations shall be maintained within the Department. In the event of a conflict between the provisions of this Appendix and the Medical Staff Bylaws, Rules & Regulations or any applicable policy, the provisions of this Appendix will apply to Department Practitioners and Department operations.

**DEFINITIONS**

12. "Administrator" means the President of the Department who has overall administrative responsibility of the Department. The Hospital's President shall serve as the Administrator of the Department.
13. "Board" means the Board of Trustees of PinnacleHealth Memorial Hospital, which shall assume full legal authority and responsibility for the Department.
14. "Department" means the PinnacleHealth Memorial Hospital Outpatient Surgery Center, an outpatient surgery center, which is operated as an outpatient department of PinnacleHealth Memorial Hospital.
15. "Department Clinical Privileges" means the Board's recognition of a practitioner's competence and qualifications to render outpatient ambulatory surgery and outpatient ambulatory services within the Department.
16. "Department Practitioners" means practitioners who have been granted privileges by the Board to provide patient care services in the Department.

17. "Departmental Standards" or "Appendix" means these standards of the Department. The Departmental Standards are adopted in connection with the Medical Staff Bylaws of PinnacleHealth Memorial Hospital and made a part thereof. A copy of the Departmental Standards along with the Medical Staff Bylaws shall be maintained in the Department.
18. "Hospital" means PinnacleHealth Memorial Hospital.
19. "Medical Director" means the individual appointed by the Board to oversee the overall medical care provided in the Department.
20. "Medical Staff" means the formal organization of practitioners who have been granted medical staff membership by the Board to attend patients in the Hospital, including the Department.
21. "Medical Staff Bylaws" means the PinnacleHealth Memorial Hospital Medical Staff Bylaws and all ancillary documents, including but not limited to, the Medical Staff Credentials Manual, the Allied Health Professionals Manual, the Medical Staff Committee Manual, the Medical Staff Policies and Procedures Manual, general Medical Staff policies and Hospital policies.
22. "Services" means outpatient ambulatory surgery and outpatient ambulatory procedures approved by the Board as services that can be safely provided in the Department.

## **ARTICLE I**

### **PURPOSES**

With regard to the Department, the primary purpose of the Medical Staff is to provide for the collegial organization and thereby to:

- a) Permit all Department patients to receive quality medical, surgical and procedural care according to accepted standards relating to the provision of ambulatory surgical services.
- b) Participate in and promote Department activities designed to improve and protect the general health of those patients to whom the Department may from time to time provide services.
- c) Provide a means whereby the Medical Staff is assured of an effective means of communication with the Medical Director and Board, particularly with regard to the quality of care offered by the Department, and provide an effective organization for the observation and evaluation of professional practice and professional conduct in the Department.
- d) Permit an acceptable level of professional performance of Department Practitioners through the appropriate delineation of the clinical privileges which each Department Practitioner may exercise and through a continuing review and evaluation of each Department Practitioner's performance in the Department.

- e) Assist the Medical Director and the Board in evaluating the quality of care and ethical conduct of Department Practitioners.

## **ARTICLE II**

### **MEDICAL STAFF MEMBERSHIP**

All practitioners seeking to provide Services in the Department and who are included in the Medical Staff Bylaws definition of Medical Staff must successfully obtain and maintain Medical Staff membership and Department Clinical Privileges pursuant to the requirements and procedures delineated in the Medical Staff Bylaws. Medical Staff membership shall be extended only to the practitioners who continuously meet the qualifications, standards, obligations and requirements set forth in the Medical Staff Bylaws. A copy of the credentials file for Medical Staff members with Department Clinical Privileges shall be maintained within the Department.

#### **Section 1. Qualifications and Standards for Membership**

Medical Staff membership and clinical privileges shall be requested and granted pursuant to the procedures and requirements set forth in the Medical Staff Bylaws.

#### **Section 2. Conditions and Duration of Appointment**

The duration of all appointments to the Medical Staff and the procedures associated with requests for a leave of absence and modification of appointments shall be governed by the requirements outlined in the Medical Staff Bylaws.

#### **Section 3. Staff Category**

All practitioners that apply for Medical Staff membership with Department Clinical Privileges, shall request and be assigned to the appropriate category of the Medical Staff pursuant to the Medical Staff Bylaws. All Medical Staff members providing patient care services in the Department shall continuously fulfill the basic obligations of Medical Staff membership and the obligations of the appropriate Staff category as outlined in the Medical Staff Bylaws.

