ST. JOSEPH
HOSPITAL

MEDICAL STAFF GENERAL RULES AND REGULATIONS, MEDICAL STAFF ORGANIZATION AND MEDICAL STAFF POLICIES AND PROCEDURES

Approved by the Board of Directors
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PART ONE: ADMISSION OF PATIENTS

1.1 NONDISCRIMINATION

Patients are admitted without regard to race, creed, color, sex, sexual preference or national origin. Admission of patients is contingent upon the Hospital's current capacity, capability and personnel resources available to care for patients at the time of admission.

1.2 ADMITTING PREROGATIVES AND REQUIREMENTS

Only a practitioner in good standing with inpatient admitting privileges, may admit patients to the Hospital, subject to the relevant sections of the Medical Staff Bylaws, associated documents and to such other policies of the Hospital as may be in effect from time to time.

Physician members may admit and/or contribute to the care of patients without limitation, as appropriate for the privileges granted pursuant to the CPM, unless otherwise provided in the Medical Staff Bylaws, Rules and Regulations.

An Oral Surgeon or Podiatrist may admit provided it is demonstrated that either a physician member of the Medical Staff has assumed responsibility for the basic admission medical appraisal of the patient, or the Oral Surgeon or Podiatrist has specific privileges to do so as set forth in the Credentials Procedures Manual and that a Physician member of the Medical Staff has assumed responsibility for the care of any medical problem that may be present or that may arise during hospitalization.

Each Admitting physician is required to:

A. Provide a provisional diagnosis or reason for admission.

B. Refer elective cases to the Admitting Department for advance arrangements.

C. Provide information required to secure payment of insurance or compensation claims by the Hospital.

D. Record information required for Hospital billing.

E. Record information needed by the Admission Office if the admission and/or proposed procedure requires pre-certification.

F. Record information known to the admitting physician regarding the presence of an advance directive executed by the patient.

G. Record information related to the presence and source of communicable or significant infection in the patient.

H. The attending practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners who have patients who are a danger to themselves and/or others should follow the hospital "Suicide Prevention" policy. Psychiatric consultation should be considered if the patient is not imminently transferable to another facility or as clinically indicated.

I. Record any observed need for protecting the patient from self-harm.

J. Adhere to Hospital admitting policies and procedures including pre-admission laboratory tests, documentation and scheduling.

1.3 ADMISSION CATEGORY PRIORITIES

The House Supervisor shall admit patients on the basis of patient acuity with those with the highest illnesses receiving the highest priority for admission.

1.4 ADMISSION STATUS

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area.

1.4.1 ADMISSIONS THROUGH THE EMERGENCY DEPARTMENT

Any patient to be admitted as an emergency should be evaluated by the Emergency Department physician, or by an authorized practitioner under the direction of the Emergency Department physician, unless such evaluation would be likely to result in a delay that could reasonably cause serious harm to the patient. Following evaluation, the Emergency Department medical record should be signed by the Emergency Department physician and transferred with the patient to the nursing unit.

The admitting physician should complete an admission note and provide initial orders at the time of a patient's admission, and an appropriate history and physical examination should be written or dictated by the attending physician within 24 hours of admission. The history and physical examination should clearly justify the need for emergency admission, and these findings must be recorded in the medical record as soon as possible after admission. Staff members should be able to respond to any questions from the Utilization Review staff relating to the emergency nature of the admission.

Pregnant women who come to the Emergency Department with a question of active labor are directed to the Labor and Delivery area for assessment by a person who is qualified to determine whether the patient is in active labor.

1.5 TIMELY VISITATION AFTER PATIENT ADMITTED/TRANSFERRED

All patients who are admitted to the acute inpatient service of St Joseph Hospital should be evaluated by the attending physician or his/her designee in a timely manner based on the severity of the patient's illness at the time of admission, or no later than next calendar day.

Patients transferred/admitted to the ICU should be seen and evaluated in a timely manner, based on the severity of the patient's illness at the time of transfer/admission, or no later than 4 hours after the time of transfer/admission. At the time of the attending physician's visit, s/he or his/her designee should record a note updating the record as to the patient's clinical status, including the rationale for transfer to the ICU and plans for treatment and admitting ICU orders.

Non acute special care units may establish alternative guidelines for timely evaluation of patients at the time of admission.

PART TWO: ATTENDANCE OF PATIENTS

2.1 ATTENDANCE OF PATIENTS

The patient has the right to be treated by the patient's choice of physician when that physician is available. A patient to be admitted on an emergency basis who does not have an attending a member of the Emergency Department Staff will refer the patient to an appropriate physician with inpatient privileges from the on-call rotation, or to the hospitalist service for general medical admissions. The assigned physician shall be considered the patient's attending physician until either the patient's discharge occurs or until the responsibility for the care of the patient has been transferred in accordance with these Rules and Regulations.

2.2 PARTICIPATION IN THE ON-CALL ROSTER AND EMTALA RESPONSIBILITIES

The chair of each clinical department is responsible for arranging for the provision of a listing of Staff members for purposes of on-call coverage for the Hospital's Emergency Department.

Unless specifically exempted by the Medical Executive Committee (MEC) and the Board of Directors, each member of the Medical Staff, including Courtesy Staff members, may be assigned to the on-call roster by the

Department Chair. When a Staff member is designated as the physician on call, s/he is responsible for accepting responsibility for providing care for patients who present in the Emergency Department.

If a physician has a conflict with the published schedule, it is his or her responsibility to locate an appropriate replacement and to notify the Medical Director of the Department of Emergency Medicine or his/her designee of the replacement at least 24 hours prior to the scheduled rotation.

On-call physicians are responsible for: Providing consultation, including diagnosis and treatment, when requested by the Emergency Department physicians to contribute to providing medical screening examinations and stabilizing treatment for patients with emergency medical conditions. The expected response time and other details related to these requirements and requirements related to transfer of patients are specified within the Emergency Medical Treatment and Active Labor Act (EMTALA) policy which was approved by the MEC and the Hospital's Board of Directors (referred to herein as EMTALA policy).

2.2.1 RESPONSE TIME

It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame. The on-call physician, or designee, should respond to calls or hospital approved notification means from the Emergency Department no longer than thirty (30) minutes by telephone, and must arrive at the Hospital, if requested to see the patient, in a timeframe based on the communication between the ED practitioner and the on-call physician.

The on-call physician should be able to respond in a timeframe based on the discussion between the ED practitioner and the on-call physician. In areas of dispute, the ED physician decision rules. If there is disagreement on the timeframe, the ED practitioner shall define the timeframe.

2.2.2 FAILURE TO RESPOND AND ESCALATION

If the on-call physician does not respond to being called or notified by approved hospital means, the physician's designee shall be contacted. If the physician's designee does not respond to being notified, the appropriate Department Chair shall be contacted. If the Department Chair does not respond, the CMO/VPMA shall be contacted. If the CMO/VPMA is unavailable, the Medical Staff President shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

2.2.3 DISCHARGE FROM THE EMERGENCY DEPARTMENT

Patients discharged from the hospital shall have medically necessary follow-up regardless of ability to pay. Those patients discharged after a procedure, the proceduralist will have the responsibility to follow-up for thirty (30) days post procedure. Other patients will have the assigned physician responsibility for one (1) outpatient visit within two (2) weeks of discharge.

2.3 CONTINUED HOSPITALIZATION

The attending Staff member is required to document the medical necessity for continued hospitalization and the specific acute care needs of the patient under his or her care, according to criteria adopted and utilized by the Utilization Review Committee. Documentation should also include the estimated period of time that the patient will remain hospitalized.

Inadequate documentation may result in the Hospital's issuance of a notice of non-coverage to the patient or his/her legal representative, due to lack of medical necessity for hospitalization. Repeated failure to comply with these requirements will be brought to the attention of the Utilization Review Committee, which may refer individuals involved to the Professional Development Committee or to the Medical Executive Committee.

PART THREE: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 GENERAL

All physicians and practitioners who care for patients within the hospital (on an outpatient or inpatient basis) are responsible for providing such care within these rules and regulations.

3.2 TRANSFER OF RESPONSIBILITY

Transfers of patients from one staff member or service to another should be made only after there has been consultation with the recipient staff member or service and his/her agreement to accept the patient.

The transfer and accepting physician or designee should discuss the case at the time of or prior to the transfer.

Once the patient is transferred, the responsibility for orders, progress notes, discharge summary and completion of the front sheet and medical record rests with the recipient Staff member.

A formal transfer from one service to another is not required for diagnostic procedures, such as endoscopy procedures, biopsies, etc. but documentation is required consistent with Part Seven of these Rules.

Patients undergoing major surgery should be transferred to the Surgical Service. Admission of patients to the Senior Behavioral Health Unit (SBHU) and the Acute Inpatient Rehabilitation Unit requires formal screening and admission to those units and discharge from the general Hospital inpatient unit.

3.3 ALTERNATE COVERAGE

Each attending physician must assure timely, adequate professional care for his/her patients in the Hospital by being personally available or by arranging for a member of the Medical Staff or similarly qualified physician who has appropriate temporary privileges to be available for coverage. If the alternate is unavailable when needed, the applicable Department Chair or the Medical Staff President has the authority to assign any qualified member of the staff to provide coverage for the patient.

3.4 ORAL SURGEONS

An oral surgeon who has been granted privileges to perform a history and physical examination and assess the medical risks of a proposed procedure to the patient may do so. However, the oral surgeon who possesses these clinical privileges still is responsible for obtaining consultation(s) when the patient has a medical condition identified prior to or upon admission. A physician member of the Medical Staff should assume responsibility for the care of any patient that has been identified as having a medical condition. The physician will have the responsibility for the overall medical care of the patient and any surgical procedure(s) to be performed must be with his/her knowledge and concurrence. In the case of a disagreement between the oral surgeon and the physician, the Chair of the Department of Surgery will decide whether the surgery should be performed. Except in the event of an emergency case, the oral surgeon should identify the responsible physician prior to admission of the patient.

3.5 DENTISTS AND PODIATRISTS

Other than as described in Section 3.4 for oral surgeons, a physician member of the Medical Staff must perform a medical appraisal on dental/ podiatric patients and document such in the medical record. The physician and the dentist/podiatrist should assess the risk and effect of any proposed procedure on the total health status of the patient. Dentists and podiatrists are required to have a physician with inpatient privileges who is responsible for the care of all patients on which they perform procedures in the hospital. The physician will have the responsibility for the overall medical care of the patient and any surgical procedure(s) to be performed must be with his/her knowledge and concurrence. In the case of a disagreement between the dentist or podiatrist and the physician, the Chair of the Department of Surgery will decide whether the surgery should be performed. Dentists and podiatrists are required to identify who the responsible physician is prior to admission of the patient.

Dentists and podiatrists are responsible for documenting in the medical record, in a timely fashion, a complete and accurate description of the services provided to the patient. More specifically, the dentist/podiatrist is responsible for the following:

A. A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;

B. A detailed description of the examination of the oral cavity (in the case of a dentist) or the foot or feet (in the case of a podiatrist) and a preoperative diagnosis;

C. A complete operative report, describing the findings, technique, specimens removed, and the postoperative diagnosis;

D. Progress notes as are pertinent to the dental or podiatric condition;

E. Pertinent instructions relative to the dental or podiatric condition for the patient and/or significant other at the time of discharge;

F. Making appropriate transfer of responsibility or coverage arrangements for the patient's dental/podiatric care as necessary and required under Sections 3.2 and 3.3 of these Rules and Regulations;

G. Clinical resume or final summary note; and

H. Writing the discharge orders for the patient.

3.6 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has any reason to question the care provided to that patient by a particular practitioner, or is of the opinion that appropriate consultation is needed and has not been obtained, such individual is encouraged to bring the matter directly to the attention of the practitioner. If resolution cannot be obtained, the health care professional may refer the matter to his/her supervisor and then to the director of the Hospital department. The director may bring the matter to the attention of the applicable Medical Staff Department Chair or his/her designee. The Department Chair or designee may take such action as is deemed warranted by the circumstances, consistent with the Medical Staff Bylaws.

3.7 CONSULTATIONS

3.7.1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The attending physician is responsible for ordering a consultation from a qualified Staff member when indicated or required pursuant to the guidelines in Section 3.7-2 below. In an urgent or emergent situation, the practitioner is responsible for communication with the consultant. In all cases, it is required that the referring practitioner communicates pertinent information with the consultant or designee. In non-urgent or non-emergent situations, practitioners who are not the attending should coordinate all consultations with the attending or their designee prior to initiating a consult.

When responsibility for consultation is transferred to another physician, the consultant is responsible for communicating pertinent information directly to the follow-up consultant.

3.7.2 GUIDELINES FOR CALLING CONSULTATIONS

Guidelines for calling consultations are as follows:

A. When the referring practitioner requires input for diagnostic and/or therapeutic assistance,

B. When the policy of any clinical unit, including intensive or special care units, require it;

C. When required by state law;

D. When requested by the patient or family;

E. In complex cases where there is diagnostic uncertainty or when treatment involves procedures for which the attending is not privileged; or

When a consultation is required under these Rules, any of the following persons may direct that a consultation be performed and, if necessary, arrange for the consultation: The applicable Department Chair, the physician director of a special unit; the Medical Staff President or the Vice President of Medical Affairs. If the attending physician disagrees with the necessity for consultation, the matter shall be

brought immediately to the next supervisory level. If the matter cannot be resolved satisfactorily, it should be referred to the MEC through the Medical Staff President.

3.7.3 QUALIFICATIONS OF CONSULTANT

Any qualified physician with appropriate ambulatory, consulting or inpatient privileges may be called as a consultant. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by evidence of a comparable degree of competence based on equivalent training and experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

Consultant physicians are expected to respond to requests for consultation in a timely manner by evaluating the patient and discussing his or her findings and opinions with the referring physician or his/her covering physician within twenty-four (24) hours of the consultation request, unless otherwise requested by the attending physician.

3.7.4 DOCUMENTATION

Consultation Request

When requesting a consultation, the attending physician must document the patient's condition and reason for the request in the medical record.

Consultant's Report

The consultant should report his/her findings, opinions and recommendations in the medical record following evaluation and examination of the patient. When operative or invasive diagnostic procedures are involved, a consultation note shall, except in true emergency situations, be recorded prior to the procedure.

Attending Physician's Response to Consultant's Opinion

In cases of elective consultation when the attending physician does not substantially follow the advice of the consultant, he/she shall record in the medical record his/her reasons for electing not to follow the consultant's advice and/or plans to seek the opinion of a second consultant. In cases of required consultation, as specified in Section 3.7-2, when the attending physician does not agree with the consultant, he/she shall either seek the opinion of a second consultant or refer the matter to the applicable Department Chair, CMO/VPMA or Medical Staff President for final advice. If the attending physician obtains the opinion of a second consultant and does not agree with it either, he/she shall again refer the matter to the applicable Department Chair.

3.8 MASS CASUALTY ASSIGNMENTS

The hospital has an Emergency Preparedness Plan which includes a plan for the care of mass casualties due to any type of event, whether accidental, infectious or terrorist activity in origin. The Emergency Preparedness Plan includes an Incident Command System (ICS), which includes a structure that assigns personnel, including physicians and other members of the healthcare team, based on the particular situation. Physicians shall be assigned posts under the Incident Command System and it is their responsibility to report to their assigned stations. Physicians will be asked to participate in assessing, triaging and caring for patients, as appropriate for the situation.

3.9 USE OF SECLUSION OR RESTRAINTS

All restraints, as defined by the Hospital's policy and procedure on Restraints and Seclusion, must have a written physician's order. For each use of restraint there must be a "time limited order" (i.e. each order shall have a "start time" and an "end time") and there must be justification for the use of the restraint documented in the patient's medical record. Other requirements regarding care of patients requiring restraints are found in the Hospital policy, as required by regulatory agencies.

3.10 QUALIFIED MEDICAL PERSONNEL FOR SCREENING EXAMINATIONS

For purposes of (1) performing an appropriate medical screening examination of an individual presenting to the Medical Center to determine whether the individual suffers from an emergency medical condition, and

(2) completing the required physician certification for transfer of a patient with an emergency medical condition who has not been stabilized to another facility for treatment at the direction of the Responsible Physician, the following professionals are deemed to be Qualified Medical Personnel (QMP):

A. Physicians,

B. Nurse Practitioners and Physician Assistants with documented assessment skills and orientation to medical screening criteria established by the medical and nursing directors of the Emergency Department; and

C. For labor medical screening registered nurses (RNs) and certified nurse midwives with documented assessment skills.

PART FOUR: TRANSFER OF ADMITTED PATIENTS

4.1 INTERNAL PHYSICAL TRANSFER OF PATIENTS

Internal transfers from one patient care area to another shall take place in accordance with the Hospital's policy and procedure on patient transfers.

4.2 TRANSFER OF SERVICE

Transfers from one service to another should be consistent with Section 3.2.

4.3 TRANSPORT TO ANOTHER FACILITY WITH THE EXPECTATION OF RETURNING (i.e., NOT DISCHARGED).

Patients may be transported to another facility for diagnostic or therapeutic procedures and/or services that are not available at this Hospital with an expectation that the patient will return. Prior to the patient leaving the Hospital, the attending physician should be notified, and arrangements should be made to assure that the patient is safety transported to and from the facility.

When a patient is being transferred from the Emergency Department to another facility or ED, this will be done in accordance with the EMTALA policy of the hospital.

