



**BYLAWS RULES AND REGULATIONS  
OF THE MEDICAL STAFF**

**July 19, 1979**

**Recent Bylaws Board Approved Changes November 23, 2016**

**Recent Medical Staff Rules and Regulations/Appendices Board  
Approved Changes January 18, 2017**

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**BYLAWS OF THE MEDICAL STAFF  
OF SHADY GROVE MEDICAL CENTER  
PREAMBLE**

WHEREAS, Shady Grove Medical Center is a nonprofit corporation organized under the laws of the State of Maryland; and

WHEREAS, its purpose is to serve as a general Hospital providing patient care, education and research;

WHEREAS, the Medical Staff is organized in a manner approved by the Governing Board; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Board, and that the cooperative efforts of the Medical Staff, the Hospital's President and the Governing Board are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the Physicians, Dentists and Podiatrists practicing in this Hospital hereby organize themselves into an operating organization within the legal structure of the Hospital, known as the "Medical Staff" in conformity with these Bylaws.

**MEDICAL STAFF STRUCTURE**

The organized Medical Staff is structured using the following guiding principles:

- Single organized Medical Staff.
- Designated members of the organized medical staff who have independent privileges provide oversight of care, treatment and services provided by practitioners with privileges.
- The organized Medical Staff is responsible for structuring itself to provide a uniform standard of quality, treatment, and services.
- The organized medical staff is accountable to the Governing Board.
- Applicants for privileges need not necessarily be members of the Medical Staff. (i.e. Allied Health Professionals)

Self governance of the organized Medical Staff includes the following and is located in the medical staff's bylaws:

- Initiating, developing, and approving medical staff bylaws and rules and regulations.
- Approving or disapproving amendments to the medical staff bylaws and rules and regulations.
- Selecting and removing medical staff officers.
- Determining the mechanism for establishing and enforcing criteria and standards for medical staff membership.
- Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to Members with independent privileges.
- Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges.
- Engaging in performance improvement activities.

The organized Medical Staff has a leadership role in organization-wide performance improvement activities to improve quality of care, treatment, and services and patient safety including, but not limited to:

- Measuring, assessing and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process.
- Medical assessment and treatment of patients.
- Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process.
- Use of medications.
- Use of blood and blood components.
- Operating and other procedure(s).
- Appropriateness of clinical practice patterns.
- Significant departures from established patterns of clinical practice.
- The use of developed criteria for autopsies.
- Sentinel event data.
- Patient safety data.
- Participates in education of patients and families
- Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient.

## MEDICAL STAFF STRUCTURE (con't)

- Accurate, timely, and legible completion of patient's medical records.
- Review findings of the assessment process that are relevant to an individual's performance including determining the use of this information in the ongoing evaluations of the practitioner's competence.
- Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

## DEFINITIONS

For purposes of these Bylaws:

- A. **Allied Health Professional Staff** means those members admitted to the Allied Health Professional Staff (AHPs).
- B. **Bylaws** means these Medical Staff Bylaws, including the Credentialing Manual and any and all duly adopted Rules and Regulations and policies, as such shall be amended from time to time.
- C. **Hospital's President or Administrator** means the individual appointed by the Governing Board to act in its behalf in the overall management of the Hospital. The Hospital President may appoint a designee to act on his or her behalf with regard to any actions taken within the Medical Staff Bylaws.
- D. **Credentialing Manual** means the Manual, as duly adopted and approved by the Credentials Committee, Executive Committee, and Governing Board, and as may be amended from time to time, which describes the process whereby Members attain membership on the Medical Staff and are granted clinical privileges at the Hospital.
- E. **Executive Committee** means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Board.
- F. **Governing Board** means the Governing Board of the Hospital.
- G. **Hospital** means Shady Grove Medical Center, Incorporated, a Maryland nonprofit corporation.
- H. **Medical Staff** means all Members of the Physician, Dental and Podiatry Staff.
- I. **Director of Medical Staff Services** means the individual employed by the Hospital to serve as secretary to the Medical Staff in support of its day-to-day organizational functions. The **Director of Medical Staff Services** may appoint a designee to act on his or her behalf with regard to any actions taken within the Medical Staff Bylaws.
- J. The **Medical Staff Year** commences on the first day of January and ends on the thirty-first day of December of each year.
- K. **Member** means any Member (unless the context of these Bylaws requires otherwise), possessing Medical Staff membership and clinical privileges in the Hospital pursuant to these Bylaws.
- L. The term **Physician** refers to an appropriately licensed medical physician, osteopathic physician or qualified oral and maxillofacial surgeon.
- M. **Physician Staff** means those Physicians admitted to the Medical Staff.
- N. **Member** means an appropriately licensed Physician, Dentist or Podiatrist.
- O. **State** means the State of Maryland.
- P. **Peer** means a licensed Member with similar ABMS Board Certification or a member of the medical staff.
- Q. **Medical Staff Leadership** means the President of the Medical Staff, Vice President of the Medical Staff, Secretary/Treasurer of the Medical Staff and the Past President of the Medical Staff. Any one of the Medical Staff Leadership may appoint another Medical Staff Leader listed here as their designee to act on his or her behalf with regard to any actions taken within the Medical Staff Bylaws.

**ARTICLE I  
NAME**

The name of this organization shall be the "Medical Staff" of Shady Grove Medical Center, Incorporated. It may also be referred to herein as the "Medical Staff". It shall not be deemed to be a legal entity separate and distinct from the Hospital.

**ARTICLE II  
PURPOSES**

The purposes of this organization are:

- A. To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive the best possible care which meets or exceeds the standard of care in the community;
- B. To provide a mechanism to ensure a uniform standard of quality patient care, treatment and services and be accountable to the Governing Board for such;
- C. To ensure appropriate levels of professional performance of all Members through the appropriate delineation of the clinical privileges that each Member may exercise in the Hospital and through an ongoing review and evaluation of each Member's performance in the Hospital;
- D. To provide an appropriate educational setting that will maintain appropriate scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- E. To initiate and maintain rules and regulations for self-governance of the Medical Staff; and
- F. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Board and the Hospital's President.

**ARTICLE III  
MEDICAL STAFF MEMBERSHIP**

The provisions of this Article III, formerly set forth in detail in these Bylaws, are now found in the Credentialing Manual. Those provisions addressed in the Credentialing Manual include the conditions and duration of appointment.

**ARTICLE IV  
CLINICAL PRIVILEGES**

The provisions of this Article VI, formerly set forth in detail in these Bylaws, are now found in the Credentialing Manual. Those provisions addressed in the Credentialing Manual include:

- a) the determination of clinical privileges
- b) any changes in Medical Staff category, clinical privileges, and clinical department or section;
- c) Medico-Administrative Officers
- d) Limitation of Inpatient Admitting Privileges for Hospital-Based Physicians
- e) Proctoring
- f) Mentoring

**ARTICLE V**  
**MEMBERSHIP QUALIFICATIONS AND CREDENTIALING PROCESS**

**Section 5.1: Nature of Medical Staff Membership**

Membership on the Medical Staff of the Hospital is a privilege, not a contractual right, which shall be extended only to professionally competent health care professionals who continuously meet the qualifications, standards and requirements set forth in the Bylaws. No health care professional shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice his or her profession in this State or in any other state, or that he or she is a member of any professional organization, or that he or she has in the past had, or presently has, such privileges at another hospital.

**Section 5.2: General Qualifications for Membership**

**5.2-1 Minimum Qualifications:** Each applicant and Member of the Medical Staff shall document his or her continuous compliance with the following minimum qualifications with sufficient adequacy to assure the Medical Staff and the Governing Board that any patient he or she treats in the Hospital will receive medical care of the type generally recognized by the Hospital as an acceptable level of professional quality and efficient care. Each such applicant or Member shall demonstrate that he or she at least:

- A. Possesses a current, unrevoked and unsuspended license to practice his or her profession in this State of Maryland as a MD, DO, DDS, DMD, DPM; or an Allied Health Practitioner with a sponsoring/collaborating physician who is on staff here at Shady Grove Medical Center.
- B. Is in sufficiently good physical and mental health;
- C. Has sufficient academic background, clinical experience and professional training;
- D. Has current clinical and technical competence, as demonstrated by experience in the management of patients representative of those admitted to this Hospital;
- E. Adheres to the ethics of his or her profession;
- F. Possesses good reputation and professional character;
- G. Works harmoniously with other professionals and Hospital personnel and interacts appropriately with such persons, as well as with patients and the general public;
- H. Agrees to accept and complete all Medical Staff responsibilities;
- I. Does not support, practice, or claim to practice any exclusive or sectarian system of medicine;
- J. Has established or will have established by the time the applicant or Member is approved for membership, a bonafide medical office within Montgomery County or Frederick County, Maryland limited to 15 miles North of the Montgomery County/Frederick County borderline. This requirement applies to all applicants who intend to become Members of the Medical Staff excluding Consultants, Emeritus without privileges staff, Community Staff and Telemedicine Physicians.
- K. Meets the requirement for membership in the department which he or she intends to join;
- L. Except as may be permitted by departmental rules and regulations or otherwise specifically provided for in the Bylaws, possesses Active Candidate Status or board certification by a specialty board which is a member of the American Board of Medical Specialties for the applicant's or Member's practice area, or has completed an approved residency training program within the past two years;
- M. Has performed adequately as a member of the medical staff at other hospitals or health care facilities, if the applicant or Member has held such other membership;
- N. Two professional or peer references, with being a non-associate/employee/partner and who is qualified to verify the applicant's training, professional competence, ethical character and experience in the requested delineation of privileges. These references/recommendations include the general competencies developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiatives:
  - a. Patient Care
  - b. Medical/Clinical Knowledge
  - c. Practice-based Learning and Improvement
  - d. Interpersonal and Communication Skills
  - e. Professionalism



f. System-based Practice  
5.2-1 Minimum Qualifications (con't)

Providers with Active status are not required to have professional or peer references.

- O. Provides sufficient documentation of pending and past liability claims, any settlements or monetary payments made, and any denials or cancellations of any professional liability insurance policy;
- P. Provides acceptable responses to such other items of information or inquiry which may be contained on the application for initial appointment or reappointment;
- Q. Fulfills the medical staff's continuing medical education requirements and agrees to abide by Maryland State Law regarding Continuing Medical Education (CME) requirements;
- R. Agrees to provide for the continuous care of his or her patients;
- S. Agrees to cooperatively participate in the Hospital's Case Management (CM) Program;
- T. Providers must provide the following based on the recommendation Center of Disease Control (CDC) for positive or negative TB.
  - a) Newly credentialed providers with a history of Negative Tuberculosis Skin Test (TST) will receive a TST at the Adventist HealthCare entity accordingly (or) provide proof of a TST within 1 year of the application date.
  - b) Current Providers with a known Negative Tuberculosis Skin Test will receive a TST every other year and will complete a Tuberculosis Symptom Screening Survey every other year (opposite the TST).
  - c) Newly credentialed providers with a history of Positive Tuberculosis Skin Test will receive baseline Interferon Gamma Release Assay and will receive baseline chest x-ray or provide a chest x-ray within 90 days of the application date.
  - d) Current providers with a history of Positive Tuberculosis Skin Test will receive baseline Interferon Gamma Release Assay if not already on file and will complete a Tuberculosis Symptom Screening Survey annually
  - e) Testing is provided by the hospital's Occupational Health Department.
  - f) Occupational Health does not obtain copies of test results. Please keep copies for your file and future reference.
- U. Possesses a current, unrevoked and unsuspended Drug Enforcement Administrative Certificate (DEA) and Controlled Drug Substance Certificate (CDS). There are situations such as in the Departments of Radiology and Pathology that this requirement may be waived; and. Military providers are not required to obtain a Maryland CDS as members of the military. They are permitted to write prescriptions in all 50 states and territories within the United States. They are required to have a Federal DEA certificate. Emeritus w/o Privileges, Community Staff and Telemedicine Providers are not required to have a current CDS or DEA.
- V. Must not be excluded from participation in Medicare or Medicaid programs. Exclusion would prohibit appointment or reappointment to the Medical or AHP staff at Shady Grove Medical Center.
- W. Agrees to respond in writing and completely within 14 days to any hospital related inquiry including but not limited to patient complaints, peer review concerns or any physical, behavioral or clinical care concerns.
- X. Agrees to provide and maintain a working e-mail address to allow for ongoing Hospital and Medical Staff communication and all other correspondence.