## **ARTICLE III**

### **PROCEDURE FOR MEDICAL STAFF APPOINTMENT**

#### **AND REAPPOINTMENT**

#### **Section 1. Appointment Process**



All practitioners seeking to provide Services in the Department and who are included in the Medical Staff Bylaws definition of Medical Staff shall be members of the Medical Staff, and shall be initially appointed to the Medical Staff pursuant to the procedures for Medical Staff appointment set forth in the Medical Staff Bylaws. All initial applications shall be processed in the same manner as outlined in the Medical Staff Bylaws.

## **Section 2. Reappointment Process**

All practitioners providing Services in the Department and who are included in the Medical Staff Bylaws definition of Medical Staff shall be members of the Medical Staff, and shall be reappointed to the Medical Staff pursuant to the procedures for Medical Staff reappointment set forth in the Medical Staff Bylaws. All applications for reappointment shall be processed in the same manner as outlined in the Medical Staff Bylaws.

## **ARTICLE IV**

### **ALLIED HEALTH PROFESSIONALS**

## **Section 1. Qualification and Standards for Privileges**

Allied Health Professionals seeking to provide patient care services in the Department shall continuously meet the basic qualifications and conditions for Allied Health Professionals outlined in the Medical Staff Bylaws. Allied Health Professionals providing patient care services in the Department shall obtain and maintain Department Clinical Privileges pursuant to the requirements and procedures for privileging Allied Health Professionals in the Medical Staff Bylaws. A copy of the credentials file for Allied Health Professionals with Department Clinical Privileges shall be maintained within the Department.

## **Section 2. Prerogatives and Responsibilities**

Allied Health Professionals providing patient care services in the Department shall have the same prerogatives and responsibilities as those set forth in the Medical Staff Bylaws for Allied Health Professionals. Allied Health Professionals providing patient care services in the Department shall provide Services within the limits established in the Medical Staff Bylaws and by Pennsylvania law.

## **ARTICLE V**

### **PRIVILEGES**

## **Section 1. Department Privileges**

- a) Department Clinical Privileges shall be specific to the Department and to outpatient ambulatory surgery and individual outpatient ambulatory procedures. The Board shall, upon recommendation from the Medical Staff, establish the specific Department Clinical

Privileges. Procedures performed in the Department are limited to procedures that are approved by the Board, upon the recommendation of the Medical Staff and congruent with state law.

- b) Every Department Practitioner providing direct clinical services in the Department shall be entitled to exercise only those Department Clinical Privileges specifically granted to him/her by the Board. Said Department Clinical Privileges must be within the scope of the license authorizing the Department Practitioner to practice in Pennsylvania and consistent with any restrictions thereon. The Board shall approve the list of specific Department Clinical privileges and limitations for each category of Department Practitioner, and each Department Practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.
- c) All Department Clinical Privileges shall be requested and granted pursuant to the requirements and procedures concerning clinical privileges outlined in the Medical Staff Bylaws. Department Clinical Privileges granted shall reflect the results of peer review and utilization review programs specific to the Department. The delineation of Department Clinical Privileges shall address the administration of anesthesia as applicable.

## **Section 2. Temporary Privileges**

Temporary Department Clinical Privileges shall be requested and granted pursuant to the requirements and procedures concerning temporary clinical privileges as outlined in the Medical Staff Bylaws.

## **Section 3. Emergency, Disaster and Telemedicine Privileges**

Emergency, disaster, and telemedicine Department Clinical Privileges shall be requested and granted pursuant to the requirements and procedures concerning emergency, disaster, and telemedicine clinical privileges outlined in the Medical Staff Bylaws.

# **ARTICLE VI**

## **CORRECTIVE ACTION**

### **Section 1. Routine Corrective Action**

Any request for corrective action or a performance improvement plan regarding a Department Practitioner shall be made and processed pursuant to the procedures associated with routine correction action delineated in the Medical Staff Bylaws and Rules & Regulations.

### **Section 2. Summary/Precautionary Suspension**

Any summary/precautionary suspension imposed against a Department Practitioner shall be imposed and processed pursuant to the requirements and procedures related to summary suspensions outlined in the Medical Staff Bylaws and Rules & Regulations.

**Section 3. Automatic Suspension/Relinquishment.**

The provisions concerning automatic suspensions/relinquishments in the Medical Staff Bylaws and Rules & Regulations shall equally apply to all Department Practitioners.

**Section 4. Interviews and Fair Hearings**

The provisions concerning interviews and fair hearings in the Medical Staff Bylaws and Rules & Regulations shall equally apply to all Department Practitioners. Any adverse action affecting an Allied Health Professional who provides Services in the Department shall be accomplished in accordance with the requirements and procedures for Allied Health Professional adverse actions in the Medical Staff Bylaws.