4.4 PATIENT REQUEST FOR SHORT-TERM PASS (Leave of Absence)

Day or night short-term passes of inpatients to their homes or any other outside facility for personal reasons generally are discouraged and should not be permitted, except in unusual and extenuating circumstances. When a patient insists upon leaving the hospital for a short period of time, the attending Staff member may either grant permission for a short-term pass or request that the patient sign out against medical advice, as required in Section 5.4. In any case, the patient should sign a sign a statement releasing the attending Staff member and hospital of any liability for harm resulting to the patient during his or her temporary absence.

PART FIVE: DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER

A patient may be discharged only on the order of the attending Staff member or designee practitioner and in compliance with discharge criteria, as applicable. The discharge order form, medication reconciliation, and any other required documentation must be completed prior to patient discharge.

5.2 DISCHARGE PROCEDURES

The attending Staff member or designee is responsible for discharging his/her patients upon the authenticated order of the attending physician, or designee, who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

A. A list of all medications the patient is to take post-discharge;

B. Dietary instructions and modifications;

C. Medical equipment and supplies;

D. Instructions for pain management;

E. Any restrictions or modification of activity;

F. Follow up appointments and continuing care instructions;

G. Referrals to rehabilitation, physical therapy, and home health services; and

H. Recommended lifestyle changes, such as smoking cessation.

5.3 DISCHARGE PLANNING FOR ROUTINE DISCHARGES

In collaboration with the multidisciplinary team, the attending Staff member shall make arrangements as early as possible after admission for anticipated discharge needs and post discharge care of patients who will likely require aftercare.

5.4 DISCHARGE TO OTHER ACUTE CARE FACILITIES

Patients may be discharged from an outpatient or inpatient area of the Hospital to another acute care facility. A decision to transfer a patient to another acute care facility should factor into the decision: the capability of the Hospital to care for the patients' medical needs and the informed choice of the patient having knowledge of the risks and benefit of transfer. The request for transfer may be expressed by the patient and/or his legal representative.

5.4.1 GENERAL REQUIREMENTS FOR DISCHARGE TO AN ACUTE CARE FACILITY

All transfers require consent of the patient or his or her legal representative.

Appropriate arrangements between this Hospital and the receiving facility must be communicated in advance and the receiving facility and the physician at the facility must accept the patient.

All pertinent medical information necessary to ensure continuity of care must accompany the patient. The medical record should reflect a notation as to the type of medical information that accompanied the patient (such as discharge summary, radiology and laboratory reports, etc.). Appropriate staff and equipment may accompany the patient to the receiving facility to assure patient safety as allowed by New Hampshire Emergency Medical Services (EMS) protocols.

5.4.2 MEDICALLY UNSTABLE PATIENTS

Transfers of medically unstable patients should be avoided, whenever possible, especially if it is within the capability of the Hospital to care for the patient.

When a medically unstable patient and/or his legal representative or family requests transfer to another acute care facility, there should be documented discussion with the patient, family and/or legal representative regarding the seriousness of the patient's condition and the potential risks associated with the transfer.

When stabilizing treatment is necessary but it cannot be provided within the Hospital's capability and capacity, the Staff member or designee must explain to the patient and/or his legal representative that transfer is needed. Consent is required. I addition, the Staff member or designee is responsible for certifying that based on the medical information available at the time, the medical benefits of transfer to another facility outweigh the risks of transfer.

5.5 DISCHARGE TO SUBACUTE LEVEL FACILITY

A patient may be transferred to a subacute or skilled nursing facility only upon the order of the attending physician or designee. The attending physician or designee shall complete the transfer summary and designated form prior to transfer.

5.6 LEAVING AGAINST MEDICAL ADVICE (AMA)

If a patient desires to leave the Hospital against the advice of the attending physician or designee or without proper discharge, the attending physician or designee shall be notified and the patient or legally responsible individual shall be requested to sign the appropriate release form. The Hospital's "Leaving Against Medical Advice (AMA) and Refusal of Care, PR-15" Policy provides the procedure for documentation of information related to the patient's departure. A patient leaving the Hospital without a discharge order and without signing the AMA release form shall be considered officially discharged.

5.7 DISCHARGE OF MINOR OR INCOMPETENT PATIENT

Any individual who cannot legally consent to his/her own care should be discharged only to the custody of parent(s), a legal guardian, foster parents, or any other person or agency standing in loco parentis ("legally authorized individual"), unless otherwise directed by the legally authorized individual or by a court of competent jurisdiction.

PART SIX: ORDERS

6.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize the electronic health record (EHR), All healthcare providers will undergo appropriate EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

When the EHR is not available, the "EPIC Downtime Policy" will be followed. During downtime procedure, all handwritten entries in the paper medical record, including pre-printed orders, shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record.

All medications and treatments will be reviewed and continued, discontinued or changed as necessary at the time of admission, discharge or transfer to a different level of care such as transfer to or from the ICU or the OR, including medication reconciliation, per Hospital policy.
Orders for diagnostic tests, which necessitate the administration of test substances or medications, will be considered to include the order for this administration providing a policy is in place which identifies the medications or test substances to be used. Orders for diagnostic tests must also include adequate clinical information indicating the reason for the test and establishing medical necessity.

6.2 PATIENT CARE PROTOCOLS

Patient care protocols may be developed through collaborative efforts involving physicians, patient care services and/or other hospital departments. Pharmacy and Therapeutics Committee must approve and review annually any protocol referencing medication. After review and approval of protocols by the MEC, they may be utilized in patient care on the order of a qualified practitioner.

6.3 VERBAL ORDERS

6.3.1 BY WHOM AND CIRCUMSTANCE

Verbal orders increase the risk of medical error and shall not be permitted except when circumstances require, such as during an invasive procedure, during CPR or other exceptional situations.

Telephone orders also increase the risk of medical error and shall be permitted only when it is not practical for the ordering physician to enter orders directly, either by computer or in writing when computer order entry is not available. The ordering practitioner must remain on the telephone until completion of computer order entry or the completion of transcription and verbal order read back when computer order entry is not available.

Only a duly authorized person functioning within a defined sphere of competence may take telephone or other verbal orders. Such a "duly authorized person" may be a licensed independent practitioner, certified nurse midwife, advanced practice nurse or physician assistant with appropriate privileges, a registered nurse, a registered pharmacist, a registered respiratory therapist, a registered physical therapist, a registered occupational therapist, a certified speech pathologist, a registered dietician, an orthopedic technologist or nuclear medicine technologist.

Registered Nurses may take all orders from a physician or designee.

Orthopedic Technologists may take orders for orthopedic equipment from a physician or designee;

Registered Dietitians may accept verbal orders related to diets and supplements to be administered orally or by feeding tube from a physician or designee;

Registered Pharmacists may clarify an existing medication order from a practitioner who ordered the medication.

Registered Respiratory Therapists may take orders pertaining to respiratory therapy. These orders are to include:

A. Mode of therapy
B. Frequency of delivery
C. Concentration of oxygen
D. Dosage and type of medication

Administrative and technical staff of Laboratory Services and Diagnostic Imaging may take verbal orders for laboratory and/or radiological tests for outpatient procedures (excluding pathology), but only in unusual circumstances. Written orders given to the patient or orders that are faxed from the physician's office to the department are preferred over verbal orders.

6.3.2 DOCUMENTATION

All verbal and telephone orders not entered directly by computer shall be transcribed in the proper place in the medical record and shall include the date, time of order, name and signature of the person transcribing the order, the name of the practitioner, and documentation that the order has been read back to the practitioner.

All telephone and verbal orders for inpatients must be countersigned by the prescribing or other responsible practitioner within twenty-four (24) hours. Telephone orders provided for outpatients must be verified by acceptable electronic means, including fax, in a timely fashion.

6.4 ORDERS BY ADVANCED PRACTICE PROFESSIONALS

An Advanced Practice Professional (APP) may write orders only to the extent permitted by state licensing laws and as may be specified in Hospital and Medical Staff policies.

6.5 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically discontinued when the patient is transferred to and from a Critical Care Unit or surgery. Orders must be reviewed and either continued or changed at the time of transfer to or from the Critical Care Unit. Medication orders will be dealt with by following the Hospital's Medication Reconciliation Policy.

6.6 STOP ORDERS

6.6.1 DRUGS/TREATMENTS COVERED AND MAXIMUM DURATION

Automatic stop orders shall be defined in Hospital Policy "Order-Pharmacy"

6.6.2 NOTIFICATION OF STOP

At least 24 hours prior to an automatic stop order a notification will be sent to attending physician to allow the daily rounding health care team to review the order If the medication is not renewed it will be discontinued.

6.7 PATIENT'S OWN MEDICATIONS AND SELF ADMINISTRATION

Medications brought into the Hospital by a patient may not be administered unless the Hospital pharmacist has identified the medications and there is a written order from the attending practitioner to administer the medication(s). Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner. The medication should be identified as to drug strength, route and frequency of administration.

Herbal supplements and other alternative medications (collectively referred to as herbal supplements) are not recommended for therapeutic use. If the prescriber, based on the assessment of potential risks versus potential benefits, approves the continued use of an herbal supplement, the order will be written on the Physician Orders Form after obtaining from the patient the names of herbal supplements, doses, frequency and routes of administration. The Pharmacy will add the herbal supplements to the patient's medication profile and screen for drug interactions, disease state interactions, and potential adverse effects. The herbal supplements must be identifiable to the Pharmacy, labeled and appropriately dispensed by the pharmacy. Patients may not take unidentifiable substances while in the hospital.

6.8 DO NOT RESUSCITATE AND SIMILAR TYPE ORDERS

The Hospital's policies and procedures regarding advance directives, do not resuscitate orders, withholding and withdrawal of life supportive therapy, refusal of treatment and related or similar matters shall be followed. Policy specifics are included in the Hospital's general administrative policy manual.

6.9 FORMULARY AND INVESTIGATIONAL DRUGS

6.9.1 FORMULARY

A formal process exists whereby the Pharmacy and Therapeutics Committee selects from the drugs available, those that are considered to produce the best balance of efficacy, safety and cost. The Formulary of Approved Drugs lists by generic name those agents selected for stocking in the pharmacy. All Formulary agents administered to patients shall be either FDA approved or those listed in the latest edition of the United States Pharmacopoeia, the National Formulary, the New and Non-Official Remedies, the American Hospital Formulary Service or the AMA Drug Evaluations. Each member of the Medical Staff and Allied Health Professionals is required to use the formulary system.

6.9.2 NON-FORMULARY MEDICATIONS

Any medication that does not appear in the formulary is considered a non-formulary (NF) medication. When a NF drug is ordered, a pharmacist will inform the prescribing practitioner of those formulary agents which are similar or preferred by the Pharmacy and Therapeutics Committee. If medically necessary, the Pharmacy will obtain a small supply of the drug for that particular patient.

6.9.3 INVESTIGATIONAL DRUGS AND DEVICES

The initiation of a protocol using investigational drugs or devices within the hospital or within any affiliates of the hospital requires the prior review and approval by the St. Joseph Healthcare's designated Institutional Review Board (IRB). A Medical Staff member may be a principal investigator (PI), provided

that an application is submitted to the IRB and all of the requirements are met to ensure protection of human subjects.

The Pharmacy has established policies and procedures, approved by the Pharmacy and Therapeutics Committee, regarding the use of investigational drugs.

When patients who are receiving investigational drugs under an IRB approved protocol are admitted to the hospital, the PI (if on Staff) is responsible for documenting that the patient is on the protocol and that s/he has consented to receiving the investigational drug. The PI is also responsible for assuring that there are orders to administer the drug in accordance with the clinical protocol and for providing all known information related to the drug to the pharmacy and nursing staff. Such information shall include the pharmacology of the drug, possible side effects, toxicology, possible drug interaction effects, dosage requirements and other relevant information.

When a patient is on a clinical trial involving an investigational drug is admitted and the protocol is not one that is currently approved for use by the IRB or the PI is not a Medical Staff member, the attending staff member is responsible for notifying the Director of Pharmacy (or designee) as soon as possible to provide all information that is necessary to determine whether the drug is to be administered while the patient is in the hospital.

6.9.4 SUBSTITUTION POLICIES

The Pharmacy is authorized by virtue of the Formulary System to substitute an FDA approved, equivalent generic drug any time a trade name drug is ordered. The Pharmacy and Therapeutics Committee is authorized to approve therapeutic substitutions subject to approval by the MEC. The specific instances in which this therapeutic substitution may be performed are detailed in the Formulary of Approved Drugs.

6.10 RESTRICTION OF SPECIFIC DRUGS

The Pharmacy and Therapeutics Committee subject to approval by the MEC may restrict the use of a specific drug or class of drugs, either entirely or for use only in stated conditions, for use by specific specialties or for use only on consent of the Department Chair/designee or the Physician Chair of the Infection Control or Pharmacy and Therapeutics Committees.

6.11 MEDICATION - FOOD INTERACTION MONITORING

Potential medication-food interactions shall be monitored and managed through a multi-disciplinary effort (i.e., involving physician, pharmacist, nurse, and dietitian) designed to educate patients and minimize the effects of these incompatibilities. Patient education, including that provided at the time of discharge, shall be documented in the medical record.

6.12 DISCHARGE MEDICATIONS

When medications are prescribed for a patient at the time of discharge, the patient will be informed of the important aspects of the medication, its proper use, side effects and storage requirements, and potential significant adverse drug-food interaction(s). The responsible physician must document the discharge medications being prescribed including the dosage, frequency and duration for time-limited medications, following the Hospital's Medication Reconciliation Policy. The individual responsible for providing the medication information to the patient must record in the patient's medical record that the patient received and understood the information concerning the discharge medications.

PART SEVEN: MEDICAL RECORDS

7.1 REQUIRED CONTENT

The attending physician, other Medical Staff members, clinical staff and Allied Health Professionals involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for all inpatients and outpatients. All entries in the medical record should be dated, timed and authenticated. The record's content shall be pertinent; i.e. facilitate continuity of care; support treatment provided; provide appropriate documentation for performance improvement purposes; and be accurate, legible, timely and current.

The specific requirements for a complete medical record are specified within accreditation standards and Medicare hospital conditions of participation.

7.2 HISTORY AND PHYSICAL EXAMINATION AND ADMISSION NOTE

7.2.1 GENERAL

Inpatients

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

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

A. A complete history contains at a minimum:

- Clinical appropriate evaluation of the chief complaint;
- Present illness;
- Past medical and surgical history including medications and allergies;
- Review of systems, family history and social history.

B. A complete physical examination includes, at a minimum:

- Clinically appropriate evaluation of the vital signs;
- Head and neck;
- Lungs;
- Heart;
- Abdomen;
- Extremities;
- Neurological status and
- The involved specific organ system or body part.

Ambulatory Patients

A brief history and physical examination, assessment and plan of treatment shall be recorded for all moderate-risk ambulatory procedures on otherwise healthy patients (ASA classification 1 and 2) prior to the procedure. These moderate-risk procedures shall include all those done with conscious/moderate sedation, diagnostic and therapeutic invasive vascular procedures, needle biopsy of an intra-abdominal or intra-thoracic organ and normal vaginal deliveries. Other low-risk diagnostic or therapeutic procedures do not require a history or physical examination. A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

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

an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

A. A brief history consists, at a minimum of:
- Clinically appropriate evaluation of the chief complaint;
- Present illness and past medical and surgical history including medications and allergies.

B. A brief physical examination includes, at a minimum:
- Clinically appropriate evaluation of vital signs;
- Lungs;
- Heart;
- And the involved specific organ system or body part.

7.3 PREOPERATIVE DOCUMENTATION

7.3.1 HISTORY AND PHYSICAL EXAMINATION

A relevant history and physical examination is required on each patient having surgery. Except in an emergency, certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and required laboratory tests have been recorded in the medical record. Elective surgery (whether to be performed on an inpatient or outpatient basis except if being performed under local anesthesia) will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record.

In cases of emergency, the responsible practitioner shall, prior to induction of anesthesia and start of the procedure, make at least a comprehensive note regarding the patient's condition stating the basic nature of the proposed surgery/ procedure and the condition for which it is to be done, the condition of the heart and lungs, the presence or absence of known allergies, and other pertinent pathology and information relating to the patient. The history and physical examination shall be recorded immediately after the emergency surgery has been completed.

7.3.2 CLINICAL LABORATORY TESTS AND X-RAYS

Appropriate advance lab tests, EKGs, and x-rays must be performed within guidelines developed by the Department of Surgery for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia. Reports from laboratories outside the Hospital may be acceptable provided the laboratory is appropriately accredited, and the test is recent enough to be pertinent. Examinations or procedures (radiologic or pathologic) performed outside the Hospital may be submitted to the appropriate Hospital Department for review at the discretion of the operating surgeon.

7.3.3 ANESTHESIA EVALUATION

Anesthesia is defined as general, regional, monitored anesthesia care (MAC), and deep sedation. The pre-anesthesia evaluation must be completed and documented within 48 hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the end of the 48-hour time frame.
In accordance with current standards of anesthesia care, some of the individual elements contributing to the pre-anesthesia evaluation may be performed prior to the 48-hour timeframe. However, under no circumstances may these elements be performed more than 30 days prior to surgery or a procedure requiring anesthesia services. Review of these elements must be conducted, and any appropriate updates documented, within the 48-hour timeframe.

A post-anesthesia note shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or sedation.