**5.2-2 Additional Qualifications:** In addition to the minimum requirements set forth in Section 2.2-1, all applicants for reappointment shall demonstrate satisfactory compliance with the following additional qualifications:

- A. Compliance with Hospital policies and Bylaws;
- B. Acceptance of committee assignments;
- C. Acceptable coverage of emergency room and special care unit assignments;
- D. Appropriate levels of use of the Hospital's facilities for care rendered to the Member's patients; and
- E. Attendance at meetings when requested by the Medical Executive Committee.

**5.2-3 Equal Opportunity:** No professional who is otherwise qualified shall be denied privileges because of race, color, creed, age, sex, marital status, religion, disability, sexual orientation or national origin or other legally protected category including patient type (i.e. Medicaid) in which the practitioner specializes. The Medical Staff Office will monitor and track any complaints received and review this information at least annually. We accept all applications as long as they meet our criteria for membership and privileges.

**5.2-4 Professional Liability Insurance:** Applicants for membership to the Medical Staff shall present written evidence of an insurance certificate and any and all endorsements relating to the policy which indicate adequate and continuous professional liability insurance (including "tail" or "prior acts" coverage) in the required minimum amount of \$1,000,000 each claim/\$3,000,000 annual aggregate limitation for privileges granted at Shady Grove Medical Center. The Member must state in the application that he or she will notify the Medical Staff Coordinator when he or she or his or her carrier cancels or does not renew for any reason a claims-made or occurrence policy and that he or she will purchase the tail coverage or show proof that the new carrier is providing prior acts coverage. All such coverage must exist through a company authorized to issue policies in Maryland. Additionally, the member must inform the Medical Staff Coordinator when they limit their professional liability insurance coverage, i.e. minor surgery or Gyn only.

**5.2-5 Membership Appointment Procedure**

1. Submit Application for privileges in person and show driver's license for verification of identity or mail in the application with the identification verification form notarized.
2. Submit signed Delineation of Privileges form (except those applying for Emeritus or Community Staff Status (without clinical privileges).
3. Be recommended by the subsection and/or Department Chair after completion of appointment application and review of supporting documentation.
4. Be recommended by the Vice President, Medical Staff and/or President, Medical Staff, and Hospital President.
5. Be recommended by the Credentials Committee.
6. Be recommended by the Medical Executive Committee and approved by the Governing Board.
7. Meet, and continue to meet, the standards and requirements set forth in the Medical Staff Bylaws.
8. Professional and Peer recommendations shall be a part of the basis for the development of recommendations for membership and individual clinical privileges. These recommendations include written information regarding the practitioner's current:
  - a. Medical/Clinical Knowledge
  - b. Technical and Clinical Skills
  - c. Clinical Judgment
  - d. Interpersonal Skills
  - e. Communication Skills
  - f. Professionalism
10. Complete Orientation prior to obtaining temporary privileges and/or Board approval.
11. Demonstrate competency in the use of the electronic health record by completing any and all required electronic medical record training and testing prior to obtaining temporary privileges (except those applying for Community Status).

**Section 5.3: Special Qualifications for Membership**

In addition to the general qualifications for membership outlined in Sections 5.2-1 and 5.2-2 above, all applicants and Members so indicated shall meet the following additional qualifications:

**5.3-1 Oral and Maxillofacial Surgeons and Dentists:** All Medical Staff members who meet the requirements of this Sections 5.2-1 and 5.2.2 above shall be assigned to the Department of Surgery, Section of Oral and Maxillofacial Surgery, Section of General Dentistry and shall comply with the Rules and Regulations of that Department and Section. All qualified general dentists, pedodontists, periodontists, prosthodontists, orthodontists, and oral pathologists will be eligible for membership on the Medical Staff.

A. Qualified oral and maxillofacial surgeons will be eligible for membership on the Physician Staff, holding the same rights and privileges as medical and osteopathic Physicians, including admitting patients on their own service and performing history and physical examinations on their own patients. Active Physician Staff membership will require the successful completion of an accredited oral and maxillofacial surgeons' surgical training program and fellowship in the American Academy of Oral and Maxillofacial Surgeons.

B. Dentists shall conform to standards established by the Medical Staff in accordance with the Code of Ethics of the American Dental Association.

**5.3-2 Podiatrists:** All Medical Staff members who meet the requirements of this Section 5.3-2 shall be eligible for membership on the Medical Staff and be assigned to the Department of Surgery, Section of Podiatric Surgery, and shall comply with the Rules and Regulations of that Department and Section.

A. Podiatrists shall conform to standards established by the Medical Staff in accordance with the Code of Ethics of the American Podiatric Medical Association.

B. Podiatrists rendering podiatric services in the Hospital must be qualified professionally and ethically for the position in which they are appointed, must be recommended by the Credentials Committee, and shall conform to the rules and regulations of the surgical service.

C. Podiatrists shall be eligible for podiatric clinical privileges who:

1. Have graduated from a college of podiatric medicine accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
2. Are licensed by the State of Maryland;
3. Have demonstrated competence to perform podiatric surgery; and

4. are either:

- a) board certified by the American Board of Podiatric Surgery, or
- b) possess Board Eligibility by virtue of completing a two-year surgical residency program.

## **Section 5.4: Application Forms**

**5.4-1 Application for Membership:** Application for membership on the Medical Staff shall be presented in writing on the Uniform Credentialing Application form required by the State of Maryland. The application form shall request information on at least each of the following:

A. Details regarding undergraduate education, medical or other graduate school and date of graduation, post-graduate education, including internship and residencies, and current appointments;

B. Two professional or peer references, with at least one being qualified to verify the applicant's training, professional competence, ethical character and experience in the requested delineation of privileges;

C. Information as to whether the applicant has voluntarily or involuntarily resigned, limited or reduced, or has suffered revocation, suspension or reduction of staff privileges or membership at any other hospital, institution or health care facility, or whether there has been voluntary or involuntary failure to renew such privileges;

D. Information as to whether the applicant has had his or her membership in local, state, or national medical or other professional societies revoked, suspended, not renewed or reduced;

E. Information as to whether his or her license to practice medicine (or another profession) or prescribe drugs (including narcotics) in any jurisdiction is currently being or has ever been investigated, curtailed, suspended, or voluntarily or involuntarily not renewed or terminated;

F. Information related to involvement in any past, present or anticipated professional liability actions, which shall include, but not be limited to, claims resolved or pending before the Maryland Health Claims Arbitration Office or similar forum, and any lawsuits resolved or pending in any state or federal court;

- G. A statement from the applicant showing evidence of good physical and mental health and information concerning any relevant history of medical or psychiatric conditions or care, or other disability, so as to assure that he or she can adequately care for his or her patients;
- H. The applicant must provide home address and home telephone number;
- I. Information as to whether the applicant is being investigated for a Medicare/Medicaid violation or has been excluded from participation in the Medicare or Medicaid programs or is being investigated for, or has been charged or convicted of a criminal offense. Information will need to be obtained even if only the physician's practice is investigated or excluded. Notifications should also include investigations regarding DEA certification, controlled substance license, and any peer review investigation. The written notification shall be received in the Medical Staff Office within 30 days of the Member's receipt of the original investigation notice or update. The Medical Staff will follow-up with the physician at least every six months regarding the status of any investigations.
- J. During the appointment process and for the duration of the applicant's membership on the Medical Staff (if the applicant is granted such membership), the applicant is responsible for promptly notifying the Medical Staff Coordinator of any changes in this information as stated above in section 3.1-2; A through I. Applicants who believe there are extenuating circumstances which exempt them from this requirement must supply their reasons, in written form, to the Medical Staff Services Coordinator for forwarding to the Credentials Committee; alternatively, such applicants may request an interview with the Credentials Committee.
- K. Decisions on membership and granting or privileges include criteria that are directly related to the quality of healthcare, treatment and services.

#### **5.4-2 Shared Credentialing Information**

Adventist HealthCare, Inc. ("AHC"), and its subsidiaries and related entities, use a common credentialing verification system. By submitting an application for Medical Staff membership and/or clinical privileges, all applicants, Members and Allied Health Professionals consent to their credentialing information being entered into this system, which will cause their credentialing information to be shared among all AHC entities, including but not limited to Shady Grove Medical Center, Washington Adventist Hospital, Adventist Physical Medicine and Rehabilitation, and Adventist Behavioral Health and Wellness. Verification of credentials may be conducted through this common system, although privileges at each facility will be determined by that facility.

### **Section 5.5: Effect of Application**

**5.5-1 Effect of Application:** By applying for appointment to the Medical Staff, each applicant thereby:

- A. Signifies his or her willingness to appear for interviews (which the Hospital, in its discretion, may request) in regard to his or her application;
- B. Authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his or her competence, character, ethical qualifications, and general fitness for membership on the Medical Staff;
- C. Consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges he or she requests, as well as to an evaluation of his or her moral and ethical qualifications for Medical Staff membership;
- D. Specifically releases from any liability the Hospital and all representatives of the Hospital and its Medical Staff for acts performed in good faith and without malice concerning any evaluation of the applicant and his or her credentials, and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for Medical Staff appointment and clinical privileges; and

- E. Certifies that the application is true and complete in all material respects, contains all of the information and fulfills all of the standards required by the Bylaws, and does not contain any misleading or incomplete significant relevant information. Such false or misleading information is not only grounds for remedial action, but any such remedial action may also be reportable to the National Practitioner Data Bank. Violation of the foregoing is a ground for denial of an application and/or for remedial action under Article VII of the Bylaws, as appropriate.
- F. The applicant specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's qualifications for clinical privileges as a Physician or Allied Health Professional. This authorization includes the right to inspect and obtain any and all communications; reports, records, and documents from said third parties. The applicant also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.
- G. To the fullest extent permitted by law, the applicant releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, its authorized representatives, and any third parties with respect to any acts, communications or documents, recommendations, or disclosures involving the applicant.

## **Section 5.6: Processing of Information**

- 5.6-1 Submission of Information:** The annual Medical Staff dues, the application and supporting documents shall be presented by the applicant to the Medical Staff Services Coordinator; when the application is deemed complete by the Medical Staff Services Coordinator, he or she shall transmit the documents to the Credentials Committee. An application shall be deemed complete when all questions on the application have been answered by the applicant, Medical Staff dues have been paid, and all supporting documents and verifications have been obtained by the Medical Staff Services Coordinator (or, after reasonable effort, the Medical Staff Services Coordinator believes that he or she will be unable to obtain certain verifications despite further inquiry).
- 5.6-2 Status of Application:** An applicant may online via our MSONet online credentialing module or contact the Medical Staff Services Coordinator at any time regarding the status of their application.
- 5.6-3 Incomplete Application:** If the application is deemed incomplete because it is missing minimum data, objective eligibility criteria (e.g., license, required malpractice insurance, letters of reference, education verification, board certification status, evidence of training/ experience), as well as any additionally requested information the applicant shall be so notified. If the applicant fails to supply the missing information within 20 days of receiving such notice, this shall constitute such application to be withdrawn by the Director of Medical Staff Services, and any Medical Staff dues paid by the applicant shall be refunded; however, the Director of Medical Staff Services shall retain the processing fee paid by the applicant. The fair hearing rights set forth in Article VIII of the Bylaws shall not apply if the application is discarded for this reason.
- 5.6-4 Changes in Information:** Changes in information which occur during the processing of the application shall be transmitted by the applicant to the Medical Staff Services Coordinator immediately. Practitioners may correct erroneous information within 10 business days of receipt of their application or of being contacted by the Medical Staff Coordinator regarding the erroneous information. Corrections must be made in writing to the Medical Staff Office or the applicant may present in person to the Medical Staff Office and make the correction directly on their application by crossing out the erroneous information, writing error beside it as well as initialing and dating it. The correct information may be then written on the application. Erroneous information not corrected within 10 days will be considered accurate and complete.
- 5.6-5 Additional Relevant Information:** The applicant or Member also agrees to provide on a continuous basis any relevant information which the Hospital may request.
- 5.6-6 Distribution of Lists of New Applicants:** A list of new applicants for membership shall be distributed monthly to all Members of the Active Staff. Members wishing to make comment on or provide information regarding applicants may do so at the meetings of the Executive Committee or the Credentials Committee.