**ARTICLE VII**

**DEPARTMENT MEDICAL DIRECTOR**

**Section 1. Medical Director**

The Medical Director shall oversee the overall medical care provided in the Department.

**Section 2. Qualifications of Medical Director**

The Medical Director shall be a Physician who is able to demonstrate qualifications acceptable to the Board, who maintains Department Clinical Privileges and who is board certified by an American Board of Medical Specialties recognized board or the osteopathic equivalent.

**Section 3. Appointment of Medical Director**

The Medical Director is appointed by the Board, upon the recommendation of the Administrator. The Medical Director shall hold that position until such time as he/she is relieved of the position by the Board.

**Section 4. Removal of Medical Director**

Except as otherwise provided herein, the Board may remove and replace the Medical Director with or without cause.

**Section 5. Vacancy in Office**

July 2012, May 2015 – Memorial Hospital  
Rev. September 2017

If there is a vacancy in the office of Medical Director, the Board or its designee shall appoint a new Medical Director.

## **Section 6. Duties of Medical Director**

The Medical Director shall:

- a) Oversee all Services within the Department and report directly to the Administrator;
- b) Act in coordination with the Administrator and Board in all matters of concern within the Department, and carry out all of the duties and responsibilities of a Medical Director as required under applicable Pennsylvania rules and regulations governing ambulatory surgery facilities;
- c) Be physically present in the Department as necessary to carry out the duties set forth in this Appendix and as required from time to time by the Board;
- d) Ensure Department compliance with any applicable federal regulations, state statutes/rules, and local municipality and accrediting body standards;
- e) Implement, review and enforce all Departmental Standards, policies and procedures;
- f) Supervise the provision of anesthesia services or appoint another Physician who shall be approved by the Board to supervise the provision of anesthesia services in the Department;
- g) Develop and implement policies and procedures with respect to the evaluation of patients who have received anesthesia in the Department. Such policies and procedures shall be approved by the Medical Staff and Board;
- h) Assure that post operative monitoring of anesthesia is conducted in accordance with the criteria set forth in this Appendix, the Medical Staff Bylaws and Medical Staff Rules and Regulations;
- i) Assure that surgical procedures performed in the Department are limited to those procedures that are approved by the Board and make recommendations to the Board regarding which surgical procedures should be approved to be performed in the Department;
- j) Assure that appropriate personnel provide adequate supervision of Services provided in the Department and make recommendations to the Board regarding the supervision of Services;

- k) Provide medical supervision of the Department (directly or by a credentialed designee) on a twenty-four (24) hour basis;
- l) Review infection control activities in the Department and validate compliance with state, federal and Hospital programs;
- m) Be familiar with and oversee Department compliance with state and federal patient confidentiality and state advanced directive requirements;
- n) Review all Department quality indicators; cooperate and participate in the Department education and in-service programs; review at least quarterly all deaths of Department patients; and generally oversee quality of care in the Department;
- o) Counsel, as necessary, any Department Practitioner not meeting the performance standards set forth in this Appendix, the Medical Staff Bylaws or the Rules & Regulations;
- p) Supervise the planning of the quality assessment and performance improvement program as related to the Department;
- q) Review and support all reasonable, clearly defined, vendor activities in the Department as approved by the Board;
- r) Report to the Board of any emergency, such as a strike, fire or natural disaster which significantly interrupts or alters Department services and threatens the health and safety of patients pursuant to state law; and
- s) Organize an annual safety program for all Department personnel, and oversee a Department specific disaster and fire plan.

## **ARTICLE VIII**

### **COMMITTEES**

#### **Section 1      General Provisions**

The Hospital Medical Executive Committee may appoint special or ad hoc committees to perform Medical Staff functions with regard to the Department. Each Department committee shall keep a permanent record of its proceedings and actions. All Department committee actions shall be reported to the Hospital Medical Executive Committee. All information pertaining to activities performed by the Medical Staff and its committees shall be privileged and confidential to the full extent provided by law. The Administrator or his/her designee shall

serve as an ex-officio member, without vote, of each standing and special Department committee.

## **Section 2. Medical Executive Committee Representation**

The Hospital Medical Executive Committee shall include the Medical Director of the Department. In addition to the Medical Executive Committee functions delineated in the Medical Staff Bylaws, the Medical Executive Committee shall ensure that the Medical Staff performs the functions delineated in this Appendix.