A pre-anesthesia evaluation of the patient by an anesthesiologist or privileged APP to provide anesthesia must be conducted and documented in the medical record and shall include: Pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other

pertinent anesthetic experience, any potential anesthetic problems, the patient's allergies, previous medications, smoking or alcohol use history, ASA patient status classification, orders for preoperative medication and the anticipated location for post anesthesia recover. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered. The anesthesiologist responsible for the patient's anesthesia care must also conduct and document in the record a post-anesthesia follow-up of the patient's condition. All practitioners providing anesthesia shall adhere to the "Standards for Basic Intra Operative Monitoring" established by the American Society of Anesthesiologists.

7.4 PROGRESS NOTES

7.4.1 GENERAL

Pertinent progress notes must be recorded at the time of observation on all inpatients, outpatients, and observation patients to permit continuity of care and transferability, including a brief admission note to be recorded at the time of admission. Except for the Senior Behavioral Health Unit and the Inpatient Rehabilitation Units that have specific requirements, progress notes shall be written at least daily by the attending practitioner or designee. For those patients awaiting extended care facility placement, progress notes shall be as frequent as medically indicated.

Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Progress notes should provide a chronological report of the patient's course in the hospital and should reflect any change in the condition and the results of treatment. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders, with reasons for instituting various tests or treatment given and results of tests and treatments recorded.

7.4.2 AMBULATORY CLINIC VISITS:

Clinic visit documentation shall be completed within three (3) business days.

An ambulatory summary list shall be initiated by the patient's 3rd visit and shall contain:

a. Significant medical diagnosis and conditions (problem list).
b. Operative and invasive procedures.
c. Any adverse and/or allergic drug reactions.
d. Current medications, over-the-counter medications and herbal preparations.

7.4.3 EMERGENCY DEPARTMENT DOCUMENTATION

Emergency Department visit notes shall be completed within 24 hours of patient discharge or admission.

7.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

7.5.1 OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative reports should be written or dictated immediately following surgery and before the patient is transferred to the next level of care. These should include at least the name of the primary surgeon and assistants, preoperative and postoperative diagnoses, a detailed account of findings at surgery, details of surgical technique, type of anesthesia, specimens removed, any complications and the condition of the patient at the termination of the procedure as well as estimated blood loss. Any staff member with unrecorded operative reports immediately following the day of surgery, who has been notified of his/her delinquency within said period, shall be subject to suspension for operative privileges except for patients who have already been scheduled.

7.5.2 BRIEF POSTOPERATIVE NOTE

If the operative report is not placed in the medical record immediately after, then a brief postoperative note should be entered in the record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This note should contain, at a minimum, primary surgeon and assistants, pre-op and post-op diagnosis, technical procedures performed, specimens removed, complications if any, type of anesthesia administrated, graft or implants, and estimated blood loss.

7.5.3 TISSUE EXAMINATION AND REPORTS

All tissues and artifacts removed during a procedure, except those specifically excluded by joint policy approved by the MEC and of the Departments of Surgery and Pathology shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the Hospital's Department of Pathology.

Objects of a criminal nature, such as a bullet extracted following a gunshot wound require certain "chain of custody" procedures as required by law enforcement agencies that are involved in the investigation of a crime.

If the object is something that caused injury, but is not a part of a criminal act (e.g. a nail, a piece of glass or metal) removal must be documented in the medical record. If the object cannot be identified, or if there is question regarding the identification, then the object should be sent to the Department of Pathology. The specimen(s) must be accompanied by a form completed, signed and dated by the operating practitioner or his designee in the OR indicating any pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. An authenticated report of the pathologist's examination shall be made a part of the medical record.

7.6 OBSTETRICAL RECORD

The current obstetrical record should include the complete prenatal record, if a record is available, with relevant laboratory tests, as determined by the Department of Obstetrics. The prenatal record may be a durable, legible copy of the attending physician's office or clinic record transferred to the Hospital before admission; but an interval admission note, either handwritten in the progress notes, EHR or on the designated form as required by policy or state law, that includes pertinent additions to the history and any subsequent changes in the physical findings, must be signed and dated by the responsible practitioner.

In the case of Caesarean sections a current complete history and physical examination shall be required. Prenatal notes may be used to fulfill the past history, family history and social history requirements of the complete history and physical examination.

7.7 OBSERVATION STATUS

An initial note describing the clinical history and physical findings, ancillary testing results, the reason for observation and the plan for diagnosis and/or therapy should be recorded by the attending physician at initiation of outpatient status. The physician's progress notes should document the course of treatment. A discharge note must be written or dictated which indicates the patient's diagnosis, treatment, condition on discharge, instruction and follow-up care needed. An appropriate history and physical examination shall be required if the status is changed to inpatient.

7.8 ENTRIES AT CONCLUSION OF HOSPITALIZATION

All diagnoses, co-morbidities, complications, and procedures must be recorded in full at the time of discharge such that the document serves to convey important information to the next level of care. The use of unapproved symbols or abbreviations is prohibited. Acronyms and abbreviations should be minimized, but when used they should be readily understood and in common use. The attending practitioner has the responsibility for the accuracy and clarity of this information and will authenticate the document. The following definitions are applicable to the terms used herein:

A. **Principal Diagnosis:** The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the Hospital for care.

B. **Secondary Diagnosis (if applicable):** A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.

C. **Comorbidities (if applicable):** A condition that coexisted at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day (for about 75% of the patients).

D. **Complications (if applicable):** An additional diagnosis that describes a condition arising after the beginning of Hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.

E. **Principal Procedure (if applicable):** The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.

F. **Additional Procedures (if applicable):** Any other procedures, other than principal procedure, pertinent to the individual stay.

G. Dietary summary if applicable

H. Activity recommendations, if applicable

I. Patient condition on discharge

J. Follow-up care plan

7.8.1 DISCHARGE DOCUMENTATION

In General

A discharge summary must be recorded for all patients whose length of stay exceeds forty-eight (48) hours, all deaths and complicated cases. The summary must concisely recapitulate the reason for hospitalization, the significant findings including complications, the procedures performed and treatment rendered, the condition of the patient on discharge stated in a manner allowing specific, measurable comparison with the condition on admission, discharge instructions, and principal and secondary diagnoses.

The physician is responsible for completing the applicable sections of the state-mandated forms used when the patient requires practitioner-assisted level of care.

Exceptions

A final progress note may be substituted for the discharge summary in the case of the following categories of patients:

(1) Those with problems of a minor nature who require less than 48 hours of hospitalization;

(2) normal newborn infants;

(3) patients having uncomplicated vaginal deliveries.

The content must include: Diagnosis, procedures, conditions on discharge, medications, instructions to patient and family and discharge disposition.
In those instances when an autopsy is performed, provisional anatomic diagnoses will be recorded in the medical record and the complete protocol shall be made part of the record as soon as possible, but not later than 60 days, unless otherwise required by state law.

7.8.2 INSTRUCTIONS TO PATIENT

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care. If no instructions are required, a record entry must be made to that effect.

Deaths: A discharge summary is required on all inpatients who have expired and will include:

1. Reason for admission;

2. Summary of hospital course and cause of death; and

3. Final diagnoses.

7.9 AUTHENTICATION

Each clinical entry in the patient's record must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, written initials, fax or electronic authentication. If an entry is interrupted, it will be dated, timed and authenticated when interrupted. If finished at a later time, the subsequent entry will be dated, timed and authenticated separately.

A record shall be considered incomplete until all entries are authenticated.

Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has the legal responsibility for the order or the information bearing his authentication.

7.10 MEDICAL RECORD COMPLETION REQUIREMENTS AND ENFORCEMENT POLICIES

A. Expectations

All portions of the patient's medical record must be prepared within the time frames provided in these Rules and Regulations. All portions of the medical record of a hospitalized patient should be complete at the time of discharge except when there are pending reports, transcriptions and associated authentications. A medical record shall not be permanently filed until the responsible Medical Staff member completes the record or it is ordered filed by the Director of Health Information Management.

B. Definition of Delinquent

Medical records are considered delinquent if they are incomplete fourteen (14) days or more after discharge, or in the case of an operative report, more than one (1) day post procedure.

C. Suspension of Privileges

Physicians shall be notified of all delinquent records by a weekly Incomplete Record letter listing all outstanding records. Ten (10) days after the date of notification, suspension of privileges will be carried out if delinquent records have not been completed.

Physicians who meet suspension criteria will be informed via telephone and in writing. Notification will also be sent to the: Chief Executive Officer, Vice President of Medical Affairs, President of the Medical Staff, Department Chairs, Director of Admissions, Director of Emergency Services, Patient Care Services, Operating Room, Quality and Resource Management and the Medical Staff Office. A record of each suspension imposed shall be made part of the practitioner's credentials file after verification with the Director of Health Information Management.

D. Recurring Suspension

When a physician remains on the Suspension list for the same delinquencies for greater than 30 days from the initial date of suspension, this shall be considered an additional suspension. If during the time a suspension, new records become delinquent and now meet suspension criteria, a new suspension will be issued.

E. Effect of Suspension

Except as otherwise specified in these Rules, the sanctions for failure to complete a patient record in a timely fashion are suspension of the practitioner's right to admit patients, provide Emergency Department services, to consult with respect to patients and to schedule and perform surgery/other invasive procedures and of voting and office-holding prerogatives until all of his/her outstanding records are completed or until such later time as provided in this Section.

If a suspended physician attempts to admit a patient, s/he will be required to complete all outstanding incomplete records within twenty-four (24) hours. If s/he is not willing to make this commitment, the Department Chair shall be contacted to help in processing the admission at hand. At that point, it is

the Department Chair's decision as to how the admission is to be handled; i.e. delegate it to another physician in the Department, assume the admission him/herself, or allow the physician to admit and deal with the delinquency in a different manner.

If an "emergency", defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in treatment would add to that harm or danger, exists requiring the practitioner to immediately treat the patient, then the practitioner shall so certify in writing.

The admitting office and other notified departments are expected to enforce the suspension. Any new admissions, consults or procedures will be administered by the Department Chair or designee. The practitioner will remain on enforced suspension until completion of all overdue medical records.

Any physician who appears on the suspension list two (2) times within a calendar year must appear before the Medical Executive Committee to explain the recurring suspensions. If the physician fails to appear or the MEC does not find the reasons provided satisfactory, the MEC may institute a corrective action plan that may include the imposition of a fixed period of suspension of clinical privileges whenever a pattern of non-compliance with this section exists.

Under New Hampshire law and directives provided by the NH Board of Medicine, if a physician is suspended three times or more within a calendar year for failure to complete medical records, the Hospital is required to report this to the Board of Medicine.

7.11 USE OF SYMBOLS AND ABBREVIATIONS

The use of symbols and abbreviations is discouraged in the medical record. Final diagnoses and complications shall always be recorded without the use of symbols and abbreviations.

A list of unsafe abbreviations approved by the MEC is maintained by the Pharmacy and Therapeutics Committee. All entries in the Medical Record using unacceptable abbreviations must be clarified prior to medication administration, diagnostic testing or therapeutic interventions.

7.12 COPY AND FORWARD FUNCTIONALITY:

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided during the current encounter. "Cut and Paste", "Copy and Paste", or "Carry Forward" of entries in the Medical Record is governed by Hospital medical records policy.

7.13 ERRORS

If an error is made on a written entry in the medical record, a single-line shall be drawn through it, and the correct entry written in along with the date and authentication of the practitioner. The error is not to be obliterated or erased, but will be identified as an error. Electronic errors are corrected as per the Electronic Health Record process of updated addendums and electronic, date and time stamped authentication.

7.14 FILING OF INCOMPLETE RECORDS

In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Director of Health Information Management shall consider the circumstances and may enter such reasons in the record and order it filed.

No Medical Staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him/her, regardless of the status of the practitioner who is responsible for completing the record. Any practitioner who is removed per the Bylaws and these Rules and Regulations for delinquent records or who resigns from the Medical Staff without adequately completing all medical records will not be allowed to reapply for staff membership until such records are satisfactorily completed.

7.15 ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APP) are physician assistants (PAs), doctors of physician assistant studies (DPAS), and advanced practice registered nurses (APRNs). Advanced Practice Registered Nurses or APRNs means those individuals who are certified nurse midwives, certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) providing direct patient care.

A. APPs may perform the history and physical examination, if privileged to do so;
B. APPs may perform the consultation, if privileged to do so;
C. APPs may perform the progress note in lieu of a physician;
D. Routine orders of APPs do not need co-signature by a physician except for the order to admit if the APP does not have admitting privileges or they do not have their own prescriptive authority. The order for admission must be signed prior to discharge, preferentially within the twenty-four (24) hours after admission; and
E. The delegating/supervising physician will review and authenticate all discharge summaries prepared by all APPs within fourteen (14) days after discharge.

7.16 STUDENTS, RESIDENTS, AND FELLOWS IN TRAINING

Students, residents and fellows in a formal training program, who are not moonlighting outside of their training program, must have their:

A. History and physical examinations performed by Residents and Fellows in Training (not students) cosigned within twenty-four (24) hours by the attending physician, or their physician designee;
B. Progress notes do need to be cosigned within fourteen (14) days after discharge;
C. Operative notes and operative reports performed by surgical residents are to be cosigned within fourteen (14) days after discharge;
D. Consultations must be cosigned within fourteen (14) days after discharge;
E. Discharge summaries are to be cosigned within fourteen (14) days after discharge;
F. Orders of the resident or fellow do not need to be cosigned except that the order for admission must be cosigned prior to discharge, preferentially within the twenty-four (24) hours after admission; and
G. Orders of students will not be implemented until after co-signature by a licensed practitioner.

Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Joint Credentials Committee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

7.17 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including x-ray films, pathological specimens and slides, are the property of the Hospital and the information contained therein is the property of the patient. Medical records and the information contained therein may be removed only in accordance with hospital policy. Unauthorized removal of a medical record or any portion thereof from the Hospital is grounds for disciplinary action, including immediate and permanent revocation of Staff appointment and clinical privileges, as determined by the MEC and Board of Directors.

7.18 ACCESS TO RECORDS

7.18.1 BY PATIENT

Patients, hospital personnel, and Medical Staff members may have access to information contained in the medical record per hospital policy. Requests for access by persons other than the patient or his or her legal representative shall be addressed through Hospital policy and procedures.

7.18.2 ON READMISSION

In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner. This shall apply whether the patient is attended by the same practitioner or another.

7.18.3 TO FORMER MEDICAL STAFF MEMBERS

Subject to hospital policy, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the Hospital.

7.19 ORGANIZED HEALTH CARE ARRANGEMENT

A. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA"), the Medical Staff of this Hospital are deemed to be members of, and a part of, an *Organized Health Care Arrangement* ("OHCA") as that term is defined within HIPAA. This designation is required to comply with the privacy regulations promulgated pursuant to HIPAA and Health Information Technology for Economic and Clinical Health (HITECH) Act based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with the Hospital and the hospital's medical staff. No member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

B. The members hereby adopt the Hospital Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital and agree to comply with all requirements contained in the joint Notice of Privacy Practices.

C. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, though any portal that is not solely operated by the Hospital, shall enter into a Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Hospital information through a portal maintained by the member.

D. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

PART EIGHT: CONSENTS AND PATIENT RIGHTS

8.1 GENERAL

Patients have the right to consent to or to refuse treatment. Practitioners performing procedures or administering treatments are responsible for explaining the risks, benefits and alternatives of such treatment. The process of informed consent or informed refusal should be documented in the medical record in accordance with the Hospital's Informed Consent Policy.

DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital policy delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur

Restraints and Seclusion

The Hospital policy "Violent / Self-Destructive Restraint & Seclusion Policy" on delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

PART NINE: SURGICAL REQUIREMENTS

9.1 ASSISTANTS AT SURGERY

The primary operating surgeon shall determine the level and number of assistants required (e.g. qualified nurse or surgical technician/assistant, qualified surgeon or physician extender) commensurate with the gravity and complexity of the procedure being undertaken, generally recognized professional standards of care for the performance of the procedure, particular medical condition which the patient may have which would require care during surgery, and any other exceptional circumstances present. Patients should be informed of the identity of all operating surgeons and assistants.

9.2 CURETTAGE

No curettage or other such procedures shall be done except in accordance with the most recent version of the Ethical and Religious Directives for Catholic Health Care Facilities and any amendments thereto.

9.3 PERIOPERATIVE EVALUATION

Preoperative patient care areas and surgical areas are responsible for reviewing each patient's chart scheduled for an elective operative procedure to ensure that an appropriate history and physical, preoperative anesthesia evaluation and required laboratory testing, radiological studies or other special studies are present on the chart prior to the procedure beginning.

9.4 SURGERY SCHEDULING

Surgeons must be in the operating room and ready to commence the operation within fifteen (15) minutes of the scheduled time or the case may be rescheduled after all other scheduled surgeries have taken place.

9.5 PRESENCE OF NON-STAFF DURING INVASIVE PROCEDURES

Hospital and Operating Room policies address who may be present during invasive procedures.

Surgical privileges: A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

Surgical Policies and Procedures: All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

Anesthesia: A complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition must be completed for each patient receiving general/regional/MAC anesthesia. Only anesthesiologists, certified registered nurse anesthetists, or physicians privileged to perform deep sedation (which is part of MAC) shall be able to perform these procedures.

Moderate sedation may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

Procedural sedation (including moderate and deep sedation) is performed under the authority of the Anesthesia Department Chair.