**5.6-7 Query of National Practitioner Data Bank:** When the applicant's or Member's application to the Medical Staff is deemed complete by the Medical Staff Services Coordinator, the Medical Staff Services Coordinator shall routinely query the National Practitioner Data Bank for adverse action reports and malpractice payment reports regarding the applicant. Performance of such queries shall be the responsibility solely of the Medical Staff Services Coordinator. The results of such queries shall constitute an integral portion of the applicant's or Member's application, but shall not alone be dispositive. The Credentials Committee upon recommendation of the appropriate Department and/or Section Chair shall not make its report to the Executive Committee regarding the applicant or Member until it has evaluated the Bank's report regarding such applicant or Member. The applicant or Member may, but need not, be provided with a copy of the results of the query to the Bank.

**5.6-8 Primary Source Verification:** Primary Source Verification of licensure, education, board certification, etc. is completed as required by The Joint Commission Medical Staff Standards. Please see Appendix G in the Credentials Manual for a listing of all primary source verifications utilized.

**5.6-9 Expeditious Processing of Application:** All applications for appointment and reappointment, and for initial, renewed or revised clinical privileges, shall be processed in as expeditious a manner as practicable. The Medical Staff Services Coordinator shall submit complete applications to the next scheduled meeting of the Credentials Committee. All documentation submitted with the application must be signed and dated within 180 days of the applicant's signature on the attestation page. If the application is not processed and approved within 180 days from the date of the applicant's signature, rather than having the applicant re-submit all the documentation, the applicant may re-sign the attestation declaring that the information on the application and submitted with the application is still valid and accurate. Unless either the Governing Board grants an exception or recommends or mandates remedial action or fair hearing rights are exercised as set forth in Articles VII and/or VIII of the Bylaws, all completed applications shall be reviewed by the Credentials Committee, the Medical Executive Committee, and the Governing Board within two months of the date the application is deemed complete by the Chair of the Credentials Committee.

An applicant for privileges is ineligible for the expeditious process if any of the following has occurred:

- a. The applicant submits an incomplete application.
- b. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
- c. There is a current challenge or a previously successful challenge to licensure or registration.
- d. The applicant has received an involuntary termination of medical staff membership at another hospital.
- e. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
- f. The hospital determines that there has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

### **Section 5.7: Departmental Action**

After receipt of the application, the Chair or appropriate committee of each department, and, if applicable, section, to which the application is submitted shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the Chair's or committee's discretion. The Chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted. The Chair or appropriate committee shall transmit to the Credentials Committee and Executive Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department, and, if applicable, section, affiliation, clinical privileges to be granted, and any special conditions to be attached. The Chair or appropriate committee may also request that the Credentials Committee or Executive Committee defer action on the application for specified reasons.

### **Section 5.8: Credentials Committee Action**

The Credentials Committee shall review the application or reapplication, and evaluate and verify the supporting documentation, the department Chair's or appropriate committee's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information or request evaluations/additional information of the practitioner in instances where there is doubt about an applicant's ability to perform the privileges requested. As soon as practicable, the Credentials Committee shall transmit to the Executive Committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, Medical Staff Term, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the Executive Committee defer action on the application for specified reasons.

**5.8-1 Partners Medical Staff Files:** Partners will recuse themselves from approval of new appointment and reappointment considerations and disciplinary actions except where there is no separate, independent group, or qualified alternative reviewer or qualified alternative reviewer on the Active Staff.

#### **Section 5.9: Executive Committee Action**

Upon receipt of the report of the Credentials Committee, the Executive Committee, at its next regular meeting, shall consider the report and recommend to the Governing Board that the application or reapplication be accepted, deferred, or rejected. Prior to making a decision, the Executive Committee may request evaluations/additional information of the practitioner in instances where there is doubt about an applicant's ability to perform the privileges requested.

**5.9-1 Favorable Recommendation:** When the recommendation of the Executive Committee of the Medical Staff is favorable to the applicant, that recommendation shall be forwarded, through the Hospital President, to the Governing Board.

**5.9-2 Adverse Recommendation:** When the recommendation of the Executive Committee of the Medical Staff is adverse to the applicant with respect either to appointment or to the nature or extent of clinical privileges, the Associate Vice President of Quality and Medical Staff Services shall promptly so notify the Member by certified mail, return receipt requested within seven business days. The applicant shall have the rights of hearing and appeal set forth in Article VIII of the Bylaws only if the denial required a report to the Maryland Board of Physicians or the National Practitioner Databank . No adverse recommendation shall be forwarded to the Governing Board until after the applicant's rights to hearing and appeal have lapsed or been waived as provided in Article VIII of the Bylaws.

#### **Section 5.10: Governing Board Action**

The Governing Board may accept the recommendation of the Executive Committee or may refer the matter back to the Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall apply with respect to action on the application or reapplication:

**5.10-1 Favorable Action:** If the Governing Board or designee(s) concurs with the recommendation of the Executive Committee, the decision shall be deemed final action.

**5.10-2 Adverse Action:** If the Governing Board or designee(s) does not concur with the recommendation of the Executive Committee, then the matter shall be referred to any appropriate department or committee for further consideration, stating the reasons for such action and setting a time limit within which a report shall again be made to the Governing Board. Alternatively, it may send the matter back to the Executive Committee for a full, formal review with right to appellate review thereafter, pursuant to Article VIII of the Bylaws if such is deemed appropriate and such a hearing has not yet been held with respect to the matter.

**5.10-3 Sub-Committee Action:** The governing body, pursuant to its bylaws, may elect to delegate the authority to render initial appointment, reappointment, and renewal, or modification of clinical privileges decisions to a committee of the governing body, which consists of the President of the Medical Staff or designee, the Hospital President, or designee and the Credentials Committee Chair or designee.

**5.10-4 Final Action:** When the Governing Board or designee(s) has taken a final action on any application for membership on the Medical Staff, the Governing Board, acting through the Hospital President or designee, shall notify the Medical Staff Coordinator, the President of the Medical Staff, the relevant department Chair, and the applicant of the action taken. The applicant may reapply for membership to the Medical Staff after two years if the decision of the Governing Board is to deny the appointment, subject to the provisions of Section 3.13. Notification of the Governing Board's final action will be sent within fifteen (15) business days to the member. The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities.

### **Section 5.11: Reappointment Process**

At least 120 days prior to the expiration date of the present Medical Staff or Allied Health Professional Staff appointment of each Member, the Medical Staff Services Department shall provide such Member with an application for reappointment to the Medical and Allied Health Professional Staff via MSONet, our online credentialing module. Emeritus w/o Privileges and Community Staff Physicians will be required to complete a demographic update at each reappointment cycle. The demographic update paperwork will be e-mailed to the provider for completion. Data requested on this application will include, but not be limited to: professional qualifications and standing, physical and mental health status, and proof of current clinical competence. When insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations. All Medical Staff reappointment applications must be returned to the Medical Staff Coordinator prior to the expiration of that Member's Medical Staff Term. A reminder will be sent to the practitioner 30 days and 45 days after the reappointment application was sent via MSONet. A certified reminder letter will be mailed to the member if their reappointment application is not received within 52 days of the date of mailing or sending via MSONet their application. The member will be charged a late filing fee of \$300 and their privileges may be suspended until final Board approval of their reappointment if the review and approval process is not complete by the end of their medical staff term. If a member does not wish to renew their reappointment application, they may submit a letter of voluntary resignation stating the reason and effective date of their resignation. If a member does not return their reappointment application by the end of their medical staff term, their membership and privileges will be recommended as a voluntary resignation.

### **Section 5.12: Effect of Application for Reappointment**

The effect of an application for reappointment or modification of Medical Staff status or privileges is the same as that set forth for initial applications. The applicant for reappointment shall have the same burden and obligations as an initial applicant.

### **Section 5.13: Standards and Procedure for Review**

When a Member submits the first application for reappointment, and every Medical Staff Term thereafter, or when the Member submits an application for modification of Medical Staff status or clinical privileges, the Member shall be subject to an in-depth review of the standards described in Sections 5.2 and 5.3 and the information to be provided pursuant to Section 5.4, generally following the procedures set forth in Sections 5.6 through 5.10, inclusive. Review also shall consider the level of performance of clinical skills, performance and competence demonstrated during the preceding term of appointment, quality assurance and peer review information developed during the preceding term of appointment, adherence to the Bylaws, an assessment of the Member's cooperation and ability to work harmoniously with others in the Hospital, appropriate utilization of Hospital services and facilities, and attendance at required Medical Staff and committee meetings.

### **Section 5.14: Extension of Medical Staff Term**

When a Member is entitled to a hearing and appeal because of an adverse recommendation of the Executive Committee of the Medical Staff with respect to his or her reappointment or the delineation of his or her clinical privileges, his or her medical staff term will be processed as a reappointment pending final outcome of the hearing or appeal process has been completed or until his or her rights of hearing and appeal have lapsed or been waived as provided in Article VIII of the Bylaws.

### **Section 5.15: Bar to Reapplication**

**5.15-1 Reapplication After Two Years:** An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two years. The Governing Board may increase this time in individual cases at its discretion.

**5.15-2 Members Not Eligible for Reapplication:** In circumstances where the Member is recommended for non-reappointment or that certain privileges be denied, for cause, the Executive Committee may recommend to the Governing Board whether the Member will be allowed to reapply for membership on the Medical Staff, and, if so, when and under what circumstances.

**5.15-3 Reapplication Process:** Any such reapplication arising from Sections 5.14 or 5.15 shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.



### **Section 5.16: Burden of Producing Information**

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of his or her qualifications and suitability for the clinical privileges and Medical Staff category requested, of resolving any doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for withdrawal of the application. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Credentials Committee or Executive Committee, which may select the examining physician.

### **Section 5.17: Clinical Performance Information**

The hospital determines whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

### **Section 5.18: Scope of Privileges**

- a. Each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.
- b. The Credentialing and Privileging process is consistently applied for each requesting practitioner.
- c. If privileging criteria are used to grant privileges are unrelated to quality of care, treatment, and service or professional competence, then there must be other evidence that will determine how decisions on the quality of care, treatment and services are evaluated.
- d. The hospital consistently determines the resources needed for each requested privilege (i.e. space, staffing, equipment)

### **Section 5.19: Emergency and Temporary Privileges**

**5.19-1 Emergency Privileges:** In the case of emergency, a physician currently on staff may assume immediate privileges outside the scope of their existing privileges if a physician with the necessary skills is not immediately available in order to save the life of a patient. An "emergency" is defined as a condition which would result in serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

**5.19-2 Temporary Privileges:** Temporary privileges may be granted for the following:

- A. To fulfill an important patient care, treatment, and service need;

Temporary privileges under section 'A' may be granted on a case by case basis for a period not to exceed 30 days by the Hospital President as a representative of the Hospital Board upon recommendation of the applicable clinical department or the President of the Medical Staff provided there is verification of current licensure and current competence. An urgent patient care need, treatment and service is defined as one where we do not have any physicians on staff with the necessary scope of privileges to perform the necessary treatment and any delay may cause harm to the patient.

Temporary privileges under section 'A' may be granted for a specified period of time necessary to care for the urgent patient need (usually a one-time surgery or consult) by the Hospital President or designee as a representative of the Hospital board upon recommendation of the applicable clinical Department and/or Section chair, Medical Staff President or designee. The following information/documents must be provided by the applicant: Current State of Maryland License, DEA and CDS Certificates; Letter of Introduction from the requesting physician; Reference from most recent Chief of Services (confidential evaluation form) and a Peer reference letter; Current Malpractice Insurance Certificate and Endorsements; Evidence of Board Certification; Current Curriculum Vitae (CV) and a Signed consent and release form to allow SGMC to query all required primary source verifications.