## **Section 3. Quality Management Committee Representation**

The Hospital Quality Management Committee, or the committee performing the quality management function of the Medical Staff, shall include one (1) member of the Medical Staff who maintains Department Clinical Privileges and who is responsible for the quality assurance and improvement activities within the Department. The Department shall routinely present quality assurance and improvement reports to the Hospital Quality Management Committee or equivalent committee. Committee minutes shall specifically address the Department in all activities affecting the Department, and copies of such minutes shall be maintained on file in the Department. The Committee shall make regular reports to the Hospital Medical Executive Committee and Board. In addition to the Hospital Quality Management Committee functions delineated in Hospital policies, the Committee shall:

- a) Evaluate data submitted by the Department as part of the quality assurance program; and review Department tissue examination reports;
- b) Review Department infection control procedures; and
- c) Review the standard of practice in all specific areas of the Department.

## **Section 4. Quality Assessment and Performance Improvement Activities**

The Hospital quality assessment and performance improvement program shall describe the program's objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluating and problem solving activities with regard to the Department. The Hospital quality assessment and performance improvement program shall be endorsed by the Medical Staff, Board and Medical Director. The program shall emphasize the ongoing nature of the quality assurance program and the comprehensive scope of the program with regard to the Department. The program, including all processes delineated in this Appendix, shall be reviewed and approved annually by the Hospital Quality Management Committee (or equivalent committee), Medical Executive Committee and Board.

The activities shall include monitoring and evaluation of data collected from the Department, based on defined criteria that reflect current knowledge and clinical experience and that relate to the care provided in the Department. Sources of data include medical

records, incident reports, infection control records and patient complaints. In the event the Department treats pediatric patients, the Hospital Quality Management Committee, or equivalent committee, shall segregate data regarding these patients. The program shall also provide for the identification of problems, actions on said problems and continued monitoring of actions taken which improve the quality and appropriateness of patient care within the Department.

The frequency, severity and source of suspected Department problems and concerns are evaluated by Department Practitioners and staff. Measures shall be implemented to resolve important Department problems or concerns identified in accordance with 28 Pa. Code 557.3. The results of these corrective measures shall be monitored to assure that the problem has been satisfactorily resolved.

In addition to any other requirements mandated by the Medical Staff Bylaws and Hospital policies, the Hospital quality assessment and performance improvement program shall address the following matters:

- a) Peer-based review of clinical performance of Department Practitioners;
- b) Department surgical case and tissue review;
- c) Department anesthesia services;
- d) Department nursing services;
- e) Department pharmaceutical services;
- f) Department pathology and radiology services;
- g) Department infection control procedures;
- h) Procedures performed within the Department and their necessity; and
- i) Reports of accidents, injuries and safety hazards within the Department.

## **Section 5. Infection Committee Representation**

The Hospital Infection Committee, or the committee performing the infection control function of the Medical Staff, shall include one (1) member of the Medical Staff who maintains Department Clinical Privileges and who is responsible for the infection control and prevention activities within the Department. The Department shall routinely present infection control and prevention reports to the Hospital Infection Committee. Committee minutes shall specifically address the Department in all activities affecting the Department, and copies of such minutes shall be maintained on file in the Department. The Committee shall make regular reports to the Hospital Medical Executive Committee and Board. In addition to any other requirements mandated by the Medical Staff Bylaws and Hospital policies, the Hospital Infection Committee, or equivalent committee, shall be responsible for:

- a) The prevention, control and investigation of infection in the Department and for assuring the effectiveness of current procedural techniques;
- b) Maintaining written standards for Department sanitation and asepsis;
- c) Maintaining isolation procedures within the Department; and
- d) Maintaining records of infections which originate in the Department among patients and personnel to trace the sources of infection and to identify epidemic situations;

## **Section 6. Functions of the Medical Staff**

The Medical Staff shall perform the functions delineated in this Appendix and the Medical Staff Bylaws and Rules & Regulations. The Medical Staff shall meet and conduct all business in accordance with the Medical Staff Bylaws and Rules & Regulations. In addition to the functions of the Medical Staff delineated in the Medical Staff Bylaws and Rules & Regulations, the Medical Staff shall perform the following functions with regard to the Department:

- a) Ensure compliance with applicable state and federal laws related to the Department;
- b) Ensure that all Services meet the state law criteria for ambulatory services and ambulatory surgery on pediatric patients as outlined in 28 Pa. Code § 551.21-22;
- c) Ensure that a copy of a Department specific patient bill of rights is generally made available to Department patients;
- d) Maintain and enforce written policies for the admission, discharge, transfer and proper referral of Department patients, minor patients and incompetent patients;
- e) Establish and maintain a Department specific disaster and fire plan;
- f) Establish policies and procedures related to Department sterilization control, preventative equipment and physical plant maintenance, and waste services;
- g) Appoint a qualified individual with Department Clinical Privileges to supervise the radiology services in the Department, and maintain policies addressing radiology services in the Department;
- h) Maintain policies addressing routine and emergency laboratory services in the Department, to include a requirement that tests be performed in a timely manner and that test results be furnished within twenty four (24) hours after completion of a test;
- i) Appoint a qualified individual with Department Clinical Privileges to supervise the pharmaceutical services in the Department, and maintain policies addressing pharmaceutical services in the Department;
- j) Ensure that the Department shall be prepared to initiate immediate onsite resuscitation or other appropriate response to an emergency which may be associated with Services performed in the Department;