Verification of correct patient, site, and procedure: The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by

the hospital. The Hospital policy on "Verification of Correct Site/Procedure/Patient for Invasive Procedures" shall be followed.

PART TEN: HOSPITAL DEATHS AND AUTOPSIES

10.1 HOSPITAL DEATHS

10.1.1 PRONOUNCEMENT

In the event of a death, the deceased shall be pronounced dead by the attending physician or his/her designee, a duly licensed physician or a registered nurse in accordance with New Hampshire state law. The body may not be released from the Hospital until an entry has been made and signed in the deceased's medical record by the individual pronouncing. If an anticipated death occurs in the hospital, the registered nurse attending at the last sickness may pronounce the person dead and release the body to the funeral director after having signed the death certificate on the designated line.

10.1.2 DEATH CERTIFICATE

The attending physician or his designee is required to complete the New Hampshire's electronic database as per state regulations. If the patient was pronounced deceased in the Emergency Department, the patient's outpatient provider will be asked to complete the death certificate. If the patient does not have an outpatient provider, the ED physician that pronounced the patient as deceased will complete the death certificate.

Release or removal of the body, reporting of deaths, and issuance of the death certificate are to be carried out in accordance with current Hospital policy and New Hampshire law.

10.1.3 NOTIFICATION OF NEXT OF KIN

Notification of next of kin will be followed in accordance with hospital policy.

10.2 AUTOPSIES

10.2.1 RESPONSIBILITY

It is the responsibility of every member of the Medical Staff to secure autopsies, whenever possible, in accordance with criteria approved by the Medical Executive Committee and which are listed below, and attempt to gain insight into the cause, nature or course of a disease process. Proper consent for an autopsy shall be obtained in accordance with Hospital policy and applicable state law. The order and reason for requesting the autopsy shall be documented in the medical record. The provisional anatomic diagnoses must be recorded on the medical record within 72 hours; and the complete protocol shall be made a part of the medical record within 60 days. These rules do not apply to cases which, according to law, must be referred to the Medical Examiner's Office.

The attending physician will be notified of the initiation of the autopsy by the Pathologist as noted on the Postmortem Examination Permit.

10.2.2 AUTOPSY CRITERIA

Autopsy Criteria approved by the Medical Executive Committee include:

A. Deaths in which the autopsy may help to explain unknown and unanticipated medical complications to the attending physician;

B. Deaths in which the cause of death is unknown or unexpected;

C. Stillborns;

D. Neonatal or pediatric deaths in which the cause of death is unknown;

E. Obstetric deaths in which the cause of death is unknown;

F. Deaths resulting from a suspected infectious condition, but questions remain as judged by the attending physician such as etiology or circumstances;

G. Deaths in which autopsy results may have some bearing on the transplantation of organs;

H. Cases in which the family might have some special realistic concerns or questions;

I. Other cases that the clinician feels might be helpful.

PART ELEVEN: PROFESSIONAL CONDUCT AND IMPAIRED PRACTITIONERS

11.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The "Medical Staff Code of Conduct Policy" shall be followed.

11.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, loss of cognitive skill, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Center policies on practitioner health and impairment as per "Policy Regarding Practitioner Health Issues" and the Credentials Procedure Manual.

11.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include spouses, domestic partners, parents, parents-in-law, children, stepchildren, and siblings.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

PART TWELVE: COMPLIANCE, CONFIDENTIALITY, IMMUNITY, AND CONFLICT OF INTEREST

12.1 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the Minimum Necessary Policy regarding access to medical records of themselves or family members to maintain compliance with Covenant Policy. Practitioners must utilize the Patient Portal or the traditional release of records process to access their own, or their family member's, medical records.

12.2 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on testing/vaccinations.

12.3 COMMUNICATION METHODS

All practitioners must maintain a current accessible e-mail address on file in the Medical Staff System Credentialing Office, as well as a current cell phone number.

All practitioners must use the accepted method of communication determined by the MEC and shall maintain their profile and other required elements of information. Additionally, all practitioners are expected to have access to the MEC approved email for non-patient care business.

12.4 CONFIDENTIALITY OF INFORMATION

To the fullest extent permitted by law, the following shall be kept confidential:
Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;

Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and

Confidential information related to teaching or clinical research; or

Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

12.5 IMMUNITY FROM LIABILITY

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of their duties as an official representative of the hospital or medical staff performed or made in good faith and without malice. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

12.6 COVERED ACTIVITIES

The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- **A.** Applications for appointment/affiliation, clinical privileges, or specified services;
- **B.** Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- **C.** Corrective or disciplinary actions;
- **D.** Hearings and appellate reviews;
- **E.** Quality assessment and performance improvement/peer review activities;
- **F.** Utilization review and improvement activities;
- **G.** Claims reviews;
- **H.** Risk management and liability prevention activities; and
- **I.** Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

12.7 RELEASES

When requested by the Staff President or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

12.8 CONFLICT OF INTEREST

A member of the medical staff requested to perform a Board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under

review, their spouse, or their first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

PART THIRTEEN: INFECTION CONTROL

13.1 PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES

Any patients with a suspected infectious or communicable disease will be placed on appropriate precautions in accordance with the provisions of the Hospital's Infection Control policies. Infection control personnel will call cases which may need isolation to the attention of the attending practitioner.

13.2 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

All cases of reportable infectious diseases shall be reported in accordance with the provisions of the Hospital's Infection Control Policy to the Infection Control Department and as required by New Hampshire state law, for review by the Infection Control Committee. Perceived disease outbreaks will be assessed in accordance with the Infection Control Policy.

Every Staff member shall report promptly to the Infection Control surveillance individual, any post-discharge infections which develop after discharge and which may have been Hospital-acquired.

13.3 GENERAL AUTHORITY

The Infection Control Committee has the authority to institute appropriate infection control measures or studies at its discretion.

PART FOURTEEN: REVIEW AND AMENDMENT

14.1 REVIEW AND AMENDMENT

Procedure for review and amendment can be found in the Medical Staff Bylaws.

PART FIFTEEN: ENFORCEMENT OF THESE RULES

15.1 ENFORCEMENT OF THESE RULES

Violation of any responsibility imposed by these rules by a member of the Medical Staff may subject the member to disciplinary action, including termination of clinical privileges or Medical Staff membership, as set forth in the Medical Staff Bylaws.

PART SIXTEEN: ADOPTION

16.1 ADOPTION

These General Rules and Regulations were adopted and recommended to the Board of Directors by the Medical Staff on February 25, 2003, and were adopted by the Board of Directors on February 25, 2003.

16.2 REVISION

These General Rules and Regulations were updated and recommended to the Board of Directors by the Medical Staff on, and were adopted by the Board of Directors on

President of the Medical Staff
St. Joseph Hospital

SECTION II: MEDICAL STAFF ORGANIZATION

PART A: MEDICAL STAFF DEPARTMENTS

A. MEDICAL STAFF DEPARTMENTS

Per the Medical Staff Bylaws, Article IV, the Medical Staff of St. Joseph Hospital is a departmentalized Medical Staff. Future departments may be created, or current departments eliminated or consolidated by recommendation of the Medical Executive Committee with the Board of Directors' approval. Members of the Medical Staff will be assigned to departments based on their area of primary clinical practice. This may or may not correspond with their area of academic training, e.g. adult inpatient hospitalists will all be assigned to the Department of Medicine.

Current Medical Staff Departments Include:

1. Department of Medicine
2. Department of Surgery
3. Department of Family Medicine
4. Department of Pathology
5. Department of Radiology
6. Department of Anesthesiology
7. Department of Pediatrics
8. Department of Obstetrics and Gynecology
9. Department of Emergency Medicine

PART B: MEDICAL STAFF COMMITTEES

B. MEDICAL STAFF COMMITTEES

Per Article V of the Medical Staff Bylaws: There shall be such standing and special committees of the staff as may from time to time be necessary and desirable to perform the functions of the staff. All committees named below, whether standing or special, shall be responsible to the Medical Executive Committee of the Medical Staff and shall submit reports as designed by the Medical Executive Committee.

The Medical Staff, acting as a whole or through committee, participates in and have oversight over activities in the following areas:
1) governance, 2) medical care evaluation/performance improvement/patient safety activities, 3) hospital performance improvement and patient safety programs, 4) credentials review, 5) information management, 6) emergency preparedness, 7) strategic planning that impact medical staff, 8) bylaws review, 9) nominating process, 10) infection prevention and control, 11) pharmacy and therapeutics, 12) practitioner health, and 13) utilization management, 14) advocacy for Medical Staff concerns.

B.1 AMBULATORY CARE COMMITTEE

COMPOSITION

The Ambulatory Care Committee shall consist of:

- **A.** Three members of the Active Staff with vote whose primary patient activity relates to the use of outpatient services, one of whom shall serve as Chair.
- **B.** Senior administrator primarily responsible for Outpatient Services, with vote.
- **C.** One administrative representative from Diagnostic Imaging, without vote.
- **D.** One administrative representative from Laboratory Services, without vote.
- **E.** Other physicians or administrators as may be appropriately invited from time to time, without vote.

FUNCTION AND RESPONSIBILITIES

The duties of the Ambulatory Care Committee shall include:

- **A.** To provide input into the management of outpatient services and review of the services provided from the perspective of referring physicians and patients.
- **B.** To make recommendations concerning the scope and nature of services provided

C. To report to the MEC concerning the quality, safety and adequacy of services provided to outpatients.

D. Between committee meetings, the Chair shall serve as a resource to the Administration when questions or concerns arise that are related to Outpatient Services.

MEETINGS AND MINUTES

The committee shall meet at least twice a year and at the call of the Chair with at least 2 weeks notice. Minutes will be prepared by the Chair and filed with MSO. They will be reviewed at the MEC with special presentations as necessary by the Chair.

B.2 BYLAWS COMMITTEE

COMPOSITION

The Bylaws Committee shall consist of:

A. A minimum of three (3) members of the Medical Staff, with vote

B. President Elect of Medical Staff, with vote shall serve as the Chair

C. A representative of the Chief Executive Officer, without vote

D. CMO/VPMA, without vote

E. Medical Staff Coordinator, as staff, without vote

F. Hospital Legal Counsel, as needed

FUNCTIONS AND RESPONSIBILITIES

The Bylaws Committee shall review and recommend changes and amendments to the Bylaws, and related documents upon written request of the Medical Executive Committee, Credentials Committee, or any member of the Active Staff. It shall maintain current knowledge of federal and state laws, guidelines and regulations as they relate to the Medical Staff documents.

MEETINGS AND MINUTES

The Bylaws Committee shall meet at least every two years to review the existing Bylaws and related documents or as often as necessary to fulfill its functions and responsibilities and shall maintain a permanent record of its proceedings and actions and shall report to the MEC.

B.3 CANCER COMMITTEE

COMPOSITION

The Cancer Committee of St. Joseph Hospital is multidisciplinary and its members shall include:

A. Medical Staff Representatives from: Family Medicine, Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology and Pathology, with vote

B. Cancer liaison physician, with vote

C. Certified oncology nurse, with vote

D. Representatives from the following Hospital Departments: Pharmacy, Nutrition Services, Rehabilitation Services, Pastoral Services, Social Services, Health Information Management, Quality Resource Management, Breast Health Center, Vice President of Patient Care Services, Radiation Therapy Representative, Hospice and Oncology Inpatient Nurse Manager, Circle of Life Program, Clinical Research RN, Oncology Case Manager, with vote

E. Tumor Registrar, and Tumor Registry Assistant, as staff, without vote

FUNCTIONS AND RESPONSIBILITIES

The Cancer Committee provides leadership to plan, initiate, stimulate and assess all cancer-related activities in the institution. The committee functions as a policy-advisor and administrative body over all cancer-related activities. Its responsibilities are to:

A. Develop and evaluate the annual goals and objectives for the clinical, educational and programmatic activities related to cancer.

B. Participate in at least two (2) patient care evaluation studies (PCEs) annually. Involvement ranges from setting criteria (or approving criteria), problem solving, action and follow-up.

C. Promote a coordinated, multidisciplinary approach to patient management.

D. Ensure that educational and consultative cancer conferences cover all major cancer sites and

related issues annually and are primarily oriented and prospective.

E. Ensure that an active supportive care system is in place for patients, families and staff, including consultative services to patients with cancer through multidisciplinary physician attendance at conferences.

F. Monitor quality management and performance improvement through completion of quality management studies that focus on quality, access to care and outcomes.

G. Serve as liaison between physicians and Tumor Registry and as registry physician advisor(s).

H. Promote clinical research.

I. Supervise the Cancer Registry and provide quality control for accurate and timely abstracting, staging and follow-up reporting.

J. Encourage cancer data usage and regular reporting.

K. Upholds medical ethical standards.

MEETINGS AND MINUTES

The Cancer Committee shall meet at least quarterly or as frequently as necessary to fulfill its functions and responsibilities and shall maintain a permanent record of its proceedings and actions and shall report to the Medical Executive Committee.

B.4 CREDENTIALS COMMITTEE

COMPOSITION

The Credentials Committee of St. Joseph Hospital shall consist of:

- At least three (3) members of the Active Staff all of whom shall not be department chairs
- VP Patient Care Services, with vote
- President Elect of Medical Staff, with vote
- The CMO/VPMA shall attend ex officio, without vote
- The Medical Staff Coordinator shall attend as staff, without vote

Members of the Credentials Committee shall have served at least two (2) years on the Active staff and have expressed interest and/or experience in the function of the committee and have served in some other Medical Staff leadership activity. All new members will be provided an orientation to the roles and responsibilities of the committee and will also be provided an opportunity for Medical Staff leadership training. Representatives may be re-appointed for additional terms without limit.

FUNCTIONS AND RESPONSIBILITIES

The responsibilities of the Credentials Committee are as follows:

A. To receive and analyze applications and recommendations for initial appointment, reappointment, provisional period conclusion or extension, return from leave of absence, clinical privileges and changes therein and recommending action thereon.

B. To review and recommend qualifications and criteria for granting clinical privileges.

C. To conduct review of professional character or competence of any licensed independent practitioner, applicant or Medical Staff member.

D. To develop, recommend, maintain and consistently implement contemporary policies and procedures for all credentialing activities at St. Joseph Hospital by recommending standards for the content and organization of the credentials files including periodically reviewing and revising the Credentials Procedures Manual.

E. Proctoring.

CONFIDENTIALITY

The Credentials Committee shall function as a peer review committee consistent with NH Rev. Stat. Ann §151:13-a. All members of the Credentials Committee shall, consistent with the Medical Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee. Members of the Credentials Committee will be able to obtain certain minutes and information to review before each regularly scheduled meeting. Such materials are confidential and must be returned at the relevant meeting or destroyed in a confidential manner

MEETINGS AND MINUTES

The Credentials Committee will meet at least ten (10) times per year or as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions and shall report to the Medical Executive Committee.

B.5 INFECTION CONTROL COMMITTEE

COMPOSITION

The Infection Control Committee of St. Joseph Hospital is multidisciplinary and its members shall include:

A. Four Medical Staff Representatives from the Departments of Pathology, Surgery, Medicine, with vote

B. One representative each from Nursing and Hospital Administration, Pharmacy, Surgical Services, Quality Resource Management, Employee Health & Wellness, Risk Management with vote

C. Infection Control Coordinator and Infection Control Nurse Educator, with vote

D. Microbiology Supervisor, with vote

E. Assistant to Director Materials Management, with vote

FUNCTIONS AND RESPONSIBILITIES

The Infection Control Committee is responsible for approving the type and scope of surveillance activities that include at least the following:

A. Review of designated microbiology reports.

B. Review of patient infections, as appropriate, to determine whether an infection is health care associated, using definitions and criteria approved by the committee.

C. Review of infections that present the potential for prevention or intervention to reduce the risk of future occurrence.

D. Review of surveillance data, if appropriate.

E. Routine or special collection of other data, as approved by the committee.

F. On an annual basis, the committee will review and revise, if necessary, and approve the type and scope of surveillance activities by reviewing:

- Data trend analyses generated by surveillance activities during the past year.
- The effectiveness of prevention and control intervention strategies in reducing the health-care-associated infection risk.
- Services instituted and procedures, priorities or problems identified in the past
- year.
- The committee shall also approve actions to prevent or control infection, based on an evaluation of the surveillance reports of infections and of the infection potential among patients and hospital personnel, volunteers and visitors.
- At least every two years, reviews and approves all policies and procedures related to the infection surveillance, prevention and control activities in all departments/services.

MEETINGS AND MINUTES

The Infection Control Committee shall meet bimonthly or as often as necessary to fulfill its functions and responsibilities and shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Medical Executive Committee.

B.6 INTEGRATED PATIENT CARE COMMITTEE WITH UTILIZATION REVIEW

COMPOSITION

(Previously Critical Care Committee & Inpatient Care Committee). The Integrated Patient Care Committee shall consist of:

A. Medical Director of the ICU, Medical Director of the Hospitalist Program, Acute Rehabilitation Unit, and Geriatric Psychiatry Unit as well as four physician members of the Active Medical Staff with inpatient/core privileges, one each from the Departments of Medicine, Surgery, OB-Gyn Anesthesia and Emergency Medicine.

B. Two physician members shall be appointed as Co-Chairs by the President of the Medical Staff.

C. Chief Nursing Officer/Vice-President Patient Care Services, with vote.

D. Nurse representatives of each medical/surgical unit ICU, ED, and PACU a member of the pharmacy staff, and Director of Respiratory Therapy.
E. A representative of the Quality Management Department without vote.
F. VPMA without vote.
G. Members of the Utilization Review team without vote.
H. A representative of Medical Staff Office to serve as staff.
I. Other physicians, nurses, administrators and hospital staff personnel as may be appropriately invited from time to time without vote.