- B. When a new application is complete that raises no concern is pending review and recommendation by the Credentials Committee, Medical Executive Committee, and approval by the Hospital Board;

Temporary privileges under section 'B' may be granted for a period not to exceed 120 days by the Hospital President or designee as a representative of the Hospital Board upon recommendation of the applicable clinical Department and/or section chair, Credentials Committee Chair, and President

of the Medical Staff provided: there is verification of current licensure, relevant training or experience, current clinical competence, and the ability to perform requested privileges, other criteria required by the Medical Staff Bylaws, the results of the National Practitioner Data Bank query have been obtained and evaluated. The applicant has: a complete application, no current or previously successful challenge to licensure or registration, not been subject to involuntary termination of medical staff membership at another organization; not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

**Addenda:**

1. At any time, temporary privileges may be terminated by the Hospital's President with the concurrence of the Chair of the department (or their designees), subject to prompt review by the Executive Committee. In such cases, the appropriate department Chair or, in the Chair's absence, the President of the Medical Staff shall assign a Member of the Medical Staff to assume responsibility for the care of such Member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Physician.
2. A person shall not be entitled to the procedural rights afforded by Article VIII of the Bylaws because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended or expire.
3. All persons requesting or receiving temporary privileges shall be bound by the terms of the Bylaws.

**Section 5.20: Privileges for Dentists and Podiatrists**

**5.20-1 Privileges Generally for Dentists and Podiatrists:** Privileges granted to Dentists and Podiatrists shall be based on the Member's licensure, training, experience, and demonstrated current competence, and where applicable, upon an examination of the records of previous cases treated, and other such information as may be relevant. The scope and extent of surgical procedures that each Dentist and Podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by Dentists and Podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. All patients admitted to the care of a Dentist or Podiatrist shall receive the same basic medical appraisal as patients admitted to other surgical services. An MD, DO or Oral Surgeon Staff Member shall be responsible for the care and required records of any medical problem that may be present at the time of admission or that may arise during hospitalization. Dentists and Podiatrists may take patient histories and perform physical examinations, if granted such privileges and if the findings, conclusions and assessment of risk are confirmed or endorsed by an appropriately qualified Medical Physician prior to major diagnostic or therapeutic intervention or within 24 hours, whichever occurs first. See individual delineation of privileges for admitting privileges..

**5.20-2 Dentists:**

- A. As used in this Section 5.20-2, the term "dentist" shall include all qualified general dentists, pedodontists, periodontists, prosthodontists, orthodontists, and oral pathologists.
- B. Patients admitted for dental services shall be admitted on the surgical service and shall be under the care of a Medical Physician Staff Member with admitting privileges.
- C. Adequate medical evaluation of the patient shall be done in advance of dental services by an MD, DO or Oral Surgeon Staff Member, although the dentist is responsible for the portion of the patient's history and physical that relates to dentistry. If indicated, appropriate consultations shall be obtained.
- D. The scope of dentists' services shall be delineated by, and their privileges shall be under the jurisdiction of, the Department of Surgery, Section of General Dentistry. All privileges granted shall be in accordance with the proficiency of the dentist as to the various subdivisions of the dental profession. Dentists shall comply with the applicable Bylaws, Rules and Regulations governing the Medical Staff Members of such department and section.
- E. Operating room privileges will be given to pedodontists with training in a program recognized by an American specialty board, but such privileges shall be limited to routine pediatric operative dental procedures. Operating room privileges may be granted to other dentists who have had at least two years of hospital training and show considerable proficiency and experience in this area of dentistry; however, all delineation of such privileges shall be considered on an individual basis.

**5.20-3****Podiatrists:**

- A. Patients admitted for podiatric services shall be admitted on the surgical service and shall be under the care of an MD, DO or Oral Surgeon Staff Member with admitting privileges.
- B. Adequate medical evaluation of the patient shall be done in advance of podiatric services by a Member licensed MD, DO or Oral Surgeon, although the podiatrist is responsible for the portion of the patient's history and physical that relates to podiatry. If indicated, appropriate consultations shall be obtained.
- C. The scope of podiatrists' services shall be delineated by, and their privileges shall be under the jurisdiction of, the Department of Surgery, Section of Podiatry.
- E. Admission of patients to the Hospital by podiatrists shall be only with the concurrence of a Medical Physician Staff Member who shall be responsible for the care of any medical problem that may be present or arise during the hospitalization and who shall assume responsibility for the overall aspects of the patient's care, including the medical history and physical examination (although the podiatrist shall be responsible for the portion of the history and physical that relates to the patient's podiatric needs). Patients may be discharged only on the written orders of the podiatrist and the assigned Medical Physician. Both the podiatrist and the assigned Medical Physician must cosign the discharge orders.
- F. Podiatrist Members of the Medical Staff shall comply with the applicable Bylaws and such policies and procedures approved by the Executive Committee as may apply.
- G. The word "Physician" in this Section 5.20-3 means an appropriately licensed doctor of allopathic medicine or osteopathy.

**Section 5.21: Telemedicine Privileges**

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. If a telemedicine practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient, the telemedicine practitioner is credentialed and privileged through the medical staff mechanisms as set forth in this Bylaws Manual and in the same manner as any other medical staff member.

The Medical Staff Office will be required to receive all or a minimum of five (5) high volume satisfactory verifications for each telemedicine provider.

Additionally, if the telemedicine provider is not credentialed and privileged in the same manner as any other Medical Staff member at Shady Grove Medical Center, the hospital can furnish telemedicine services to their patients if the following conditions have been met:

- 1) The hospital must have an agreement with a distant site hospital or other telemedicine provider.
- 2) The distant-site provider must meet the Medicare Conditions of Participation Section 482.12 (a)(1) through (a)(7) regarding governing body responsibilities concerning the Medical Staff including:
  - a. Determination of eligible candidates
  - b. Appoint members after considering Medical Staff recommendations
  - c. Distance site entity has Medical Staff Bylaws
  - d. Governing Board must approve the Medical Staff Bylaws, Rules and Regulations
  - e. Medical Staff must be accountable to the Governing Board for quality of care provided to patients.
- 3) The Distance-site entity can be a Medicare or non-Medicare provider or supplier.
- 4) The hospital can grant privileges to telemedicine providers but must rely on Medical Staff recommendations.
- 5) Medical Staff recommendations may rely on the information provided by the distant-site telemedicine entity.
- 6) The distant-site telemedicine provider must be privileged at the distant site hospital or entity which must provide a current list of the provider's privileges.
- 7) The distant-site telemedicine provider must hold a license or recognized by the State of Maryland since this is where the hospital's patients are receiving telemedicine services is located.
- 8) The hospital must have evidence that an internal review of the distant site provider's Performance of privileges was conducted and further, must provide distant site entity

with performance information used in the periodic appraisal of the distant site provider including adverse events resulting from telemedicine services provided by the distant-site telemedicine provider to hospital patients, and all complaints received about the provider.

- 9) All of these conditions must be set forth in the agreement between the hospital making telemedicine services available to its patients and the distant site provider entity.

### **Section 5.22: Moderate Sedation Privileges**

See Appendix C in the Credentials Manual - To create a consistent hospital wide policy that insures safe care for both adult and pediatric patients, this policy is intended to address moderate sedation by non-anesthesiologists only.

### **Section 5.23: History and Physical Requirements**

In all cases, a complete history and physical examination shall be written within twenty-four hours after admission of the patient. An adequate admitting note shall also be recorded on the chart by the attending physician. The medical history and physical examination are completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. The history and physical for inpatients will include:

1. identification data
2. chief complaint
3. present illness
4. past personal and family medical history
5. psychosocial history
6. review of systems
7. physical examination
8. special reports (consultations, clinical laboratory, radiological, etc.)
9. provisional diagnosis
10. plan of care

The history and physical for surgical outpatients shall include the same categories as an inpatient history and physical, but will be diagnosis specific. History and physicals for inpatient and surgical outpatients including podiatry and dental patients which were performed by licensed physicians who are not members of this hospital's Medical Staff will be accepted, so long as such H & P's are reviewed, updated, and signed by a physician member of this hospital's Medical Staff within 24 hours of inpatient admission or prior to surgery or procedure.

A complete History and Physical is not required for outpatients unless the patient is receiving sedation. Before outpatients receive moderate or deep sedation or general anesthesia, a History and Physical examination must be conducted and documented in accordance with the requirements for inpatients. Patients in the cardiac catheterization lab and electrophysiology lab, endoscopy suite, and those receiving sedation for radiologic procedures must have a History and Physical prior to sedation. Pain Management patients will have a History and Physical examination conducted and documented at the time of their first series visit.

Updates to the H & P in all cases involving surgery or a procedure require moderate or deep sedation or general anesthesia must include the following:

- a) Review of original H & P
- b) Examination of the patient for any changes in the patient's condition
- c) Documentation whether changes or no changes occurred since the H & P was originally completed.
- d) Any changes in the patient's condition must be documented in an updated note. If during review of the original H & P it is found incomplete, inaccurate, or otherwise unacceptable, the H & P may be disregarded and a new H & P conducted and documented within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia.

No History and Physical is required for cases using local anesthesia or a combination of local anesthesia and minimal oral sedation unless the physician determines that the patient's condition warrants it.

In the case of a medical/surgical emergency, the history and physical will be completed and/or reviewed and signed by a physician member of the medical staff as soon as possible after the completion of the necessary procedure.

## **Section 5.24: Credentialing Physicians and AHPs in the Event of a Disaster**

During a disaster, when the Hospital Emergency Operations Plan (Code Yellow - Disaster Plan) has been activated and Shady Grove Medical Center (SGMC) is unable to handle the immediate patient needs, the Hospital President, the President of the Medical Staff or their designees(s) at the time the Disaster is implemented has the option to grant disaster privileges to Physicians and Allied Health Professionals who volunteer their services but are not members of the Hospital's Medical or AHP Staff on a case-by-case basis at his/her discretion following review of the volunteer's application for disaster privileges. The Hospital's Chief Medical Officer will determine the type(s) of medical and technical staff needed to assist with the disaster. The procedures to follow can be found in the Disaster Policy, Appendix H of the Bylaws Manual.

**ARTICLE VI**  
**CATEGORIES OF THE PHYSICIAN AND AHP STAFF**

**Section 6.1: Categories of the Physician Staff**

The Physician Staff shall be divided into Active, Courtesy, Community, Consulting and Emeritus staff. Changes in category shall be based on merit, service, and participation in Hospital activities.

All new physicians requesting membership and privileges to the hospital will be approved with Active status for two years unless the physician provides consulting services. If the physician fails to obtain 50 patient contacts within those two years, the physician will be automatically moved to Courtesy Status.

All new physicians requesting Community physician status will be approved for two years

**6.1-1 (a) Active Physician Staff:** The Active Physician Staff shall consist of Physicians actively engaged in the care of patients. To have active status a physician must have 25 patient contacts per year as defined in the Medical Staff Rules and Regulations. Physicians who do not directly admit or consult on patients may request referral privileges as defined under their department's delineation of privileges. The Active Physician Staff shall have responsibility for performing all significant organizational and administrative duties pertaining to the Medical Staff. Members of the Active Physician Staff shall be entitled to vote at all meetings involving the Medical Staff and shall be eligible to hold elective office on the Medical Staff. Emeritus Medical Staff as defined below shall be considered Active Physician Staff with respect to all duties, obligations and privileges of the Medical Staff except for the payment of dues

**6.1-1 (b) Emeritus Physician Staff:** Emeritus status shall be available to those Physicians who have either (1) served on the Active Physician Staff for longer than 25 years and are over 65 years of age; or (2) served on the Active Physician Staff and have been determined to be suffering from a long-term disability, as documented by a written statement from his/her physician, or (3) served on the Active Physician Staff and have left clinical practice for an administrative, research, or public health positions. The Medical Executive Committee may waive either the age or years of service requirement if they deem a Physician through exemplary service to the hospital and the medical staff should be entitled to Emeritus status. This category of staff shall be requested by the Member. Members of the Emeritus Physician Staff who request clinical privileges must meet the requirements for reappointment as outlined in these Bylaws. Emeritus Physician Staff may request limited privileges in lieu of the full core privileges for their special with appropriate malpractice insurance coverage. A physician requesting Emeritus status and not requesting privileges shall provide "tail" or "prior acts" insurance coverage for at least five years from cessation of clinical privileges, and shall update demographic information biannually. This request will be reviewed and recommended by the Committee on a case-by-case basis.