- k) Ensure that the Department has an effective procedure for the immediate transfer to the Hospital of patients requiring emergency medical care beyond the capabilities of the Department in accordance with state law;
- l) Recommend to the Board the appropriate anesthesia techniques to be utilized within the Department; and
- m) Maintain policies addressing Department anesthesia services in accordance with state law and federal law.

## **ARTICLE IX**

### **RULES AND REGULATIONS**

#### **Section 1. General Provisions**

The Medical Staff Rules and Regulations and Hospital policies shall apply equally to Department Practitioners, unless otherwise provided in this Appendix. In the event of a conflict between the provisions of this Appendix and the Medical Staff Rules & Regulations and Hospital policies, the provisions of this Appendix will apply to Department Practitioners.

#### **Section 2. Medical Records**

The Hospital and Medical Staff will assume responsibility for all medical record functions of the Department. Medical records for services provided in the Department shall be processed by the Hospital medical records department and integrated into the Hospital's medical records storage system in accordance with the requirements of 28 Pa. Code § 563.1. Medical records for patients of the Department will be easily retrievable through a unified retrieval system and identified as Department records. The Hospital shall provide full time staff members to provide medical records services to the Department. The Hospital's Director of Medical Records, or equivalent position, shall assume administrative responsibility for the Department's medical records functions. For Department patients, all information, including but not limited to, medical history, physical examination, preoperative diagnosis, appropriate laboratory tests and informed consents shall be documented in the medical record pursuant to the Medical Staff Rules and Regulations and Hospital policy on the day of surgery prior to induction of anesthesia and the start of surgery.

#### **Section 3. Pharmaceutical Services**

The Hospital Pharmacy, which shall be supervised by a licensed pharmacist, shall assume responsibility for the Department's pharmaceutical services. The Department's pharmaceutical services shall be supervised by a member of the Medical Staff who maintains Department Clinical Privileges and who is responsible for the pharmaceutical services within the Department.

#### **Section 4. Nursing Services**

The Hospital's organized nursing department shall assume responsibility for the Department's nursing services. The Department's nursing services shall be supervised by a registered nurse who maintains Department Clinical Privileges and who is responsible for the following nursing services within the Department:

- a) The delivery of Department nursing services;
- b) The development and maintenance of Department nursing service goals and objectives, standards of nursing practice, nursing policy and procedure manuals and written job descriptions for each level of personnel;
- c) The coordination of Department nursing services with other patient services;
- d) The establishment of a means of assessing the nursing care needs of patients in the Department and staffing to meet those needs;
- e) Department staff development; and
- f) Ensuring that at least one registered nurse shall be in attendance during the hours patients are present in the Department.

#### **Section 5. Anesthesia Services**

The Hospital Director of Anesthesia Services shall be responsible for the Department's anesthesia services, and shall appoint a member of the Medical Staff who maintains Department Clinical Privileges to supervise anesthesia services within the Department. Anesthesia services provided in the Department shall be limited to those techniques that are permitted by Pennsylvania law, or an applicable exception granted by the State Department of Health, and approved by the Board upon the recommendation of the Medical Staff.

### **ARTICLE X**

#### **ADOPTION AND AMENDMENT**

This Appendix is adopted in connection with the Medical Staff Bylaws and made a part thereof. This Appendix shall be amended and reviewed in accordance with the procedures set forth in the Medical Staff Bylaws. The amendment and review process delineated in the Credentials Manual and other Medical Staff manuals and policies shall not apply to the adoption, amendment and review of this Appendix.

**MEDICAL STAFF BYLAWS APPENDIX B**

**ADOPTED & APPROVED:**

**MEDICAL STAFF:**

By: \_\_\_\_\_  
President of the Medical Staff

\_\_\_\_\_  
Date

**BOARD OF TRUSTEES:**

By: \_\_\_\_\_  
Chairperson

\_\_\_\_\_  
Date

**MEMORIAL HOSPITAL:**

By: \_\_\_\_\_  
President

\_\_\_\_\_  
Date