FUNCTIONS AND RESPONSIBILITIES

A. To advance communication among all members of the inpatient care team.
B. To review the overall quality and appropriateness of inpatient care and to establish uniform standards of care for inpatients though out the hospital including the development of policies and guidelines.
C. To make recommendations concerning the scope and nature of inpatient services provided.
D. To assure recommendations go to appropriate medical, administrative and nursing committees/departments. All actions to be reviewed by the Medical Executive Committee.
E. To review inpatient policies, protocols, forms and preprinted orders on a periodic basis.
F. Participate in Hospital wide process improvement activities in coordination with the Nursing Department and Quality and Resource Management Department.

MEETINGS AND MINUTES

The Integrated Patient Care Committee shall meet monthly in conjunction with the Utilization Review Committee unless cancelled with advance notice by the Chair. Minutes of both meetings will be recorded together by staff and reviewed by the Chair prior to approval at the next meeting. They will be filed with the Medical Staff Office.

B.7 MEDICAL EDUCATION COMMITTEE

COMPOSITION

The Medical Education Committee shall consist of:
A. Three (3) Medical Staff representatives, one of whom shall serve as chair, with vote
B. Director of Quality and Resource Management, with vote
C. Librarian, as staff, without vote
D. Medical Education Coordinator, as staff, without vote

FUNCTIONS AND RESPONSIBILITIES

The Medical Education Committee shall:
A. Provide oversight of all continuing education activities, perform an annual review of programs, and advise the Medical Executive Committee concerning enforcement of the Accreditation Council for Continuing Medical Education (ACCME) guidelines.
B. Coordinates, internally and with other healthcare organizations, the continuing medical education programs of the Hospital, oversees the maintenance of the accreditation process in accordance with the requirements of the ACCME and the New Hampshire Medical Society.

MEETINGS AND MINUTES

The Medical Education Committee shall meet at least once per year, or as often as necessary to fulfill its functions and responsibilities, shall maintain a permanent record of its proceedings and actions, and shall report to the MEC.

B.8 NEONATAL CARE COMMITTEE

COMPOSITION

The Neonatal Care Committee shall consist of:
A. Department of Pediatrics Chairperson (or designee)
B. Director of Maternal Child Health
C. MCH Clinical Resource Nurse
D. Inpatient Lactation Consultant

E. Neonatologist (or designee)
F. Inpatient neonatal care providers (MD's, NPP's, PA's, NNP's)
G. A representative of Medical Staff Office to serve as staff
H. A representative from the Quality Department
I. Ad hoc members (without vote): VPMA, CNO/VP of PCS, other members of health care team as indicated (pharmacy, respiratory therapy, OB/GYN, ED, etc.)

FUNCTIONS AND RESPONSIBILITIES

A. To advance communication amongst all members of the neonatal care team
B. To review the overall quality and appropriateness of neonatal care and to establish standards of care for neonates including the development of policies and guidelines.
C. To make recommendations concerning the scope and nature of the neonatal services provided
D. To assure recommendations go to appropriate medical, administrative and nursing committees/departments. All actions to be reviewed by the Medical Executive Committee
E. To review neonatal forms and orders on a periodic basis
F. To participate in hospital wide and departmental process/quality improvement activities in collaboration with the nursing and quality departments.

MEETINGS AND MINUTES

The Neonatal Care Committee shall meet quarterly at minimum. Minutes will be recorded by staff and reviewed by the Chair person prior to approval at the next meeting. They will be filed with the Medical Staff Office.

Ad hoc work group meetings may occur with various members of this committee between quarterly meetings to work on policies, procedures and content. These work groups will report up directly to the Neonatal Care Committee.

B.9 NOMINATING COMMITTEE

COMPOSITION

The Nominating Committee shall consist of:

- Immediate Past Medical Staff President to serve as chairman
- Two (2) members of the Active Staff to be elected by the Active Staff, each to serve for three (3) years in staggered terms
- Hospital President/CEO or designee, without vote
- CMO/VPMA, without vote
- Medical Staff Coordinator, as staff, without vote

Nomination for committee members shall come from the floor at the Annual Meeting of the staff and shall be elected at that meeting. Each member is to serve with one (1) vote. No member shall immediately succeed himself or be nominated for other elected office. A quorum shall be two (2) members.

FUNCTIONS AND RESPONSIBILITIES

The Nominating Committee shall convene to identify one or more qualified nominees for the Medical Staff officer positions and the at-large representatives to the MEC. The committee shall contact the prospective nominees to ensure their interest and ability to perform the required responsibilities of each position. The Chair of the Nominating Committee shall provide a statement for each nominee stating that the nominee has agreed to stand for election to office.

Nominations shall be submitted to the Medical Staff President.

The names of all nominees shall be distributed to the Active Medical Staff at least 30 days prior to the Annual meeting.

MEETINGS AND MINUTES

The Nominating Committee shall meet on an as needed basis, typically ninety days prior to the Annual Meeting and as often as necessary to fulfill its functions and responsibilities and shall maintain a permanent record of its proceedings and actions and report to the MEC.

B.10 PHARMACY AND THERAPEUTICS COMMITTEE

COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of:

A. At least two (2) Medical Staff representatives, one of whom shall serve as chair, with vote;
B. Representatives from:
   - Patient Care Services, with vote
   - Quality Resource Management, with vote
   - Hospital Administration, without vote
C. Infection Control Coordinator, with vote
D. Nutrition Services, with vote
E. Risk Manager, without vote
F. Pharmacy Director or designee, as staff, with vote
G. Any other specialty/departmental representative as needed, without vote

FUNCTIONS AND RESPONSIBILITIES

The Pharmacy & Therapeutic Committee reviews and analyzes provider- and service-specific data consisting of drug-usage evaluation studies, drug mis-adventuring, develops and approves policies and procedures related to The Joint Commission (TJC) Treatment of Patient Standards, manages formulary development, additions and deletions, and identifies opportunities for process improvement as it relates to the treatment of patients. Specific responsibilities include:

A. Maintain a formulary of drugs approved for use at the hospital.

B. Create treatment guidelines and protocols in cooperation with medical and nursing staff.

C. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, and pharmacist interventions).

D. Perform drug usage evaluations (DUEs) studies on selected topics.

E. Perform medication usage evaluation (MUIs) studies as required by the Joint Commission.

a. Perform practitioner profile analysis related to medication use.
b. Approve policies and procedures related to The Joint Commission Treatment of Patients Standards; to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; procurement, storage, distribution, use, safety procedures, and other matters relating to medication usage in the hospital.
c. Develop and measure indicators for the following elements of the patient treatment function:
   1. Prescribing/ordering of medications.
   2. Preparing and dispensing of medications.
   3. Administration of medications.
   4. Monitoring of the effects of medication on the patients.
d. Analyze and profile data regarding the measurement of the patient treatment function by service and practitioner, where appropriate.
e. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified.
f. Serve as an advisory group to the hospital and Medical Staffs pertaining to the choice of available medications.
g. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

MEETINGS AND MINUTES

The Pharmacy and Therapeutics Committee shall meet at least quarterly or as often as necessary to fulfill its functions and responsibilities and shall maintain a permanent record of its proceedings and actions and shall report to the Medical Executive Committee.

B.11 PRACTITIONER HEALTH COMMITTEE

COMPOSITION

The Practitioner Health Committee shall consist of:

- Up to five (5) members of the Medical or Allied Health Professional staff, the majority of which, including the chair, should be physicians.

Except for initial appointments, each member shall serve a term of three (3) years and the terms shall be staggered to achieve continuity. Members may be reappointed to the committee. Members of this committee shall not serve as a Department Chair or chair of any other peer review or quality assessment and improvement committee while serving on this committee. Such participation shall not constitute an absolute basis for exclusion of an otherwise qualified candidate on any peer review or quality assessment committee.

FUNCTIONS AND RESPONSIBILITIES

The duties of the Practitioner Health Committee shall include:

A. Develop and provide for educational programs to the Medical Staff and other hospital staff about illness and impairment recognition issues specific to physicians and other healthcare workers.

B. Review and revise, as necessary, the Policy Regarding Practitioner Health Issues and forward recommendations to the MEC.

C. Fulfill the functions and requirements outlined in the Policy Regarding Practitioner Health Issues.

D. Consider general matters related to the health and well being of physicians and LIPs on the Medical or Allied Health Professional Staff.

MEETINGS AND MINUTES

The Practitioner Health Committee shall meet on an as needed basis or as often as necessary to fulfill its functions and responsibilities. Documentation and confidentiality shall be maintained according to the Policy Regarding Practitioner Health Issues.

B.12 PROFESSIONAL DEVELOPMENT COMMITTEE

COMPOSITION

The Professional Development Committee shall consist of:

Voting Members including:

- Immediate Past President of the Medical Staff
- President-Elect of the Medical Staff
- Department Chair or designee from the Departments of Anesthesiology, Emergency Medicine, Radiology, and Surgery.
- Department Chairs or designees from the Departments of Family Medicine, OB/Gyn, Pathology, and Pediatrics will attend as ad hoc members.
- One (1) APP representative that votes only on APP issues. This position is appointed by the President of the Medical Staff.
- One Active Staff members at large appointed by the President of the Medical Staff for a three- year term. Member at large may serve multiple terms and must be previous member of the MEC.
- Covenant CMO shall act as an ex-officio member.

Non-Voting Members (Ex-Officio and Ad Hoc):

- CMO/VPMA
- CNO or designee
- Director of Quality (Recording Secretary,

- Case reviewers who are not a member of the committee are considered "ad hoc" members for that meeting.

Chair: The President of the Medical Staff shall appoint the chair from among the physician members other than the CMO/VPMA

- Quorum for this meeting will be 5 physician members. The Chair of the committee will have tie breaking capabilities.

FUNCTION AND RESPONSIBILITIES

A. Monitor and Improve professional competency and professional conduct of all privileged practitioners.

B. To ensure implementation of the Medical Staff Professional Development Policy.

C. To review information referred to the committee by the operation of the Professional Development Policy and to act on such information in a manner consistent with that policy.

D. To report directly to the MEC concerning the activities of the Professional Development Committee (PDC) at least annually and as often as deemed appropriate by the Chair.

E. To report to the MEC, other Medical Staff Committees, the Medical Staff at large and the Hospital administration, as appropriate, the lessons learned in the course of professional development that are of general applicability to the improvement of patient care and/or safety.

F. Between committee meetings the Chair shall serve as a resource to Department Chairs and others for information regarding professional development.

MEETINGS AND MINUTES

The committee shall meet at least quarterly and at the call of the chair. Minutes will be prepared by Director of Quality and filed with Medical Staff Office.

B.13 RADIATION SAFETY COMMITTEE

COMPOSITION

Members of the Radiation Safety Committee shall consist of:

A. Two (2) physician members of the Department of Radiology, one of whom shall be appointed by the President of the Medical Staff to serve as Chair.

B. At least an authorized user of each type of use permitted by the license

C. Radiation Safety Officer

D. Representative from Patient Care Services

E. Representative from Hospital Administration

FUNCTIONS AND RESPONSIBILITIES

This committee is responsible for:

A. Overseeing the use of licensed material.

B. Review recommendations on ways to maintain individual and collective doses ALARA.

C. Review, on the basis of safety and with regard to the training and experience standards and approve or disapprove any individual who is to be listed as an authorized user, an authorized nuclear pharmacist, the Radiation Safety Officer or a teletherapy physicist before submitting a license application or request for amendment or renewal.

D. Review, on the basis of the board certification, the license or the permit identifying an individual and approve or disapprove any individual prior to allowing that individual to work as an authorized user or authorized nuclear pharmacist.

E. Review on the basis of safety and approve, with the advice and consent of the Radiation Safety Officer and hospital administration's representative or disapprove minor changes in radiation safety procedures that are not potentially important to safety and are permitted under 10 CFR, Chapter 1, Part 34.

F. Review quarterly, with the assistance of the Radiation Safety Officer, a summary of the occupational radiation dose records of all personnel working with byproduct material.
G. Review quarterly, with the assistance of the Radiation Safety Officer, all incidents involving byproduct material with respect to cause and subsequent actions taken and
H. Review annually, with the assistance of the Radiation Safety Officer, the radiation safety program.

MEETINGS AND MINUTES

The Radiation Safety Committee shall meet at least quarterly and shall maintain permanent record of its proceedings and actions and shall report to the MEC.

B.14 TRAUMA CARE COMMITTEE

COMPOSITION

The Trauma Care Committee shall consist of:

A. Medical Director of Trauma Services to serve as Chairman
B. Medical Director of Emergency Medical Services
C. One (1) Medical Staff representative from Department of Surgery, Anesthesiology and Radiology
D. Trauma Nurse Liaison
E. Emergency Medical Services Educator
F. VP of Patient Care Services (or designee)
G. A representative from the Quality Management Department

FUNCTIONS AND RESPONSIBILITIES

The duties of the Trauma Care Committee shall include:

A. To conduct timely educational case reviews.
B. To oversee Quality Improvement activities for the Trauma Center at St. Joseph Hospital in coordination with the Quality Management department.
C. To conduct quarterly meetings to review and coordinate the policies and procedures that affect the multidisciplinary function of the Trauma Center.
D. To organize an Annual Trauma Conference which includes participation from the continuum of trauma care including but not limited to pre-hospital EMS, Trauma Surgery, Anesthesia, Emergency Department, Intensive Care, Radiology and Laboratory providers.
E. To be responsible for meeting the requirements of accrediting or certifying bodies such as The Joint Commission and ACS.
F. To provide an annual report to the MEC concerning the activities of the Committee and the Trauma Center.

MEETINGS AND MINUTES

Meetings shall be at least quarterly and at the call of the chair as needed to fulfill the Committee's functions. The Annual Trauma Conference may be included in the regular meeting schedule. The Chair may request participation from trauma care providers other than Members of the Committee as needed to fulfill the Committee's functions.

B.15 STROKE COMMITTEE

COMPOSITION

The Stroke Committee shall consist of:

- Stroke Medical Director
- Neurologist
- Stroke Coordinator (s)
- Hospitalist
- ED Medical Director
- Quality representative
- ED Nurse representative
- EMS representative
- Lab Representative

- Nutrition Services representative
- Rehabilitation Representative (Speech/Physical/ Occupational Therapy representative)
- Stroke Unit Nurse representative
- Senior Leadership liaison
- Diagnostic Imaging representative
- Home Care Representative

Note: Membership may change and flex as new core measures are added, or measures are eliminated or altered

FUNCTIONS AND RESPONSIBILITIES

The duties of the Stroke Committee shall include:

A. To conduct timely educational case reviews.

B. To oversee Quality Improvement activities for the Stroke Program in coordination with the Quality and Performance Improvement Department.

C. To develop and evaluate policies and procedures of the Stroke Program at least annually.

D. To organize an Annual educational program (including health care workers and the public) that focuses on stroke education and prevention.

E. To be responsible for meeting the requirements of accrediting or certifying bodies such as DNV, Get with the Guidelines and Center for Medicare/Medicaid Services.

F. To provide an annual report to the MEC including the activities of the Stroke Committee.

MEETINGS AND MINUTES

The Stroke Committee shall meet at least quarterly or as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions and shall report to the Medical Executive Committee.

<u>SECTION III:</u> MEDICAL STAFF POLICIES AND PROCEDURES

I: POLICY REGARDING PRACTITIONER HEALTH ISSUES

INTRODUCTION

The Practitioner Health Committee (PHC) has been established by the Medical Staff of St. Joseph Hospital to provide a confidential mechanism for dealing with those matters of impairment and health that emphasizes prevention, diagnosis and treatment of physical and psychiatric illness. A practitioner, for purposes of this policy, is defined as a physician or LIP (psychologist, CNM, oral surgeon, or podiatrist) who is a credentialed member of the Medical Staff at St. Joseph Hospital and who is independently licensed and regulated by the New Hampshire Board of Medicine or the appropriate licensing board of their specialty, as well as an Advanced Dependent Practitioner (APRN, CRNA, PA) who is a credentialed member of the Allied Health Professional Staff and who is licensed and regulated by the appropriate New Hampshire Licensing Board. For all conditions, but especially those involving substance abuse, the PHC seeks to assure that all practitioners are treated with a consistent, fair policy that will protect their rights and assist them in obtaining appropriate medical help. The PHC policies are constructed to be administered in a uniform fashion, one which is also in concordance with each licensing board's regulations. For physicians and PAs, the PHC works directly with the New Hampshire Board of Medicine's Physicians Health Program (NHPHP) http://www.nhms.org/nhms/committees/index.php. The PHC is a committee that functions in the interests of quality patient care and thus is a part of the St. Joseph Hospital Patient Safety and Quality Assurance Program. All practitioners are required to sign a statement stating that they have read and understood the Policy Regarding Practitioner Health Issues as a condition for appointment or reappointment to the Medical or Allied Health Professional Staff.

PURPOSE OF POLICY

This policy establishes standardized guidelines for the identification, intervention, referral for treatment, rehabilitation and reinstatement of any practitioner who may be identified as an impaired health care provider. An impaired provider is one who is unable to deliver health care with skill, safety, and appropriate professional conduct to patients because of physical or mental illness, including but not limited to temporary or permanent loss of motor skills or cognitive abilities, behavioral impairment, and substance abuse, including abuse of prescription drugs, "recreational" drugs or alcohol. St Joseph Hospital's Code of Conduct is designed to deal with inappropriate behavior; therefore the PHC will not address such problems. The PHC is also not a forum for defending practitioners against accusations of criminal wrongdoing.