**6.1-2 Courtesy Physician Staff:**

The Courtesy Physician Staff shall consist of Physicians engaged in the care of patients.

Physicians who do not admit or consult on patients may request referral privileges as defined under their department's delineation of privileges. They are not eligible to vote or hold office. They shall

be invited to attend regular staff meetings. Courtesy Physician Staff must obtain referrals as defined by their departments delineation of privileges.

**6.1-3 Consulting Physician Staff:** The Consulting Physician Staff shall consist of Physicians who meet the qualifications set forth in these Bylaws. They shall be Physicians who are members of the active staff of other hospitals where they actively participate in monitoring activities similar to those required of the Active Physician Staff of this Hospital. Consulting Physician Staff shall be reserved for Physicians of special or unique consultative expertise not readily available within the Medical Staff who may be called upon from time to time to provide consultative assistance on unique or unusual patient care problems. Consulting Physician Staff shall be Physicians of outstanding reputation in their field who may not necessarily be residents of the community or the State. Clinical privileges shall be delineated by the Credentials Committee in consultation with the appropriate department, but shall not include admitting privileges. Consulting Physician Staff shall not vote, hold office or serve on committees. Consulting Physician Staff shall not be required to have a covering physician.

**6.1-4 Community Staff:** The Community Staff shall consist of those physicians requesting medical staff membership only with no delineated clinical privileges. Physicians currently on staff as well as new applicants may request this status category. **This includes those in research, administrative or public health positions.** They may attend department/section meetings and participate in educational activities. Physicians in this category must: 1) provide demographic updates in order to keep abreast of meetings and educational opportunities, and hospital news; 2) provide a valid State of Maryland medical license. They will not be required to have an office address as specified in these Medical Staff Bylaws. They will be subject to the reappointment process with demographic updates every two years and will pay a \$50 reappointment fee. The processing fee to apply for Community Staff status as a new applicant is \$250. They will not be subject to department or medical staff dues. Community Staff may attend meetings and participate, but will not have the right to vote or hold elective office. They will not be subject to FPPE and OPPE. Membership will be automatically terminated if the Member is convicted of a felony or crime of moral turpitude

**6.1-5 Change in Category Process:** To request a change in category within the Physician Staff, the Physician may submit a written request to the Chair of the Credentials Committee via the Medical Staff Office. Requests for promotion shall be processed in the same manner as applications to the Medical Staff.

**Section 6.2: Categories of the Allied Health Professional Staff** All applicants for the Allied Health Professional Staff will be credentialed in the same manner as Medical Staff Members. (See Appendix B in the Credentials Manual - Allied Health Professionals Policy) Allied Health Professionals include the following categories:

**6.2-1 Allied Health Professional (employed or sponsored by a member of the Medical Staff)** – Certified Registered Nurse Practitioner, Physician Assistant, Certified Nurse Anesthetist, Certified Registered Nurse First Assistants, and Certified Nurse Midwives

**6.2-2 In Training - (in training at a teaching institution and sponsored by an Active or Consulting member of the medical staff)** – Physician Assistant Student, Medical Student, Residents, Fellows and Interns

## **ARTICLE VII CORRECTIVE ACTION**

### **Section 1. Complaint Procedure:**

- A. Whenever a complaint is submitted against a Member of the Medical Staff or there are grounds for concerns about a Member's actions or performance at the Hospital, the President of the Medical Staff (or designee) will review the complaint or conduct to determine whether it may constitute disruptive behavior or failure to obey these Bylaws, the Credentialing Manual, the Rules and Regulations of the Medical Staff, Clinical Practice Expectations, or any policy of the Hospital or Medical Staff. When such concerns are deemed to merit further evaluation or action, the President (or designee) may recommend to the MEC that a formal investigation be done or may refer the matter to the appropriate department, Credentials Committee, or Medical Executive Committee for further evaluation.
- B. If a formal investigation is deemed to be warranted by the President of the Medical Staff and approved by the MEC, he/she will conduct an investigation in conjunction with the department chair and the Hospital's chief medical officer. The President of the Medical Staff may also select other additional persons to assist the investigation. The investigators will meet in person at least once and will interview such persons and review such documents and information as they deem appropriate. They will prepare a written report of their investigation and submit the report to the Medical Executive Committee within 30 days of the decision to conduct an investigation.
- C. If the complaint or conduct is determined to warrant further evaluation, the MEC may refer the matter to the appropriate department chair (or to the chief medical officer if the complaint refers to a department chair). Complaints for which collegial intervention are appropriate will be documented, and a memo will be placed by the department chair in the Member's credentialing file. Complaints found to have merit may also be referred directly to the Credentials Committee or Medical Executive Committee. These will be reviewed at the next regular meeting unless the applicable chair determines that a special meeting is required. Any department review will be reported to the Credentials Committee, and the Credentials Committee recommendation will be reported to the Medical Executive Committee for review at either their next regular meeting or any special meeting called for the purpose of the review.
- D. Complaints related to disruptive behavior will be reviewed and evaluated under the Code of Conduct Policy appended to these Bylaws. If any adverse action is proposed, the Member shall be provided with a copy of the recommended action, as well as a summary of the general nature of the complaint and, when appropriate, supporting materials. If no action is proposed, the President of the Medical Staff (or designee) shall decide whether to make the Member aware of the complaint.
- E. Actions to be taken in response to complaints may include informal coaching, mentoring, a letter or a personal interview with the Member, or a referral to a department chairperson for action, or a referral to the Health Committee or other disciplinary action.

F. All interventions to complaints described under section 'A' above shall be documented and included as a memo to the credentialing file of the Member and/or in the minutes of the appropriate committee(s). If the Member continues to have similar complaints filed against him or her, or if the complaint(s) is/are of a serious nature as determined by the President of the Medical Staff or designee, then the President of the Medical Staff or designee shall present the information to the Health Committee, to the Credentials Committee, or the Medical Executive Committee, depending on the nature of the complaint(s).

G. 1. The Health Committee or the Credentials Committee may choose to meet with the Member to discuss the complaint(s). The committee will recommend a plan of action. This plan may include, when appropriate, voluntary or required health evaluations from appropriate licensed physicians or programs, participation in health improvement and monitoring programs, and/or substance abuse monitoring or treatment programs. The Member may also be offered an opportunity to sign a "Last Chance Agreement" to be prepared by the committee to address behavioral and related issues as an attempt to avoid further disciplinary action. The plan will be reviewed by the Medical Executive Committee for approval prior to being provided to the Member for the Member's acceptance. The Last Chance Agreement will be presented to the Member by the President of the Medical Staff (or designee), preferably in person but by written communication if appropriate, with an explanation to the Member of the conduct that has led to the Last Chance Agreement and a description of the conduct to be avoided in the future. Unless the Last Chance Agreement provides otherwise, the Medical Executive Committee will be the body that determines whether the Last Chance Agreement, if signed by the Member, has been violated. The Last Chance Agreement may address due process rights. Unless the "Last Chance Agreement" specifically provides otherwise, any Member who signs a "Last Chance Agreement" waives all due process rights afforded to him/her under the Medical Staff Bylaws, including hearing rights; provided, however, that if due process rights are waived, the Member will be afforded an opportunity to present his/her perspective at the next meeting of the Medical Executive Committee before the Medical Executive Committee makes its recommendation to the Hospital's Governing Body. Such presentation shall last no longer than 30 minutes, and the Member may not bring an attorney to such presentation; such presentation is not a hearing under the Bylaws and none of the hearing provisions in the Bylaws will apply. If the Member accepts the Last Chance Agreement, the Member must sign and return it to the Medical Staff Office within ten (10) business days of its receipt by the Member. If the Member does not sign the Last Chance Agreement, the Medical Executive Committee may, if it so chooses, convert the contents to a final warning letter and/or may proceed with disciplinary action in accordance with other provisions of the Bylaws.

2. The Member will be notified of the recommended plan. If a Member disagrees with the plan, he/she may submit a written objection to the Health Committee or the Credentials Committee within ten (10) business days of receiving a copy of the recommended plan. The Committee will review the objections and sustain or modify the plan as appropriate. This action will be forwarded to the Medical Executive Committee for review. If approved by the Medical Executive Committee, the Member will be expected to comply with the plan. Failure to comply with said plan may result in suspension of the Member's privileges. The Member may exercise fair hearing rights as defined in Article VIII, Section 2.

H. The Hospital's President and the President of the Medical Staff shall keep the Governing Board apprised of the status of remedial action matters reported to them.

I. Any complaints and resolutions will be documented and maintained in the Member's credentialing file and reviewed at reappointment time.

## **Section 2. Collegial Intervention:**

When appropriate, it is the policy of the Medical Staff Leadership of the hospital to work collegially with Medical Staff Members to assist them in delivering high quality and safe medical care, to continually improve their clinical skills, to comply with the Medical Staff and hospital policies, and to meet all performance expectations as established from time to time by the Medical Staff. Medical Staff policies, including those on Peer Review, performance improvement, conduct, and Physician Health and impairment describe some of the collegial interventions available to Medical Staff Leaders in working with colleagues whose clinical performance or professional conduct is problematic. Collegial intervention may include letters of warning/concern, a reprimand, a notice that the Physician's conduct will be monitored for a period of time and/or that similar conduct in the future will result in remedial action, including but not limited to, termination from the Medical Staff, a voluntary agreement to attend meetings, CME courses, obtain consultations, or other appropriate action. Collegial interventional shall not entitle a member to a hearing or appeal under the fair hearing rights outlined in Article VIII. Serious violations of the Member's obligations to comply with the Medical Staff governing documents and/or Hospital policy may not be appropriate for collegial intervention.



### Section 3. Suspension:

- A. A Member's privileges may be suspended by the President of the Medical Staff, the Medical Executive Committee, the Hospital President or the Governing Board. Suspension may be summary, temporary or automatic.
1. Summary suspension is the immediate suspension of some or all of a Member's clinical privileges when it is deemed that the Member's conduct, behavior, health or circumstances pose an immediate risk of harm or an immediate or imminent danger to patients, staff and the general public.
    - a. In order for a summary suspension to be imposed, there must be at least a consultation or agreement by at least two parties, which can include members of the Executive Committee, the Department Chair, the President of the Medical Staff, the President of the Hospital or the Governing Board.
    - b. The Member shall be notified in person if possible and also by letter sent certified mail, return receipt requested, commercial overnight delivery service, hand delivery, or other acceptable commercial means (e.g., fax) from the Hospital administration (which may include the Medical Staff Services office).
    - c. Within ten days of the notification of the summary suspension, the suspended Member may request in writing that an informal interview before the Medical Executive Committee be held at its next regularly scheduled meeting.
    - d. The interview shall not constitute a hearing under these Bylaws and shall not be governed by provisions in Article VIII.
    - e. If the Medical Executive Committee, by majority vote, upholds the summary suspension, the Member will be given notice of such action and may exercise his/her right to a hearing under Article VIII.
    - f. If the Medical Executive Committee rescinds the summary suspension, the Member is not entitled to a hearing under these Bylaws.
  2. Automatic suspension shall occur if the Hospital or the Medical Staff receives notice from the appropriate State or National board or insurance company or agency of the suspension of a Member's State license, DEA, CDS or medical malpractice insurance. The Medical Executive Committee shall review the material from the organization, which issued the suspension.
    - a. Any Member whose State license, DEA, CDS, National Provider Identifier (NPI) number or medical malpractice insurance has expired and who has not submitted evidence of renewal shall be suspended.
    - b. The suspension shall remain in effect until the Member provides proof of renewal or adequate insurance.
    - c. If the reason for the suspension involves a risk to patient care the Medical Executive Committee may recommend termination of the Member's privileges and the Governing Board may so terminate.
    - d. No fair hearing rights shall apply when a Member receives an automatic suspension.
    - e. A Member whose privileges have been suspended who has had a reinstatement of a license, DEA, CDS or insurance shall regain his/her privileges upon proof of reinstatement so long as the Member is still within the term of his/her most recent appointment/reappointment. If said Member has had his/her privileges terminated, upon reinstatement he/she may apply to the Medical Staff as a new Member.

### **Section 3. Suspension – con't**

3. Temporary suspension is the suspension of a Member for failure to have a required document in good standing (e.g., PPD, influenza vaccine) or a working e-mail address for communication or for failure to comply with Medical Staff Rules and Regulations with regard to medical records, or for failure to respond to a request from a review/audit committee. Additionally, a temporary suspension will occur for a Member who fails to return his/her reappointment application in a timely fashion.

- a. The Medical Staff Rules and Regulations require completion of medical records within certain time periods. Failure to complete said records will result in temporary suspension.
- b. Any Member who receives a request from a performance improvement/quality improvement committee for information regarding a case or activity must reply within the requested timeframe. Failure to reply will result in a temporary suspension of privileges until such reply is received.
- c. Any Member whose reappointment application process is not completed by the end of his or her term due to late submission of their application will be suspended until final Governing Board approval of their reappointment. The hospital will make every reasonable effort to complete the credentialing process in an expeditious manner.
- d. Any Member who fails to maintain a working e-mail address to ensure review and receipt of communication from the Hospital and Medical Staff will be temporarily suspended until the information is supplied
- e. Except as set forth above, if a Member is placed on temporary suspension, the failure to correct the deficiency after 90 days of suspension shall result in revocation of the Member's Membership on the Medical or Allied Health Professional Staff and no additional hearing or appeal rights shall apply. The Member shall be given at least 30 days advance notice by certified mail, return receipt requested, of such impending revocation after 60 days of temporary suspension have elapsed.
- f. No fair hearing rights shall apply when a Member receives a temporary suspension or if the Member's privileges are revoked due to failure to correct the deficiency.
- g. A Temporary Suspension that results in revocation of the Member's privileges will be reported when required by the National Practitioner Data Bank.

### **Section 4. Automatic Termination:**

- A. Any physician excluded from participation in Medicare, Medicaid or other Federal or State funded healthcare programs shall receive an automatic termination of privileges without the right to appeal.
- B. Any physician convicted of a felony for a healthcare related crime or a crime of moral turpitude shall receive an automatic termination of privileges and/or membership without the right to appeal.
- C. An Automatic Termination of a Member's privileges will be reported as required to the National Practitioner Data Bank.

**Section 5. Reporting of Corrective Action:** The above actions will be reported to the Maryland Board of Physicians, the National Practitioner Data Bank or the appropriate State or Federal agency when the State or Federal law or regulations so requires. If reported to one of these agencies, the Member may have the right to a fair hearing.

**Section 6. Responsibility for Care of Patients:** Any Member whose privileges are suspended or terminated must provide the name of another Member who will be responsible for the care of his/her patients. If the suspended/terminated Member fails to make appropriate arrangements for the care of his/her patients, the President of the Medical Staff shall make arrangements with the covering physician as designated in the Member's credentialing file or with another physician if the covering physician refuses or is unable to provide coverage.

**ARTICLE VIII**  
**RIGHTS OF HEARING AND APPEAL**

**Section 1. Modified Fair Hearing Rights**

- A. Recommendations/Actions Covered: The following actions shall not entitle the Member to a full hearing and appellate review under Article VIII, Section 2, but rather shall entitle the Member to the more limited rights described solely in this Article VIII, Section 1. These actions generally are those which have relatively minor impacts on a Member's exercise of clinical privileges and which accordingly do not merit or require the extensive efforts associated with other hearing rights. This Section 1 applies to the following:
1. Denial of request to submit an applicant for privileges based on exclusive contractual arrangements by the hospital for a particular service or department;
  2. Denial of requested department, or service, or other clinical unit affiliation;
  3. Insubstantial reduction in a Member's existing privileges; or
  4. The granting of substantially all (but not all) clinical privileges requested by the Member.
- B. Notice: Notice of a Member's right to exercise these Section 1 modified fair hearing rights as the sole process to challenge a recommendation shall be promptly provided by the Director of Medical Staff Services by certified mail, return receipt requested. The notice shall state:
1. That a professional review action has been proposed to be taken against the Member;
  2. The reasons for the proposed action, with specific reference to the Member's deficiencies in training, experience, clinical judgment, and other adverse information;
  3. A brief summary of the Member's rights under this Section 1; and
  4. That any election to utilize these modified fair hearing rights must be made in writing to the Medical Staff Services Department within thirty (30) days of the Member's receipt of this notice.

Failure to so request these modified fair hearing rights shall constitute a waiver of the Member's right to a hearing.

- C. Resolution Process:
1. If the Member timely elects to utilize these modified fair hearing rights, the Member shall be invited to meet with the chairman of the applicable department or other appropriate personnel to discuss the intended recommendation, and they shall attempt to resolve the matter informally.
  2. Informal resolution may include, but not be limited to, an agreement that the Member shall receive additional training, be proctored, or be subject to retrospective and/or concurrent case review.
  3. This meeting should be arranged through the Medical Staff Services Department as soon as reasonably possible.
  4. The Member shall be provided, in advance, a copy of the request for the request for the recommended action or complaint, as well as any and all supporting materials.
  5. This informal meeting is not a hearing; accordingly, there shall be no transcripts made, no hearing officer or hearing committee designated or attending, no counsel present, and no formal evidentiary or other procedural rules applicable.
  6. Within ten (10) days after the conclusion of this meeting, the chairman of the applicable department or other appropriate personnel shall submit a brief written report and recommendations to the Credentials Committee.
  7. In the event the Member and the department chairman or other appropriate personnel reach such an agreement, the matters shall be presented to the Credentials Committee as a joint recommendation.
  8. In the event the Member and the department chairman or other appropriate personnel fail to reach an agreement, the department chairman or appropriate personnel shall submit his/her recommendation to the Credentials Committee.
  9. The Member may also submit a written statement to the Credentials Committee for its consideration.
  10. The Credentials Committee shall consider this matter at its next regularly scheduled meeting after it receives the department chairman's or Medical Staff Leadership's report and recommendation and the Member's statement, provided that sufficient time exists to arrange the attendance of the affected Member and department chairman or other appropriate personnel at such meeting.
  11. At the Credentials Committee meeting, the Member shall have an opportunity to present his/her views and submits any relevant written materials for consideration; the same opportunity shall be afforded to the department chairman or other appropriate personnel. The Member may be excused from the meeting after his/her presentation.
  12. This meeting is not a hearing; accordingly, there shall be no transcript made, no hearing officer or hearing committee designated or attending, no counsel present, and no formal evidentiary or other procedural rules applicable.

## **Section 1. Modified Due Process – con't**

13. The Credentials Committee shall consider the matter and make its decision in the same manner as it does with other Credentials Committee matters. The decisions shall be reflected in the Credentials Committee's minutes and shall be considered by the Executive Committee and the Board of Directors in the same manner as other committee matters is so considered.
  14. The Member may not contact any member of the Hearing Committee or other Medical Staff Members or Hospital Administration prior to and during the Hearing Process.
- D. Miscellaneous: No Article VII evidentiary hearing or appellate review is available under this Section 1, and the decision of the Credentials Committee, when affirmed by the Executive Committee and the Governing Board, shall be final and conclusive.

## **Section 2. Medical Staff Hearing**

- A. Except as provided in Article VII above or as otherwise specifically provided in these Medical Bylaws, the Credentialing Manual, Clinical Practice Expectations or the Medical Staff Rules and Regulations, in all cases in which the aggrieved Member's privileges are denied, revoked, restricted, or otherwise adversely affected, the affected Member shall be promptly provided a notice of said action. Additionally, any requirement to report to the Maryland Board of Physicians or the National Practitioner Data Bank shall constitute the Member's right to a fair hearing. It is also noted that a Member does not have the right to a fair hearing in the following circumstances: probations, reprimands, warning letters, monitoring, proctoring, mandatory consultations which do not require prior approval, concurrent and retrospective audits or review, FPPE, OPPE and the requirement for continued training or education.
1. Said notice shall be sent by the Director of Medical Staff Services by certified mail, return receipt requested.
  2. Said notice shall state the action taken against the Member and the reason for the action taken.
  3. The Member shall be given thirty (30) days within which to request a hearing.
  4. The notice shall contain a brief summary of the Member's rights as afforded in the Bylaws as well as a copy of said section of the Bylaws.
- B. The Member shall make a request for a hearing in writing addressed to the Director of Medical Staff Services. Failure to request a hearing within the 30 days shall constitute a waiver of the Member's right to a hearing.
- C. Upon receipt of a request for a hearing, the Director of Medical Staff Services shall inform the President of the Medical Staff who shall be responsible for the appointment of the hearing officer and hearing committee.
4. The Director of Medical Staff Services shall notify the Member of the place, time and date of the hearing. The date shall not be less than thirty days after the request of the hearing is received. The notice shall also include the names of the Hearing Committee and Committee Members. The notice shall also include a list of the witnesses expected to testify at the hearing on behalf of the Hospital and the Medical Staff.
  5. If the Member objects to any of the Members of the Committee or the hearing officer, he/she shall within five days of receipt of the notice make his/her objections in writing to the Director of Medical Staff Services. Said objection shall include the specific grounds for the objection. The notification shall either call upon the President of the Medical Staff to determine if the objection is valid and then if valid, replace the Member objected to, or the Member may request that the objection be put before the Executive Committee. If the Medical Executive Committee determines that the objection is valid, they shall direct the President of the Medical Staff to make a new appointment. The Member will then receive notice and have five days to object to the new Member with the same procedures as outlined in this section. Any request to refer this to the Medical Executive Committee for review shall be deemed a voluntary postponement of the hearing until such date as it can reasonably be rescheduled. Failure to object within the five days shall constitute acceptance of the composition of the hearing committee and hearing officer shall constitute a waiver of his/her right to object to said Members.
  6. Postponement of hearings may be requested by the Member or the Hospital. The President of the Medical Staff shall determine if a postponement prior to the commencement of the hearing is with good cause. Unless a postponement is granted, the time of the hearing shall be set no later than sixty days after the receipt by the Director of Medical Staff Services of the Member's request for a hearing.

## Section 2. Medical Staff Hearing – con't

- D. Conduct of the Hearing
1. The Member and the Hospital shall each have the following rights:
    - a. To be represented by an attorney of the party's choice.
    - b. To call, examine, and cross-examine witnesses.
    - c. To introduce exhibits, charts, medical records and other evidence determined to be relevant by the hearing officer.
    - d. To present generally accepted technical or scientific matter; to cross-examine opposing witnesses on any matter relevant to the issues, even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called the witness to testify; to rebut the evidence presented; to submit a written statement at the close of the hearing; and to present any pertinent material on file in the Hospital and all other information which may be considered in connection with applications for appointment or reappointment to the Medical Staff and delineation of clinical privileges. If the aggrieved Member does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination by the Hospital.
    - e. To submit a list of potential witnesses and submit supporting documents and other materials in advance of hearing.
    - f. Any procedural or other related matters that arise before the hearing may be addressed in a type of pre-hearing conference between the parties so as to facilitate a more smooth flowing hearing.
  2. Admissibility of Evidence
    - a. The hearing shall not be conducted according to technical rules of law relating to evidence and witnesses. Any relevant evidence shall be admitted if it is evidence on which responsible persons are accustomed to rely in the conduct of serious affairs without regard to its admissibility in a court of law. Oral evidence shall be taken under oath or affirmation.
    - b. The Hearing Committee and/or the hearing officer may take official notice of any generally accepted technical or scientific matter within the Hearing Committee's special field of competence and of any facts which may be judicially noticed by the Courts of this State of Maryland. Wherever practical, parties to the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record. Any party shall be given a reasonable opportunity (on timely request) to have a matter be officially noticed, and to refute the officially noticed matters by evidence in a manner to be determined by the hearing officer.
  3. All proceedings shall be transcribed by a qualified court reporter at the expense of the Hospital. Copies of transcript(s) shall be prepared at the expense of the party requesting such copy.
  4. A majority of the Members of the Hearing Committee shall be present when the hearing takes place. A Member must be present for the majority of the hearing in order to participate in the final decision. No Member may vote by proxy. The decision of the Hearing Committee shall be by majority vote.
  5. The Member must be present at the hearing. Failure to appear without good cause or to proceed shall be deemed as a waiver of the right to a hearing and shall be construed as acceptance of the action and recommendation for which the hearing was requested.
  6. The party whose adverse action or recommendation occasioned the hearing has the initial obligation to present evidence in support of its action or recommendation. The Member must establish that the recommendation is not supported by a preponderance of the evidence, or by a substantial weight of the evidenced, coupled with the arbitrary or capricious standard.
  7. The Member and the Hospital shall have the right to the assistance of counsel at all phases of the hearing (and appellate review process), including the presence of counsel at any such hearing (or appellate review).
  8. The Hearing Committee may recess the hearing and reconvene for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
  9. At the conclusion of the oral testimony and introduction of written exhibits at the hearing, both the Member and the Hospital shall have the opportunity to make written submissions to the Hearing Committee, within a timeframe to be determined by the Hearing Committee. Thereafter, upon the timely filing of any such final written submissions by the parties, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties and all others, except for the hearing officer.