The purpose of this policy is to optimize the quality of care for patients by:

1. Maintaining a safe environment for patients, health system employees and other practitioners.
2. Providing a mechanism for evaluating possible impairment of the health care professional.
3. Providing a confidential, positive medical assistance program to the impaired professional.
4. Providing ongoing education to the St. Joseph Hospital community that addresses practitioner health and emphasizes prevention, diagnosis, treatment of impairment of staff members.

STRUCTURE OF PHC

The structure is described in the Rules and Regulations of St. Joseph Hospital.

MECHANISM FOR REPORTING AND REVIEWING POTENTIAL HEALTH ISSUE

1. Practitioners who are suffering from a health issue that affects their ability to practice are encouraged to voluntarily bring the issue to any member of the PHC so that appropriate steps can be taken to protect patients and to help the practitioner to practice safely and competently. With substance misuse/abuse, the NHPHP can be directly consulted and may assist and monitor physicians independently with an individualized program focused on rehabilitation. Other licensing boards may also have similar supportive programs for the individual that seeks help.

2. If any individual has a reasonable concern that a member of the Medical Staff or another practitioner has a health issue that may affect his or her practice at the hospital, a written report shall be maintained in confidence in the Medical Staff Office. The report shall include a factual description of the incident(s) that led to the concern.

3. If any individual has a reasonable concern that a member of the Medical Staff or another practitioner is unable to safely practice due to a health issue and an immediate response is necessary in order to protect the health and safety of patients or the orderly operation of the hospital, the individual shall immediately notify the relevant department chief and/or the CEO, or designee, who shall assess the practitioner to determine whether it appears that the practitioner can safely treat patients. If a determination is made that the practitioner cannot safely practice, the responsibility for care of the affected practitioner's hospitalized patients can be assigned to another practitioner with appropriate clinical

privileges by the chief of their department. The wishes of the patient shall be considered in the selection of a covering practitioner. The Department Chief and the CEO, or designee, as well as the individual who notified those individuals, shall all file reports as described herein.

4. If the practitioner was relieved of his or her patient care responsibilities or if, after discussing the incident(s) with the individual who filed the report, the CEO, the President of the Medical Staff, and/or any member of the PHC believe there is enough information to warrant a review, the matter shall be referred to the PHC.

5. The PHC shall act expeditiously in reviewing concerns that are brought to its attention.

6. As part of its review, the PHC may meet with the individual(s) who filed the report. If necessary, the PHC may have a confidential meeting with other parties such as the department chief in the practitioner's specialty or other coworkers who work with the investigated practitioner.

7. If the PHC has reason to believe that a practitioner's ability to safely practice may be impaired, it shall meet with the practitioner. At this meeting, the practitioner should be told that there is a concern that he or she might be suffering from a health issue that affects his or her practice. The practitioner should not be told who filed the initial report, but should be advised of the nature of the concern.

8. As part of its review, the PHC may request that the practitioner's health status be assessed by an outside organization or individual and have the results of the assessment provided to it. In the case of substance abuse, the NHPHP will also be involved in determining the recommendations for the practitioner.

9. Authorization forms and a release form permitting the exchange of information between the outside organization or individual and the hospital and the PHC are attached as Appendices A, B and C. Additionally, a Health Status Assessment form is attached as Appendix D to this policy.

10. Depending upon the severity of the problem and the nature of the health issue, the PHC has the following options available to it:

- **a.** Recommend that the practitioner voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation program or receive the necessary medical treatment to address and resolve the health problem;
- **b.** Recommend that appropriate conditions or limitations be placed on the practitioner's practice;
- **c.** Recommend that the practitioner voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the practitioner is able to practice safely and competently; or
- **d.** Recommend that some or all of the practitioner's privileges be suspended if the practitioner does not voluntarily agree to refrain from practicing in the hospital.

11. When the issue involves substance abuse in a physician and the NHPHP and/or the PHC recommend that the practitioner participate in a rehabilitation or treatment program, assistance can be provided to the practitioner in locating a suitable program. For LIPs, assistance can also be provided by the PHC if requested by the appropriate licensing board.

12. If the practitioner agrees to abide by the recommendation of the PHC, a confidential report will be made to the CEO and the President of the Medical Staff. If the CEO and/or the President of the Medical Staff are concerned that the recommendation of the PHC will not sufficiently protect patients, the matter will be referred back to the PHC with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for an investigation pursuant to the Bylaws.

13. If the practitioner refuses to abide by the recommendation of the PHC, the matter shall be referred to the Medical Executive Committee for an investigation to be conducted pursuant to the Bylaws.

REINSTATEMENT

1. Upon sufficient proof that a practitioner has successfully completed a rehabilitation or treatment program, the PHC may recommend to the Credentials and Executive Committees that the practitioner's clinical privileges be reinstated. In making such a recommendation, the PHC must consider patient care interests as paramount.

2. Prior to recommending reinstatement, the PHC must obtain an assessment from the individual overseeing the practitioner's rehabilitation or treatment. An authorization for the disclosure of this information and a release from liability are attached as appendices to this policy. (If an authorization has already been obtained from the practitioner's rehabilitation or treatment program pursuant to paragraph 10, a second authorization is not necessary.) The assessment must address the following:

a. The nature of the practitioner's condition;
b. Whether the practitioner is participating in a rehabilitation program or treatment plan and a description of the program or plan;
c. Whether the practitioner is in compliance with all of the terms of the program or treatment plan;
d. To what extent the practitioner's conduct needs to be monitored;
e. Whether the practitioner is rehabilitated or has completed treatment;
f. Whether, if applicable, an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and
g. Whether the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

3. Before recommending reinstatement, the PHC may request a second opinion on the above issues from a practitioner of its choice.

4. Assuming that all of the information received indicates that the practitioner is capable of resuming care of patients, the following additional precautions may be taken before the practitioner's clinical privileges are reinstated:

a. The practitioner must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the practitioner's inability or unavailability; and
b. The practitioner shall be required to provide periodic reports to the PHC from his or her attending practitioner, for a period of time specified by the Committee, stating that the practitioner is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the practitioner's reinstatement.

5. The practitioner's exercise of clinical privileges in the hospital shall be monitored by the department chief or by a practitioner appointed by the Department Chief. The nature of that monitoring shall be recommended by the PHC.

6. If the health issue relates to substance abuse, the practitioner must, as a condition of reinstatement, agree to submit to alcohol or drug screening tests at such times and under such conditions as imposed by the NHPHP or LIP licensing board and as agreed to by the PHC. Nothing herein shall prevent the PHC from recommending that the individual be subject to a set of conditions that is stricter than what is imposed by the NHPHP if the PHC concludes that a different set of conditions would be in the best interest of patient care.

7. If a practitioner requested a leave of absence for health reasons without the involvement of the PHC and is now requesting reinstatement of privileges, the practitioner, at a minimum, shall submit a report to the PHC from his or her attending practitioner indicating that the practitioner is physically and/or mentally capable of resuming a hospital practice and performing the clinical privileges requested. The forms referenced above in paragraph 9 of the previous section should be utilized to permit exchange of information. The PHC shall provide its recommendations regarding reinstatement to the Credentials and Medical Executive Committees.

DOCUMENTATION, CONFIDENTIALITY

1. Consistent with quality of care concerns, the PHC shall handle practitioner health issues in a confidential fashion. The PHC shall keep the CEO and the President of the Medical Staff apprised of matters under review. The Credentials

Committee may also be informed in situations where a practitioner's practice may continue to be monitored over a period of time.

2. The authorization and release forms attached as appendices to this policy are designed to be compliant of the practitioner's privacy interests under HIPAA and they should be used together.

3. The PHC is to complete a confidential signed written report, with the findings, conclusions and recommendations for each review. This report along with any releases and other correspondence (including the original report to the PHC) shall be included in the practitioner's credentials file. If, however, the review reveals that there was no merit to the original report, the report will not be accepted for the file. If the review reveals that there may be some merit to the report, but does not rise to the level of seriousness to require immediate action, the report shall be included in the practitioner's credentials file and the practitioner's activities and practice shall be monitored until it can be established whether there is a health issue that might affect the practitioner's practice. The practitioner shall have an opportunity to provide a written response to the concern and this shall also be included in his or her credentials file.

4. The CEO or the President of the Medical Staff shall inform the individual who filed the report that follow-up action was taken, though the details of that action may not be revealed to anyone outside of the peer review process.

5. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this policy.

6. If at any time it becomes apparent that the matter cannot be handled internally, or jeopardizes the safety of the practitioner or others, the CEO may contact law enforcement authorities or other governmental agencies.

7. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101, et seq.; NH RSA 329:13b: I-VI; RSA 151:13a and Bylaws Article IX, Section 9.2, and any corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the hospital and its Board of Directors when engaged in such professional review activities, and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

8. All requests for information concerning the practitioner under review shall be forwarded to the CEO for response.

9. Nothing in this policy precludes immediate referral to the Medical Executive Committee (or to the Board) or the elimination of any particular steps in the policy in dealing with conduct that may compromise patient care.

10. 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 investigation, hearing and appeal sections of those bylaws and policies, the provisions of this policy shall control.

Approved: MEC 8/8/00; BOD 10/31/00; 01/08/26 Amended: Bylaws 5/25/04; MEC 6/8/04, 10/14/08, 3/9/10; BOD 6/29/04, 10/28/08, 3/30/10

APPENDIX A
AUTHORIZATION AND RELEASE FOR DISCLOSURE OF INFORMATION

I hereby authorize St. Joseph Hospital (the "Hospital") to provide _____ [facility performing health assessment] (the "Facility") all information, written and oral, relevant to an evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow the Facility to conduct a full and complete evaluation of my health status so that the Hospital can determine if I am able to care for patients safely and competently.

I also understand that the information being disclosed is protected by the state peer review law and that the Hospital, the Facility, and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to that state law.

I release from any and all liability, and agree not to sue, the Hospital, or any of its officers, directors, employees or any physician on the Hospital's Medical Staff, or any authorized representative of the Hospital, for any matter arising out of the release of information by the Hospital to the Facility.

_____ _____

Date **Signature of Practitioner**

APPENDIX B

AUTHORIZATION FOR DISCLOSURE OF INFORMATION TO MEC OR PRACTITIONER HEALTH COMMITTEE

I hereby authorize [facility performing health assessment and/or practitioner overseeing treatment or treatment program] to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice to St Joseph Hospital ("the Hospital") and its Medical Executive Committee or Practitioner Health Committee, including the information requested on the attached Health Status Assessment Form.

I understand that the purpose of this Authorization is to allow the Hospital to obtain information that is relevant to my qualifications for Medical Staff appointment and clinical privileges, including but not limited to my ability to care for patients safely and competently and to relate cooperatively to others in the Hospital.

I understand that the willingness of [facility performing health assessment and/or practitioner overseeing treatment or treatment program] to conduct this assessment or provide treatment does not depend on my signing this Authorization.

I understand that my health information is protected by federal law and that, by signing this Authorization, the information will be disclosed to the parties hereby authorized to receive it and could be disclosed to other parties. However, I also understand that the information being disclosed is protected by state peer review laws and that [facility performing health assessment and/or practitioner overseeing treatment or treatment program] the Hospital, and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to those state laws.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that _____ [facility performing health assessment and/or practitioner overseeing treatment or treatment program] has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when [facility performing health assessment and/or practitioner overseeing treatment or treatment program] has knowledge of it.

This Authorization expires when my Medical Staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, [facility performing health assessment and/or practitioner overseeing treatment or treatment program] may no longer use or disclose my health information for the purpose listed in this Authorization unless I sign a new Authorization form.

_____ _____

Date **Signature of Practitioner**

APPENDIX C
RELEASE FROM LIABILITY

Pursuant to the attached Authorization, I have authorized _____ [facility performing health assessment and/or practitioner overseeing treatment or treatment program] to provide St. Joseph Hospital ("the Hospital") and its Medical Executive Committee and/or Practitioner Health Committee with information relevant to an assessment of my health or to my treatment and/or rehabilitation.

I also request the Hospital, its Medical Executive Committee, and/or its Practitioner Health Committee to provide [facility performing health assessment and/or practitioner overseeing treatment or treatment program] with any information which may support the need for a health assessment or be relevant to my treatment and/or rehabilitation.

I release from liability, grant absolute immunity to, and agree not to sue any individuals or entities authorized to provide information pursuant to this release and the attached Authorization.

_____ _____

Date **Signature of Practitioner**

CONFIDENTIAL PEER REVIEW DOCUMENT

Please respond to the following questions based upon your assessment of s current health status and ability to safely practice in the hospital. (If additional space is required, please attach separate sheet.)

1. Does have any physical, psychiatric, or emotional condition that could affect his/her ability to safely exercise the clinical privileges set forth on the attached list and/or to perform the duties of appointment, including responding to emergency call? Yes No

If yes, please provide the diagnosis/diagnoses and prognosis: _____

_____

2. Is currently taking any medication that may affect either clinical judgment or motor skills? Yes No

If yes, please specify medications and any side effects: _____

_____

3. Is currently under any limitations concerning activities or work load? Yes No

If yes, please specify: _____

_____

4. Is currently under the care of a practitioner? Yes No

If yes, please identify: _____

_____

5. In your opinion, is any accommodation necessary to permit to exercise privileges safely and/or to fulfill Medical Staff responsibilities appropriately? Yes No

If yes, please explain any such accommodation: _____

*If this form is being completed for an individual who participated in a substance abuse treatment program, please also answer the following questions:

6. Is _____ currently participating in a treatment or rehabilitation program? Yes No

If yes, explain terms of the treatment or rehabilitation program and 's compliance with them. _____

_____

7. Has _____ successfully completed a rehabilitation or treatment program? Yes No

If yes, please describe the program and _____'s participation and ability to resume a hospital practice:

_____

_____

8. Has an after-care program been recommended? Yes No

If yes, please describe: _____

_____

_____ _____

Date **Signature of Evaluator**

Enclosure: Delineation of Clinical Privileges

II: MEDICAL STAFF PROFESSIONAL DEVELOPMENT POLICY

PURPOSE

1. Medical Staff Professional Development and the Medical Staff's effort to improve the performance of hospital systems and personnel are actions taken for the purpose of improving patient care and are not merely actions taken for the purpose of accreditation or regulatory compliance. The goal is to ensure that patients receive care at or above generally accepted levels of safety, quality and efficiency.

1. Patient safety and quality outcomes are best ensured by the competent performance of teams of qualified professionals working in effective and efficient systems.

2. It is inevitable that people will make mistakes or experience misunderstandings in any work environment, including St. Joseph Healthcare. When events occur that cause harm or have the potential to cause harm to a patient or staff member, or that place the organization at legal, financial or ethical risk, a choice exists: To learn or to blame. At St. Joseph Hospital, we choose to learn. We are committed to creating a work environment that emphasizes learning rather than blame; that cares not only for our patients and their families but for our employees and Medical Staff as well.

3. The Medical Staff of St. Joseph receives and reviews data from a variety of sources for the purpose of identifying opportunities for improvement of patient care. The core of professional development is ongoing feedback of aggregated comparative performance data to promote voluntary evaluation of and improvement in practice patterns. Performance data needs to be current, relevant, and actionable to be of maximal use to systems, teams and individuals.

4. Retrospective or concurrent review of clinical experience on an individual case basis provides another means of learning from experience to ensure that both our delivery systems and professional performance remain at or above the current standard of care. The clinical course of individual cases is reviewed when there are concerns raised by individuals, groups or quality outcome monitors.

6. All information generated and/or communicated during the process of any stage of review under this Policy is considered to be confidential and privileged as "peer review" or "quality assurance" materials as defined under relevant federal and state laws.

METHOD

1. Performance data is compiled by the Quality and Resource Management Department at the direction of the VPMA, Department Chairs and Medical Staff officers. The rationale behind individual performance measures, benchmark data relevant to the measures and statistical analysis of the resulting data is provided by QRM at the direction of the VPMA.

2. Data is aggregated for presentation to the Medical Staff through its departments, committees and as a whole. Ongoing detailed comparative data is presented to all practitioners whose performance is measured. Comparative data is kept in practitioners' Medical Staff files. Any written comments from practitioners concerning such data is kept on file.

3. Individual cases are referred to QRM through various channels including but not limited to: Patient, family, employee or physician concerns; occurrence reports from Risk Management; Sentinel events; fall out from generic indicators or core measures; focused reviews; compliance issues; and professional liability actions. These cases are logged and tracked until the professional development process is completed or referred to the MEC.

4. Initial case review is completed by the QRM department. This may result in:

4.1. No further action if review adequately addresses the question or concern raised at the time of referral;

4.2. No physician review (documentation issues, failure to follow protocols) but automatic memo generated by QRM and signed by the VPMA to the practitioner and Medical Staff file;

4.3. Referral for physician review.

5. Cases referred for physician review will be directed by the VPMA, or President of the Staff, or President Elect to either:

5.1. Department Chair, designee or action committee for review and disposition;

5.2. Professional Development Committee (PDC);

5.3. MEC for critical situations;

5.4. Professional Health Committee when appropriate.

6. Cases referred to Department Chairs undergo preliminary review and findings. They are discussed with the physician whose care is under review if more information is required or if potential issues exist. Findings are forwarded to the PDC and may reflect:

6.1. No issue identified and no further review necessary;

6.2. Collegial intervention and action taken;

6.3. Refer to Professional Development Committee for further review. Notice of referral to PDC will be forwarded to the Physician whose care is under review if further review is necessary.