## **Section 2. Medical Staff Hearing – con't**

10. Upon conclusion of the presentation of oral and written evidence and the submission of any concluding statements by either the Member or the Hospital, the hearing shall be deemed closed. The Hearing Committee shall thereupon conduct its deliberations outside the presence of the parties and all others except for the hearing officer if the committee so desires.
  11. Within fourteen (14) days, the Hearing Committee shall vote and make a written report of its recommendations and the basis for the recommendations to the Medical Executive Committee. The report may recommend affirmation, modification, or rejection of the original recommendations of the Medical Executive Committee. A copy of the report and recommendations shall be given to the Member either in person or by certified mail, return receipt requested.
- E. The Medical Executive Committee shall consider the report and recommendations of the Hearing Committee at its next regularly scheduled meeting.
1. If the decision of the Hearing Committee affirms the prior decision of the Medical Executive Committee, then the Medical Executive Committee shall accept the report and forward it along with comments to the Governing Board.
  2. If the decision of the Committee is contrary to the decision of the Medical Executive Committee, the Medical Executive Committee may accept the report and notify the Member of the reversal of the prior decision. Or the Medical Executive Committee may reject the report and forward the matter to the Governing Board for review.
  3. If a decision of the Medical Executive Committee is adverse to the Member, said Member is entitled to an Appeal by the Governing Board.

## **Section 3. Appeal**

- A. Notice of Adverse action shall be given immediately upon the decision of the Medical Executive Committee. Said notice shall be given by the Director of Medical Staff Services by certified mail, return receipt requested, hand delivery, commercial overnight delivery, or such other means as is 'commercially reasonable (e.g., fax). Said notice shall contain information about the right to appeal and the requirements to file the appeal.
- B. Within thirty days of said notice, the Member or the Medical Staff or Hospital may appeal to the decision the Governing Board by giving a written notice to the Chairman of the Governing Board, via the Director of Medical Staff Services. If the Member, Medical Staff or Hospital wishes to make oral arguments at such appeal hearing, the request for appeal shall so state. Failure to so request an appeal hearing within the thirty day period shall constitute any right to an appeal hearing before the Governing Board, which may then act upon the recommendations of the Medical Executive Committee of the Medical Staff and Hearing Committee.
- C. The Chairman of the Governing Board shall set a date and time and place for the appeal hearing within 120 days of the receipt of the request for appeal.
1. The notice shall be given within thirty days of receipt of the request for an appeal. The notice shall contain the date, time and place of the hearing as well as the hearing committee Members and hearing officer.

## **Section 4. Appellate Review Hearing**

- A. Upon receipt of a request for a hearing, the Director of Medical Staff Services shall inform the Chair of the Governing Board who shall be responsible for appointing an Appellate Review Committee and a Hearing Officer for the Hearing.
1. The hearing officer shall be an attorney knowledgeable in health care matters. The hearing officer shall preside over the procedural aspects of the hearing. The hearing officer may participate in the deliberations of the Appellate Review Committee if requested to do so by the Committee. He/she shall advise the Committee but not vote.
  2. The Appellate Review Committee shall consist of a minimum of three Members and up to five Members of the Governing Board who have not been involved in the proceedings prior to the matter coming to the Appellate Review Committee. No Member of the Appellate Review Committee shall be in direct economic competition with the Member nor shall any Member be a direct referral source to or from the Member.

3. The Chair of the Governing Board shall appoint an Appellate Review Committee Chair person from the Members. The chair person shall preside over the hearing as to substantive matters and may preside over procedural matters in the absence of the hearing officer.

4. If the Member objects to any of the Members of the committee or the hearing officer, he/she shall within five days of receipt of the notice make his objections in writing to the Director of Medical Staff Services. Said objection shall include the specific grounds for the objection. The notification shall call upon the Chairman of the Governing Board to determine if the objection is valid and if valid then replace the Member. The Member will then receive notice and have five days to object to the new Member with the same procedures as outlined in this section.

5. Postponement of a hearing may be requested by the Member or the Hospital. The Chairman of the Governing Board shall determine if a postponement prior to the commencement of the hearing is with good cause. Unless a postponement is granted, the time for the hearing shall be set no later than sixty days after the receipt by the Director of Medical Staff Services of the Member's request for a hearing.

## B. Conduct of Hearing

1. The Member and the Hospital shall each have the following rights:

a. To be represented by an attorney of the party's choice.

b. To submit a written rebuttal statement detailing the reasons that the decision of the Medical Executive Committee should be upheld or reversed. Said statement shall be delivered to the opposing party at least thirty days before the hearing. The other party may submit a rebuttal statement in writing at least ten days before the scheduled hearing and shall forward a copy to the other party. Failure to submit said statement shall indicate that said party has no disagreement with the proceedings below.

2. All proceedings shall be stenographically transcribed by a qualified court reporter at the expense of the Hospital. Copies of the transcript shall be prepared at the expense of the party requesting such copy.

3. A majority of the Members of the Hearing Committee shall be present when the hearing takes place. A Member must be present for the majority of the hearing in order to participate in the final decision. No Member may vote by proxy. The decision of the Hearing Committee shall be by majority vote.

4. The Member must be present at the hearing. Failure to appear without good cause or failure to proceed shall be deemed as a waiver of the right to a hearing and shall be construed as acceptance of the action and recommendations for which the hearing was requested.

5. The record created in the previous proceeding, including the recommendation of the Hearing Committee and the Executive Committee of the Medical Staff, the transcript and exhibits of the previous hearing, and the written statements submitted pursuant to subparagraph "B-1-b" of this section, shall be made available for consideration by the Appellate Review Committee. Copies of any or all such documents may be forwarded by the Hospital to the Members of the Appellate Review Committee and the hearing officer (if applicable) prior to the date of the appeal hearing. If oral argument is requested by either the Chairman of the Appellate Review Committee or the Member as part of the review procedure, the Member shall be present at such appellate review, shall be permitted to speak against the adverse recommendations or decision, and shall answer questions put to him/her by any Member of the Appellate Review Committee. The Executive Committee of the Medical Staff or the Governing Board, whichever is appropriate under the circumstances, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any Member of the Appellate Review Committee. The Hearing Officer (or, if there is no hearing officer, the Chairman of the Appellate Review Committee) shall maintain decorum in the appeal hearing, shall rule on all procedural matters, and shall assist the Appellate Review Committee, but he/she shall be without vote. The time for oral arguments shall be limited to one hour for each side (including time for rebuttal) unless the Appellate Review Committee agrees to extend such time.

6. New or additional matters not reflected in the record of the Medical Staff Hearing Committee shall not be introduced at the Appellate Review Hearing unless circumstances have materially changed since the Medical Staff Hearing. The Review Appellate Hearing Committee shall have the sole discretion to determine whether such new matters will be accepted.

#### **Section 4. Appellate Review Hearing – con't**

7. The Appellate Review Hearing Committee may recess the hearing and reconvene for the convenience of the participants or for consultation.
8. Upon conclusion of the presentation of oral and written evidence, the hearing shall be deemed closed. The Hearing Committee shall thereupon conduct its deliberations outside the presence of the parties and all others except the hearing officer if the committee so desires.
9. Within fourteen days the hearing Committee shall vote and make a written report of its recommendations and the basis for the recommendations to the Governing Board. The report may recommend affirmation, modification or rejection of the recommendations of the Medical Executive Committee. A copy of the report and recommendations shall be given to the Member either in person or by certified mail, return receipt requested.
10. The Appellate Hearing Committee shall sustain the recommendation of the Medical Executive Committee unless said recommendation lacks a substantial factual basis or the conclusions drawn from the facts were either arbitrary or capricious or the Member's fair hearing rights set forth in these Bylaws were materially and adversely affected during the hearing process. The Member must establish that the recommendation is not supported by a preponderance of the evidence, or by substantial weight of the evidenced, coupled with the arbitrary or capricious standard.
11. The Committee may take whatever action it deems appropriate at the conclusion of the hearing, including referring the case to the Medical Executive Committee for further consideration and or making its report to the full Governing Board.
12. A copy of the report shall be sent to all affected parties. The final decision of all appealed cases shall be made to the Governing Board at its next regularly scheduled meeting. The Governing Board shall act on the report of the committee and send a notice of its final decision to all affected parties.

**Section 5. Privileged Communications:** Any report, information or accusation filed, or any action recommended under Article VII and VIII, shall be deemed a privileged communication except as to the hearing committee members, the Governing Board, the Medical Executive Committee and other persons with a right to know.

**Section 6. Waiver of Right to Personal Redress:** By applying to become and/or becoming a Member of the Medical Staff, each Member waives any right to personal redress against any Member of the Medical Staff, the Hearing Committee, the Appellate Review Committee, any hearing officer(s), any witnesses, any Hospital officer and/or employee, the Governing Board or any member thereof or other persons who have a right to know or who give information for action taken under this Article if such persons have acted without malice.

**Section 7. Default:** Upon the failure of the Member to appear or proceed at any hearing or recessed hearing without just cause or excuse, the matter shall proceed as in case of default. The Member may be deemed to have voluntarily accepted the recommendations on which the hearing is based. Such deemed acceptance may include, where deemed appropriate by the hearing body, voluntary resignation from the Medical Staff.

**Section 8. Number of Hearings and Reviews:** Notwithstanding any other provision of these Bylaws, no Member shall be entitled to a second evidentiary hearing and appellate review on any matter which shall have been the subject of action under this Article.

**Section 9. Release:** By requesting a hearing or appellate review under this Article, a Member shall be deemed to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability.



**Section 10. Data Bank Reporting:** As to any adverse recommendation or action regarding an applicant or Member which:

- A. Relates to that individual's competence or professional conduct;
- B. Is based on a professional review activity;
- C. Has an effect of longer than thirty days;
- D. Denial of application; and
- E. Any other event required to be reported to the Maryland Board of Physicians, State Board of Dental Examiners, Medical Board of Podiatry, National Practitioner Data Bank, other State Board or State or Federal Agency,

the following actions shall occur: Within fifteen days after the execution of such an adverse recommendation or action by an authorized official, the Medical Staff Services Department shall prepare a report of the adverse recommendation or action and submit such report to the Maryland Board of Physicians, State Board of Dental Examiners or other appropriate entity (the "State Board") for forwarding to the National Member Data Bank, in accordance with federal law. If errors or omissions in such report are found after the report's submission, the Medical Staff Services Department shall immediately forward an appropriate addition or correction to the State Board. The Medical Staff Services Department shall also report to the State Board any revisions of the action originally reported within fifteen days of such revision, including the results of any appellate or other review. The Medical Staff Services Department shall similarly report to the State Board any surrender of clinical privileges or any restriction of such privileges by an applicant or Member: (a) while the applicant or Member is under investigation by the Hospital relating to possible professional incompetence or improper professional conduct, or (b) if such surrender or restriction occurs in return for the Hospital's agreement not to conduct such an investigation or proceeding.