7. The PDC will seek further input from the physician whose care is under review and may seek further expert input from external review. The PDC may determine the following:

7.1. No further review required or action necessary;

7.2. Disagree with the preliminary findings and/or action and return the matter to the Department Chair with further instructions;

7.3. Take collegial intervention;

7.4. Develop performance improvement plan (PIP) with input form the Department Chair or designee or external expert as appropriate which might include: Focused retrospective review; additional education/CME; refrain from practicing until additional training complete; second opinions/consultation; concurrent monitoring/proctoring; participation in a formal evaluation/assessment program; educational LOA; conditional continued appointment;

7.5. Refer to MEC for appropriate action pursuant to bylaws/credentialing policy.

8. If the PDC develops a PIP, notice of the plan will be given to the physician whose care is being reviewed for voluntary acceptance of the plan by the physician. Physician's refusal of the PIP will result in referral to the MEC for appropriate action pursuant to the bylaws/credentialing policy.

9. Failure to cooperate with professional development or process improvement activities of the Medical Staff shall lead to automatic relinquishment of all clinical privileges and resignation from the Medical Staff.

10. Any questions, concerns or issues that involve hospital department procedures, systems or staff competency during any phase of the process of review, as described above, should be referred to QRM for appropriate follow-up and resolution.

Approved: BOD 3/27/07

III: MEDICAL STAFF ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY

PURPOSE

Ongoing Professional Practice Evaluation (OPPE) is a program designed to monitor the professional practice of Licensed Independent Practitioners and Advanced Dependent Allied Health Professionals on a continuous basis and to feed back comparative data on selected performance metrics to individual practitioners, Department Chairs and the practitioners' Medical Staff credentials file. Performance metrics are developed based on the six core competencies:

1. Patient care
2. Medical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. System-based practice

The data generated during performance review is used by the Department Chair and Medical Staff to provide practitioners with the opportunity for self-directed professional development and as a component of the credentialing process. It is a central element of the quality improvement efforts of the Medical Staff and is closely coordinated with the activities of the Professional Development Committee (PDC).

CONTENT

Performance metrics are related to either the process or the outcome of medical care delivery. Metrics will be reviewed periodically by the MEC for usefulness and appropriateness, with input from Department Chairs, the VPMA and appropriate professional and regulatory guidelines.

Some metrics will apply to most or all practitioners. Examples might include, but are not limited to:

1. Patient satisfaction scores;
2. Participation in process improvement projects when appropriate;
3. Timely and appropriate completion of medical records;
4. Length-of-stay and cost-of-care studies;
5. Mortality and complication rates;
6. Evidence of active practice of privileges for which the practitioner is credentialed;
7. Occurrence of complaints/never events/hospital-acquired conditions/quality case reviews;
8. Use of protocols such as DVT prophylaxis.

Other metrics will apply to practitioners based on specialty or department. Examples might include, but are not limited to:

1. OB – Data from Birth Log, SCIP data, infection rates, returns to the OR;
2. Surgery – SCIP data, infection rates, returns to the OR;
3. Medicine and Family Medicine – Core measure data on CHF, AMI and pneumonia;
4. Anesthesia – Data from anesthesia events log, moderate sedation outcomes, perioperative beta blocker use;
5. Pathology – Comparative results on biopsy findings;
6. Radiology – RadPeer studies, mammography studies;
7. Emergency Medicine – Core measure data, throughput measures;
8. Psychiatry – Staff satisfaction, record completion, call-back response;

PROCESS

The OPPE program is coordinated through the office of the Vice President of Medical Affairs (VPMA), which is responsible for data collection and presentation. Reports of professional performance are reviewed by the VPMA for completeness and integrity of the data, as well as to identify outliers or potential areas for improvement.

Copies of the data, with appropriate comments, are forwarded to the individual practitioner, Department Chair and credentials file and are included in the overall practitioner profile assembled at the time of reappointment.

Action plans for outliers will be developed by the Department Chair and the VPMA or President of the Medical Staff and will be reported to the PDC. Such action plans include:

1. No intervention if performance is deemed appropriate;
2. Collection of further focused data;
3. Collegial intervention with self correction and follow-up performance measurement;
4. Recommendations for further education or training;
5. Referral to the Professional Development Committee;
6. Referral to the Medical Executive Committee.

Approved: MEC 3/10/09, 01/08/26, BOD 3/31/09, 01/27/26

IV: MEDICAL STAFF FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY

PURPOSE

Focused Professional Practice Evaluation (FPPE) is a program designed to monitor the professional performance of individual Licensed Independent Practitioners (LIP) and Advanced Dependent Practitioners (ADP) in certain situations including:

1. Provisional periods;
2. If there is concern about individual performance;
3. If there is concern about the ability to monitor performance as part of Ongoing Professional Practice Evaluation (OPPE) due to low volume at St Joseph Hospital.

FPPE is a central element of the quality improvement efforts of the Medical Staff and is closely coordinated with the activities of the Professional Development Committee (PDC) and the Credentials Committee (CC).

CONTENT

Performance data, case reviews, complaints and professional evaluations by peers, supervisors, or co-workers form the basis for FPPE. Performance metrics may include but are not limited to those used in the OPPE program. Specific metrics based on the six core competencies (see OPPE Policy) may be developed by the MEC, Credentials Committee, Professional Development Committee, or Department Chair as appropriate for the individual undergoing focused review.

PROCESS

The FPPE will be coordinated by the office of the Vice President of Medical Affairs (VPMA). The Medical Staff Office (MSO) and the CC shall be principally responsible for those individuals with provisional privileges. Quality and Resource Management (QRM) and the PDC shall be principally responsible for other individuals.

Copies of performance data and case reviews will be sent to the individual practitioner, Department Chair, appropriate Medical Staff Committee and the credentials file. Professional evaluations and complaints shall be sent to the credentials file and be made available to the individual practitioner, Department Chair and Medical Staff Committees pursuant to the Medical Staff Policy governing access to the credentials file.

If professional performance is evaluated as appropriate by the Department Chair or appropriate Medical Staff Committee, then no intervention shall be necessary.

If professional performance is evaluated as inappropriate, action plans will be developed by the Department Chair or appropriate Medical Staff Committee with assistance from the VPMA or President of the Medical Staff and will be reported to the PDC. Such action plans include:

1. Collection of further focused data.
2. Collegial intervention with self correction and follow-up performance measurement
3. Referral to the Professional Development Committee for further action per the Professional Development Policy
4. Referral to the Medical Executive Committee

Approved: Creds 11/02/09; MEC 11/10/09, 01/08/26; BOD 11/24/09, 01/27/26

V: POLICY ON CONFIDENTIALITY OF MEDICAL STAFF RECORDS

PURPOSE

It is the policy of the hospital to maintain, to the fullest extent possible, the confidentiality of all Medical Staff records and all discussions relating to credentialing, performance improvement, and peer review activities. Confidentiality is critical to enhancing quality patient care and to the legal protections for the hospital and the Medical Staff members. Disclosure of any Medical Staff records, information, and/or communications is permitted only as described in this policy.

This policy shall apply to all records maintained by or on behalf of the Medical Staff of the hospital, including, but not limited to, the credentials and peer review files of individual practitioners, the records and minutes of all Medical Staff committees and departments, and the records of all Medical Staff credentialing, performance improvement, and peer review activities conducted under the authority of the hospital.

This policy shall also apply to any and all discussions and/or deliberations regarding credentialing, performance improvement, and peer review matters that take place in the course of Medical Staff committee and department meetings.

LOCATION AND SECURITY

1. All Medical Staff records shall be maintained in either the Medical Staff Office or the Quality Resource Management Office under the care and custody of the Directors of those departments and the Vice President for Medical Affairs. The Medical Staff Office and Quality Resource Management Office shall be kept locked except when the department directors, Vice President for Medical Affairs (or an authorized representative) is able to monitor access to Medical Staff records in accordance with this policy. Access to Medical Staff records shall be allowed only in accordance with this policy and after obtaining a signed confidentiality statement.

CONTENTS OF MEDICAL STAFF RECORDS

FILES OF INDIVIDUAL PRACTITIONERS

1. The credentials, performance improvement, and peer review file of each practitioner appointed to the Medical Staff of the hospital shall include, but not be limited to, the following:

A. Applications for appointment, reappointment, and requested changes in staff status or clinical privileges, with all attachments.

B. All information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, or changes in staff status or clinical privileges.

C. Results of queries to the National Practitioner Data Bank.

D. Any periodic review and appraisal forms completed by the appropriate department chief, including those completed at the time of appointment or reappointment.

E. Any performance improvement trend sheets data, and reports concerning the individual's practice at the hospital, including quality profiles.

F. Any routine correspondence between the hospital and the practitioner.

G. Information concerning the practitioner's meeting attendance record and compliance with other citizenship requirements.

H. Notations of telephone conversations concerning the practitioner's qualifications, including date of conversation, identification of parties to the conversation, and information received and/or discussed.

I. Any and all confidential correspondence from third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents provided by persons having knowledge or information concerning a practitioner's training, clinical practice, professional competence, or conduct at any other health care facility or medical school.

J. Any evaluations or reports from proctors or monitors and any written explanation submitted by the practitioner.

K. Any and all incident reports concerning the practitioner, which are placed into the file for trending purposes, along with any written explanation submitted by the practitioner.

L. Any confidential correspondence and/or memos to file, prepared pursuant to collegial intervention efforts with the practitioner.

M. Confidential reports and/or minutes (redacted) of peer review committees pertaining to the practitioner.

N. Any and all correspondence specifically relating to subparagraphs (h) through (m), including written explanations or rebuttals submitted by the practitioner.

O. Any correspondence setting forth formal Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements, or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the practitioner submits. The practitioner shall in all cases be permitted to submit a written rebuttal or explanation which shall also be maintained in the practitioner's file.

RECORDS OF MEDICAL STAFF COMMITTEES AND DEPARTMENTS

1. Minutes and related documents and reports of Medical Staff committees and departments shall be maintained in an orderly and easily accessible fashion in the Medical Staff Office under the custody of the Vice President of Medical Affairs.

2. Information contained in the minutes of committee and department meetings shall be limited to the following:

A. Date and name of body that is meeting.

B. List of those in attendance, those absent, and any guests or visitors.

C. Notation as to presence or absence of a quorum.

D. Notation that minutes of the previous meeting were read and approved.

E. Identification of any individual who abstained from participation in any action taken or recommendation made.

F. Recommendations or resolutions made or action taken.

3. Meetings shall not be tape-recorded (or otherwise mechanically or electronically preserved) unless specifically authorized by the Chief Executive Officer. If a tape recorder is used or notes are taken by the secretary to facilitate the preparation of minutes, such tape or notes shall be destroyed immediately after the official minutes are prepared, unless specifically directed otherwise by the Chief Executive Officer.

4. Minutes and reports of committees or departments shall be maintained in an especially confidential manner when they pertain to credentialing, performance improvement, or peer review matters.

These documents shall be marked "CONFIDENTIAL PURSUANT TO (State Peer Review Statute NH RSA 151:13-a)."

5. Minutes and related documentation containing confidential practitioner or patient specific identifying information shall not be routinely distributed to committee or department members in advance of meetings but shall be made available for their review in the Medical Staff Office, in accordance with the section of this policy entitled "ACCESS TO MEDICAL STAFF RECORDS."

Confidential documents that are distributed during the course of a committee or department meeting shall be identified to ensure that all copies are retrieved and destroyed at the conclusion of the meeting, with only the originals being kept as the official records.

ACCESS TO MEDICAL STAFF RECORDS

1. Any individual permitted access to any Medical Staff records under this Section shall be afforded a reasonable opportunity to inspect the records requested and to make notes regarding them, in the presence of the Vice President for Medical Affairs (or an authorized representative). In no case shall an individual remove the records (or portions thereof) from the Medical Staff Office or Quality Resource Management Office or make copies of them, without the express permission of the Vice President for Medical Affairs or the Chief Executive Officer.

ACCESS BY INDIVIDUALS PERFORMING OFFICIAL MEDICAL STAFF FUNCTIONS

1. The following individuals shall be permitted access to Medical Staff records to the extent described:

A. The Vice President for Medical Affairs, Medical Staff Office professional and Quality Resource Management personnel shall have access to all Medical Staff records as needed to fulfill their respective responsibilities.

B. Medical Staff officers shall have access to all Medical Staff records to the extent necessary for the performance of their duties.

C. Members of Medical Staff committees shall have access to the minutes and reports of the committees on which they serve and, when necessary to fulfill their responsibilities, to the credentials, performance improvement, and peer review files of individual practitioners.

D. Department Chairs shall have access to all Medical Staff records relating to the activities of individuals seeking or exercising privileges in the respective departments. Department chiefs shall also have access to the credentials, performance improvement, and peer review files of individual practitioners whose qualifications or performance is being reviewed.

E. Department members shall have access to the minutes (and related documents or reports) of meetings of the department to which they are assigned.

F. Consultants engaged by the hospital to assist a Medical Staff committee or department shall have access to the credentials, performance improvement, and peer review files of the practitioner being reviewed and to any other relevant Medical Staff records which are necessary to enable such consultants to perform their function.

G. The Director of Quality Resource Management shall have access to the minutes of all regular or Ad Hoc Medical Staff committee or department meetings and to any performance improvement or risk management information contained in Medical Staff records.

H. The Chief Executive Officer (or designee) shall have access to those Medical Staff records necessary for the performance of official functions.

ACCESS BY MEMBERS OF THE MEDICAL STAFF

1. CREDENTIALS, PERFORMANCE IMPROVEMENT AND PEER REVIEW FILES

A. A practitioner shall not have access to the credentials, performance improvement, or peer review files of other practitioners, except as described in Paragraph 8.

B. A practitioner shall routinely be permitted access to those items in his or her personal file that are identified in Paragraph 2(a) through (g) of this policy.

C. Access by a practitioner to additional information in his or her file shall be governed by the following:

(1) With respect to items regarding matters internal to the hospital, set forth in Paragraph 2(j) - (o), the practitioner shall have the opportunity to review these documents in the presence of the Vice President for Medical Affairs, an appropriate Medical Staff leader (e.g., Chief of Staff, Department Chair, Credentials Chair), and/or the Chief Executive Officer. At this meeting, the practitioner shall be shown the document (but shall not be provided with the identities of hospital employees involved, unless, in the discretion of those involved in the meeting, revealing their identities would be conducive to quality and performance improvement and would not result in adverse consequences to the hospital employee(s) or willingness of other employees to document incidents). The practitioner shall be given the right to submit a written explanation for inclusion in the file.

(2) With respect to items relating to matters external to the hospital (including Paragraphs 2(h) and (i)), practitioners shall not be told the identity of any individual outside the hospital who provided information, unless the individual providing such information or evaluation consents to the disclosure or this information is the basis for an adverse professional review action that entitles the practitioner to a hearing pursuant to the Medical Staff Bylaws, Credentials Procedures Manual and Rules and Regulations. However, the substance of the information contained in this documentation may be discussed with the practitioner and he/she shall be given the right to submit a written explanation for inclusion in the file.

2. MEDICAL STAFF COMMITTEE AND DEPARTMENT FILES

A. A member of the Medical Staff may have access to committee files (including minutes) of those committees on which he or she serves and to the minutes of meetings of the department to which he or she is assigned.

B. A member of the Medical Staff may have access to the files of committees or departments of which he or she is not a member only if, upon the individual's written request showing good cause, the Medical Executive Committee (or its designee) grants permission in writing for such access. Factors to be considered in making such determination include: The reason for the request, whether the requested information could be obtained in a less intrusive manner, whether the individual would suffer specific and significant adverse consequences absent the release of the information, whether access would inappropriately divulge confidential information concerning other members of the Medical Staff, whether the individual might further release the information, whether the information was originally obtained in specific reliance upon continued confidentiality, and whether a harmful precedent might be established by granting access.

ACCESS BY INDIVIDUALS OR ORGANIZATIONS OUTSIDE THE HOSPITAL OR MEDICAL STAFF

1. REQUESTS FROM OTHER HOSPITALS

A. If a practitioner has not been the subject of any recommendation or action set forth in Parts Six or Seven of the Credentials Procedures Manual, then the Vice President for Medical Affairs (or authorized representative), Chief Executive Officer (or designee), Chief of Staff, or Chairperson of the Credentials Committee may release information contained in that

practitioner's credentials, performance improvement, and peer review file in response to a request from another hospital, Medical Staff, or managed care organization.
Such request must be in writing and shall include the practitioner's authorization for the release of the requested information. Disclosure shall be limited to the information requested and shall be accompanied by a statement that the information is being provided with the expectation that the requesting entity will continue to maintain appropriate confidentiality.

B. If a practitioner has been the subject of any recommendation or action set forth in Parts Six or Seven of the Credentials Procedures Manual then no information shall be released upon request of another institution until the practitioner has provided the hospital with a specific, signed release deemed satisfactory by the hospital. All responses to such requests shall be reviewed and approved by the Vice President for Medical Affairs, Chief Executive Officer (or designee), and/or President of the Medical Staff, who may consult with hospital legal counsel.

2. REQUESTS FROM HOSPITAL SURVEYORS

A. Requests for records covered by this policy from hospital surveyors from The Joint Commission (TJC), the AOA, the Federal Health Care Financing Administration, and/or the state Department of Health shall be immediately referred to the Chief Executive Officer for further disposition in accordance with applicable laws, regulations, and/or accreditation standards.

B. Under no circumstances shall original or photocopied records be removed from the hospital's premises, unless there is shown to be explicit statutory or regulatory authority to the contrary, which authority has first been reviewed by legal counsel.

3. REQUESTS FROM STATE PROFESSIONAL BOARDS

State law permits the State Medical Board, the State Board of Dental Examiners, and other state professional licensing boards to subpoena Medical Staff records concerning individual practitioners on the Medical Staff of the hospital. Hospital legal counsel (or designee) must review the subpoena and approve release of the requested records before access is granted. Disclosure shall be limited to the information requested.

4. SUBPOENAS

All subpoenas pertaining to Medical Staff records shall be referred to the hospital legal counsel (or designee) who may first consult with the VPMA, Medical Staff President and/or Chief Executive Officer regarding the appropriate response.

5. OTHER REQUESTS

All other requests for Medical Staff records (or portions thereof) by persons or organizations outside the hospital shall be reviewed by hospital legal counsel and the Vice President for Medical Affairs or the Chief Executive Officer (or designee). The release of any information may be conditioned upon approval by the Medical Executive Committee and/or the hospital Board of Directors.

CORRECTIONS OR DELETIONS OF MEDICAL STAFF RECORDS

6. CREDENTIALS, PERFORMANCE IMPROVEMENT AND PEER REVIEW FILES OF PRACTITIONERS

The Vice President for Medical Affairs (or authorized representative) shall correct or delete materials contained in a practitioner's credentials, performance improvement, and peer review file only after the practitioner has submitted a written request demonstrating good cause for the correction or deletion and that request has been approved by the Medical Executive Committee and the Chief Executive Officer (or designee).

7. MEDICAL STAFF COMMITTEE AND DEPARTMENT RECORDS

Any corrections, deletions, or omissions noted prior to the approval and adoption of Medical Staff committee or department minutes shall be made in the minutes prior to signature by the authorized

Medical Staff officer. Subsequent to formal adoption of the minutes, corrections or deletions may be made only by means of an addendum to the minutes.

8. **SANCTIONS**

All suspected breaches of confidentiality or other violations of this policy by a member of the Medical Staff shall be reported to the Medical Executive Committee. The Medical Executive Committee, or an ad hoc committee appointed by the Medical Executive Committee, shall conduct a prompt investigation and determine if there has in fact been a violation of any of the provisions of this policy. If it is determined that a violation has occurred, the committee shall, depending on the nature and severity of the violation:

A. Issue a letter of guidance, warning or reprimand;

B. Remove the individual from the committee assignment and/or Medical Staff Office; and/or

C. Recommend more severe disciplinary action in accordance with the Medical Staff Bylaws and/or Credentials Procedures Manual, which may include a recommendation to revoke the Medical Staff appointment and clinical privileges of the individual found to have violated the policy.

9. Any practitioner found to have violated this policy also risks loss of available legal protections (including loss of indemnification for any litigation costs and expenses).

10. All suspected violations of this policy by an employee of the hospital shall be referred to the Chief Executive Officer (or designee) for review and appropriate action pursuant to the personnel policies of the hospital.

APPENDIX A – CONFIDENTIALITY STATEMENT

While serving on and/or assisting Committee(s), I recognize that I may have access to confidential information, including but not limited to:

A. Information pertaining to other practitioners obtained or generated through the peer review, corrective action, credentialing, appointment/reappointment process;

B. Information pertaining to the financial or proprietary interests of the Hospital; and

C. Information pertaining to the Hospital's strategic planning and/or marketing efforts.

I hereby promise not to disclose any such confidential information to anyone except as permitted by the Bylaws and related manuals, policies, procedures, rules and regulations of the Medical Staff and the Hospital or as otherwise required by law. Furthermore, I agree to indemnify and hold harmless the Hospital, its officers, employees and agents for any and all costs, expenses, suits, actions, damages and fines arising by reason of my unauthorized release or dissemination of confidential information. Lastly, I understand that my unauthorized release or dissemination of confidential information may subject me to corrective action pursuant to the Medical Staff policies.

_____ _____

Signature Date

_____ _____

Print Name

APPENDIX B - CONFIDENTIALITY STATEMENT AND NOTIFICATION STATEMENT FOR SURVEYORS

(To be signed by surveyors to whom Medical Staff records will be disclosed.)

I have requested that I be allowed to inspect Medical Staff credentialing, peer review, or performance improvement records at St. Joseph Hospital Nashua, NH.

In recognition of the St. Joseph Hospital policy on confidentiality, the importance of confidentiality to the performance of effective credentialing, performance improvement, and peer review, and the fact that the information in these records was generated in reliance upon that confidentiality, I understand that I am expected:

A. To preserve the confidentiality of those records to the fullest extent allowed by law, disclosing that information only as absolutely necessary for completion of the survey/review process; and

B. To notify St. Joseph Hospital prior to the further disclosure of that information outside of the survey process, whether pursuant to a subpoena or otherwise, and to cooperate with any efforts of the hospital to contest that disclosure.

Signature Date

_____ _____

Print Name and Title

APPENDIX C – CONFIDENTIALITY STATEMENT STAFF RECORD REVIEW

While reviewing my own Medical Staff record, I recognize:

A. Information pertaining to other practitioners obtained or generated through the peer review, corrective action, credentialing, appointment/reappointment process;

B. Information pertaining to the financial or proprietary interests of the Hospital; and

C. Information pertaining to the Hospital's strategic planning and/or marketing efforts.

I hereby promise not to disclose any such confidential information to anyone except as permitted by the Bylaws and related manuals, policies, procedures, rules and regulations of the Medical Staff and the Hospital or as otherwise required by law. Furthermore, I agree to indemnify and hold harmless the Hospital, its officers, employees and agents for any and all costs, expenses, suits, actions, damages and fines arising by reason of my unauthorized release or dissemination of confidential information. Lastly, I understand that my unauthorized release or dissemination of confidential information may subject me to corrective action pursuant to the Medical Staff policies.

_____ _____

Signature Date

_____ _____

Print Name

VI: MEDICAL STAFF CODE OF CONDUCT POLICY

A. Policy Statement

1. This policy emphasizes the need for all individuals working in the Hospital to treat others with respect, courtesy and dignity and to conduct themselves in a professional and cooperative manner. This policy is intended to address conduct which does not meet that standard. In dealing with incidents of inappropriate conduct, the protection of patients, employees, physicians and others in the Hospital and the orderly operation of the Hospital are paramount concerns. This policy applies to members of the Medical Staff and to Allied Health Professionals.

2. For purposes of this policy, "inappropriate conduct" includes, but is not limited to those behaviors which create a hostile work environment and is regularly upsetting to Hospital staff, other physicians, visitors and patients or otherwise impairs the confidence of the community in the Hospital. Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats as well as passive activities, such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Such behaviors include reluctance or refusal to answer questions, phone calls or pages; condescending language or voice intonation; and impatience with questions.

3. Employees who engage in inappropriate conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Members of the Medical Staff and Allied Health Professional Staff ("practitioners") who engage in inappropriate conduct will be dealt with in accordance with this policy.

4. Conduct that may constitute sexual harassment shall be addressed pursuant to the Hospital's Sexual Harassment Policy.

5. In the event of any apparent or actual conflict between this policy and the bylaws, rules, regulations or other policies of the Hospital or Medical Staff, the provisions of this policy shall control.

6. This policy outlines collegial steps (i.e., several warnings and meetings with a practitioner) that can be taken in an attempt to resolve complaints about inappropriate conduct exhibited by practitioners. However, there may be a single incident of inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in this policy precludes immediate referral to the Executive Committee (or the Board) or the elimination of any particular step in the policy in dealing with a complaint about inappropriate conduct.

7. Retaliation against any person reporting an incidence of inappropriate conduct will be grounds for immediate exclusion from all Hospital facilities.

B. Procedure

1. Nurses and other Hospital employees who observe, or are subjected to inappropriate conduct by a practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, they shall notify the Chief Executive Officer (or designee). Any physician who observes such behavior shall notify the Chief Executive Officer, President of the Medical Staff or VP Medical Affairs directly. Upon learning of the occurrence of an incident of inappropriate conduct, the supervisor /Chief Executive Director shall request that the individual who reported the incident document it in writing. In the alternative, the supervisor/Chief Executive Director shall document the incident as reported.

2. The documentation shall include:

(a) the date and time of the questionable behavior;

(b) a factual description of the questionable behavior;

(c) the name of any patient or patient's family member who witnessed the incident;
(d) the circumstances which precipitated the incident;
(e) the names of other witnesses to the incident;
(f) consequences, if any, of the inappropriate conduct as it relates to the patient care, personnel, or Hospital operations; and
(g) any action taken to intervene in, or remedy, the incident.

3. The supervisor shall forward a documented report to the Chief Executive Officer or Vice President of Medical Affairs, who shall immediately notify the President. The Chief Executive Officer and the President shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident. After a determination that an incident of inappropriate conduct has occurred, the President, VPMA and/or Chief Executive Director shall proceed as set forth in Paragraph 4.

4. The President and/or Chief Executive Officer (or their respective designees) shall meet with the practitioner. This initial meeting shall be collegial. It is designed to be helpful to the practitioner in understanding that certain conduct is inappropriate and unacceptable. During the meeting, the practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident. The practitioner shall also be advised that, if the incident occurred as reported, his or her conduct was inappropriate and inconsistent with standards of the Hospital. The identity of the individual preparing the report of inappropriate conduct will not be disclosed at this time, unless the Chief Executive Officer and the President agree in advance that it is appropriate to do so. In this case, the practitioner shall be advised that any retaliation against the person reporting the incident will be grounds for immediate exclusion from all Hospital facilities.

5. This initial meeting can also be used to educate the practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling can also be identified for the practitioner, as appropriate.

6. The practitioner shall be advised that a summary of the meeting will be prepared and a copy provided to him or her. The practitioner may prepare a written response to the summary. The summary and any response that is received shall be kept in the confidential portion of the physician's credentials file.

7. If another report of inappropriate conduct involving the practitioner is received, a second meeting shall be held. It is advisable that at least three people (e.g., President, Department Chairman, VPMA, and/or the Chief Executive Officer) be present to meet with the practitioner. At this meeting, the practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The practitioner shall be advised that if there is a future complaint about inappropriate conduct, the matter will be referred to the Board Chair or to the Medical Staff Executive Committee for more formal actions. A letter shall be sent to the practitioner confirming the substance of the meeting, a copy of which shall be kept in the confidential portion of the physician's credentials file (along with any response that the practitioner may submit).

8. In the event there is a third reported incident of inappropriate conduct, the Board Chair, the Chief Executive Officer, and the President (a designee may be asked to attend this meeting for any of the above individuals) shall meet with the practitioner. The purpose of this meeting is to give the practitioner a final warning that the inappropriate conduct will not be tolerated.

9. Following this meeting, a letter shall be sent to the practitioner. The letter shall describe the inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm the consequences of an additional incident of inappropriate conduct, including, but not limited to, exclusion from all Hospital facilities for a period of time and a request that a formal investigation be commenced pursuant to the Medical Staff Bylaws.

10. The letter described in Paragraph 9 will define the conditions of continued practice at the Hospital. The practitioner shall be required to sign it. If the practitioner refuses to sign the letter, the Chief Executive Officer and/or President shall request that a formal investigation be commenced pursuant to the Medical Staff Bylaws.

11. A single additional incident shall then result in initiation of formal action pursuant to the Medical Staff Bylaws (or other consequence as may be indicated in the letter to the practitioner). Exclusion from the Hospital's facilities may be appropriate pending this process. The Medical Staff Executive Committee shall be fully apprised of the previous warnings issued to the physician and the actions taken to address the concerns.

12. The Medical Staff Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including any hearing or appeal, shall then be conducted under the direction of the Board.

13. As referenced in Paragraphs 9 and 11, when, despite prior warning, the practitioner continues to engage in inappropriate conduct, the practitioner may be excluded from the Hospital's facilities pending the formal investigation process pursuant to the Medical Staff Bylaws and any related hearing and appeal that may result. Such exclusion is not a suspension of clinical privileges, even though the effect is the same. Rather, the action is taken to protect patients, employees, physicians and others on the Hospital's premises from inappropriate conduct and to emphasize to the practitioner the most serious nature of the problem created by such conduct. Before any such exclusion, the practitioner shall be notified of the event or events precipitation the exclusion and shall be given an opportunity to respond in writing and to demonstrate that acceptable standards of conduct have not been violated. However, to ensure that there is not inappropriate delay in addressing the concerns, the practitioner must submit any response within three (3) days of being notified.

14. In order to effectuate the objectives of this policy, and except as otherwise may be determined by the Chief Executive Officer and the President, counsel shall not attend any of the meetings described above.

Approved: MEC 03/14/2000, BOD: 03/28/2000
Revised: Cred 1/5/09, MEC 1/13/09, BOD 1/27/09

VII: FAILURE TO COMPLY WITH CORPORATE COMPLIANCE POLICY

POLICY

All members of the Medical Staff must comply with the Hospital's Organizational Integrity (OI) Education Policy. Upon initial appointment, the OI policy requires an initial signature confirming delivery of the Standards of Conduct booklet and return of the Organizational Integrity Program Acknowledgement Form to the Medical Staff Office. At the time of reappointment (every two years), a signed compliance acknowledgment form returned to the Medical Staff Office.

PROCEDURE

NEW APPLICANTS

1. Upon initial application to the Medical Staff, the applicant will receive the Organizational Integrity booklet and acknowledgement form. The applicant will have 30 days to review the booklet and return the acknowledgement form to the Medical Staff Office. The acknowledgement form will remain a permanent part of the applicant's file.

2. The application will be considered incomplete until such time that the form is received. A "Missing Info" letter will be sent once during the application process. It is the applicant's responsibility to ensure the completeness of his/her file in order for them to start the credentialing process.

MEDICAL STAFF MEMBERS/REAPPOINTMENT

1. All reappointments will require attestation of OI CME and completion by signing the OI Program Acknowledgement Form. The Medical Staff Office will send a notice of any deficiency in the reappointment application to members of the Medical Staff and allied health professionals prior to reappointment. If such documentation is not received prior to reappointment, then any reappointment granted will be conditional upon receipt of the required documentation within 90 days from the time of reappointment. After 60 days, the Medical Staff member/allied health professional will receive a certified letter warning that he has 30 days to attest OI compliance. If attestation of OI compliance is still delinquent at 90 days, the Medical Staff member/allied health professional will undergo automatic administrative resignation.

Approvals: MEC 01/08/2002, BOD 01/29/2002 Revised: 11/28/2003

ADOPTION AND APPROVAL OF RULES AND REGULATIONS DOCUMENT

Bylaws: 01/24/2003	MEC: 02/11/2003	BOD: 02/25/2003

AMENDMENTS AND APPROVAL OF RULES AND REGULATIONS DOCUMENT

Bylaws: 09/05/2003	MEC: 10/07/2003	BOD: 10/28/2003
Bylaws: 02/03/2004	MEC: 2/10/2004	BOD: 2/24/2004
Bylaws: 05/25/2004	MEC: 6/08/2004	BOD: 6/29/2004
Bylaws: 02/15/2005	MEC: 3/08/2005	BOD: 3/29/2005
Bylaws: 02/14/2007	MEC: 3/13/2007	BOD: 3/27/2007
	MEC: 4/10/2007	BOD: 4/30/2007
Bylaws: 11/01/2007	MEC: 11/13/2007	BOD: 11/27/2007
	MEC: 3/11/2008	BOD: 3/25/2008
	MEC: 5/13/2008	BOD: 5/27/2008
	MEC: 10/14/2008	BOD: 10/28/2008
	MEC: 1/13/2009	BOD: 1/27/2009
Bylaws: 2/26/2009	MEC: 3/10/2009	BOD: 3/31/2009
	MEC: 4/14/2009	BOD: 4/28/2009
Bylaws: 4/29/2009	MEC: 11/10/2009	BOD: 11/24/2009
	MEC: 1/12/2010	BOD: 1/26/2010
	MEC: 3/9/2010	BOD: 3/30/2010
	MEC: 10/12/2010	BOD: 10/26/2010
Bylaws: 10/25/2011	MEC: 11/08/2011	BOD: 11/29/2011
	MEC: 5/8/2012	BOD: 5/29/2012
Bylaws: 6/20/2012	MEC: 7/10/2012	BOD: 8/7/2012
	MEC: 8/14/2012	BOD: 9/25/2012
Bylaws: 10/01/2012	MEC: 11/13/2012	BOD: 11/27/2012
Bylaws: 4/2013	MEC: 5/14/2013	BOD: 6/25/2013
Creds: 1/6/2015	MEC: 1/13/2015	BOD: 2/03/2015
	MEC: 11/12/2020	BOD: 11/17/2020
	MEC: 09/09/2021	BOD:09/28/2021
	MEC: 07/13/2023	BOD: 7/25/2023
	MEC: 01/08/2026	BOD: 01/27/2026

Approvals: MEC 01/08/2002, BOD 01/29/2002 Revised: 11/28/2003