**Section 11. Effect of Contract/Hospital Employment:** The provisions of this Article, except those of Section 11, may be completely or partially supplanted by a contract(s) and/or employment relationship(s) between the Hospital and the Member(s), to the extent such contract(s) and/or Hospital policies govern issues including, but not limited to, the selection, tenure and responsibilities of department chairmen, the staffing of departments, and the individual responsibilities and clinical privileges of Members exercising clinical privileges in the applicable department(s).

## ARTICLE IX OFFICERS

**Section 1. Officers of the Medical Staff:** The officers of the Medical Staff shall be:

- A. President
- B. Vice President
- C. Immediate Past President
- D. Secretary/Treasurer

**Section 2. Qualifications of Officers:** Officers must be members of the Active Physician Staff at the time of nomination and election and must remain Members of the Active Physician Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers shall be qualified by training, experience, and demonstrated leadership abilities for the position. Members who are suspended for 30 days or more in a calendar year for any reason shall not be eligible to hold a leadership role for the Medical Staff. If a member is currently in a leadership role, then they must step down from their position if they are suspended for 30 or more days in a calendar year for any reason.

### **Section 3. Election of Officers**

- A. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. Officers shall be elected by secret ballot only if the election is contested at the annual meeting of the Medical Staff.
- B. The Nominating Committee shall consist of five members of the Active Physician Staff including the Vice President as Chair and a minimum of two chairmen of departments to be selected by the Executive Committee. This committee shall offer one or more nominees for each office and shall notify the Active Medical Staff as to its nominees at least thirty days before the annual Medical Staff meeting. In addition, the Nominating Committee shall nominate four members-at-large to the Executive Committee and those members-at-large shall be approved by the Executive Committee prior to being placed on the slate of officers presented to the Medical Staff.
- C. Nominations may also be made from the floor at the time of the annual meeting or may be made by petitions signed by at least five (5) members of the Active Physician Staff and filed with the Associate Vice President of Quality and Medical Staff Services at least fourteen days prior to the annual meeting.
- D. Committee members (except those of the Executive and Finance Committee) shall be appointed by the Executive Committee upon recommendation from the departmental chairmen. Committee chairmen shall be designated by the Nominating Committee and accepted by the Executive Committee.
- E. All officers are elected by the staff and their appointment made by the Governing Board.
- F. The President of the Medical Staff shall annually appoint an American Medical Association (AMA) Representative for the Medical Staff.

**Section 4. Term of Office and Removal of Officers:** All officers shall serve a one year term or until a successor is elected. An officer may serve additional terms if reelected. Officers shall take office on the first day of the Medical Staff year. Officers may be removed for cause, such as neglect of duty, pending disciplinary action, unethical behavior, or failure to adhere to the Medical Staff Bylaws, by petition of one-third of those eligible to vote at any meeting of the Medical Staff. The Executive Committee, Medical Staff Semi Annual Members and the Governing Board, must approve the recommendation for removal by majority vote of those attending and eligible to vote.

**Section 5. Vacancies in Office:** Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the Executive Committee of the Medical Staff, subject to the approval of the hospital's Governing Board. If there is a vacancy in the office of the President, the Vice President or Immediate Past President may serve out the remaining term.

## Section 6. Duties of Officers

- A. President: The President shall serve as the chief administrative officer of the Medical Staff to:
1. act in coordination and cooperation with the Hospital's President in all matters of mutual concern within the Hospital;
  2. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
  3. serve as the Chair of the Medical Staff Executive Committee;
  4. serve as an ex officio member of all other Medical Staff committees without vote;
  5. be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where remedial action has been requested against a Member;
  6. represent the view, policies, needs and grievances of the Medical Staff to the Governing Board and to the Hospital's President;
  7. receive, and interpret the policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
  8. be responsible for the educational activities of the Medical Staff; and
  9. be the spokesman for the Medical Staff in its external professional and public relations.

The Officers of the Medical Staff may be compensated monetarily during his/her term in office. These funds shall be derived from the Medical Staff dues.

- B. Vice President: In the absence of the President, he/she shall assume all duties and have the authority of the President. He/she shall be a Member of the Executive Committee of the Medical Staff, the Credentials Committee, and the Performance Improvement Council, and serve as the Chair for Bylaws Committee and Nominating Committee. In the second year of tenure, he or she will serve as Chair of the Credentials Committee.
- C. Immediate Past President: The Immediate Past President shall be a member of the Medical Executive Committee, the Credentials Committee, and Performance Improvement Council. He/she shall serve as Chair of the Professional Practice Evaluation Committee and during his/her first year post-presidency will serve as Chair of the Credentials Committee. In the absence of the President and Vice President, he/she shall assume all duties and have the authority of the President.
- D. Secretary/Treasurer: The Secretary/Treasurer shall be responsible for maintenance of records of all medical staff funds and render an annual report of these funds to the Executive Committee and the Active Medical Staff. He/she shall be the Chair of the Finance Committee and may be a member of the Credentials Committee. In the absence of the President, Vice President, and Immediate Past President, he/she shall assume all duties and have the authority of the President.
- E. American Medical Association (AMA) Representative: The AMA Representative shall attend the Annual AMA Conference and ongoingly report updates and important AMA news to the President of the Medical Staff to share with other members as appropriate.

**ARTICLE X**  
**CLINICAL DEPARTMENTS**

**Section 1. Organization of Clinical Departments and Services:** Each department shall be organized as a separate part of the Medical Staff and shall establish its own rules and regulations. Each department shall have a Chair who shall be responsible for the overall supervision of the clinical work within his/her department. Each department shall also have a vice-Chair, and such other officers as are deemed necessary by the members of the department. The provisions of this Article may be completely or partially supplanted by a contract(s) between the Hospital and the Member(s) of certain Departments such as Anesthesiology, Emergency Medicine, Pathology and Radiology. Such contracts to govern issues including, but not limited to, the selection, tenure and responsibilities of department chairmen, the staffing of departments, and the individual responsibilities and clinical privileges of Members exercising clinical privileges in the department.

**Section 2. Departments:** The staff may be divided into the following departments:

- A. Department of Anesthesiology
- B. Department of Emergency Medicine
- C. Department of Family Medicine
- D. Department of Medicine
- E. Department of Obstetrics and Gynecology
- F. Department of Pathology
- G. Department of Pediatrics
- H. Department of Radiology
- I. Department of Surgery

**Section 3. Nominating Committee:** Each department shall have a Nominating Committee, which will be consist of the following:

- A. The two most immediate past chairmen of the department of whom the senior will be the Chair of the committee. If the immediate past Chair is not available, the President of the Medical Staff may appoint a suitable substitute.
- B. Three Active Physician Staff members of the department, to be elected at the September department meeting. The Nominating Committee shall meet and nominate one Physician Staff member for each office in the department. These names will be circulated to the Active Physician Staff members of the department at least four weeks prior to the November meeting of the department, at which meeting the election will be held. Twenty-percent of the Active Physician Staff members of the department may place another name in nomination for any departmental office by petition presented to the Medical Staff Services Department no less than two weeks prior to the date of the election. Thereafter, the nominations shall be closed. The names of the members of the department so nominated shall be posted and circulated to the Active Staff members of the department no less than ten days prior to the election.
- C. Issues are to be decided by a simple majority vote of the Active staff members present.

**Section 4. Qualifications, Selection, Tenure, and Removal of Department Chairperson/Vice Chairperson:**

- A. Each Chair\vice Chair shall be a Member of the Active Physician Staff, certified by an appropriate specialty board or qualified by training, and experience through the credentialing process and demonstrated leadership ability for the position.
- B. Each Chair\Vice Chair, excluding chairmen of the Departments of Anesthesia, Pathology, Radiology and Emergency Medicine, shall be elected for a one-year term, subject to approval of the Governing Board.
- C. Removal of the Chair\Vice Chair during his/her term of office may be initiated by a two-thirds majority of all Active Physician Staff Members of the department, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and by the Governing Board.

**Section 5. Meetings of Department:** Each clinical department shall meet at least quarterly for the review and analysis of clinical work of the department.

**Section 6. Functions of Department Chairmen:** Each Chair shall be responsible for:

- A. Clinically related activities of the department;
- B. Administratively related activities of the department, unless otherwise provided by the hospital; including but not limited to the minutes of meetings of the department on file in the Medical Staff Office and any necessary collegial, informal or formal interventions regarding physicians in the department;
- C. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
- D. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- E. Recommending clinical privileges for each member of the department; transmit to the Executive Committee, via the Credentials Committee, his/her department's recommendations concerning the Medical Staff classification, the reappointment, and the delineation of clinical privileges for all Members within his/her department;
- F. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
- G. The integration of the department or service into the primary functions of the organization;
- H. The coordination and integration of interdepartmental and intradepartmental services;
- I. The development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
- J. The recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- K. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- L. The continuous assessment and improvement of the quality of care, treatment and services including the maintenance of performance improvement programs within the department;
- M. Conducting peer review of patient care within the department as indicated (or delegating this responsibility to the Vice Chair or other Department/Section member), as required by the provisions of the Bylaw Manual and Credentials Manual assuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the department in the clinical performance of all individuals with clinical privileges in that department. Departmental processes for performance improvement may include:
  - 1. The routine collection of information about important aspects of patient care provided in the department and about the clinical performance of its members. This information may be collected through activities of the department, through the overall Performance Improvement program, or through other Medical Staff monitoring functions.
  - 2. The periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care.
  - 3. Establishment of objective criteria by each department or clinical service that reflect current knowledge and clinical experience, and the use of these criteria by each department or clinical service or by the Hospital's Performance Improvement program in the monitoring and evaluation of patient care.
  - 4. When important problems in patient care in clinical performance or opportunities to improve care are identified, action shall be taken and the effectiveness of those actions shall be evaluated.
  - 5. The findings from and conclusions of monitoring, evaluating and problem-solving activities shall be documented and reported, and the actions taken to resolve problems and improve patient care, and the information about the impact about the actions taken shall be documented and be reported;

## **Section 6. Functions of Department Chairmen – con't**

- N. The orientation and continuing education of all persons in the department or service;
- O. Recommending space and other resources needed by the department of service;
- P. Be responsible for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his/her department;
- Q. Be responsible for implementation within his/her department of actions taken by the Executive Committee of the Medical Staff;
- R. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the Hospital's President or the Governing Board;
- S. Be a Member of the Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care;
- T. The Radiology Department Chair assists in determining the qualifications of radiology staff who use equipment and administer procedures;
- U. The Radiology Department Chair recommends the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff to the Executive Committee; and
- V. The Radiology Department Chair assists in ensuring that ionizing radiology services are supervised by radiologists who are doctors of medicine or osteopathy qualified by education and experience in radiology.

## **Section 7. Functions of Departments**

- A. Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and of the Governing Board, for the granting of clinical privileges and for the holding of office in the department.
- B. Each department shall be responsible for conducting focused, individual case reviews when indicated, as determined by the Department Chairperson, and forwarding the results of those reviews to the Professional Practice Evaluation Committee.
- C. Each department may establish separate clinical sections within their departments. These sections shall hold meetings at least bi-annually with minutes being documented and forwarded to their Department and the Medical Executive Committee. A Chair shall be elected to each section on an annual basis with vote by the section at their meeting or via proxy vote with recommendation to the department. There is no term limit for a Section Chair. They may continue their position as long as they remain Active status and are board certified in their primary specialty. The Department shall vote and forward as a recommendation to the Medical Executive Committee and the Governing Board for final approval. A section Chair may be removed from office with 2/3 vote of the section in favor. Each section may establish their own rules and regulations; however, the department rules and regulations supersede them.

**ARTICLE XI**  
**MEDICAL STAFF MEETINGS**

**Section 1. Semi-Annual Meeting:** There will be an Semi-Annual Meeting of the Medical Staff. At this meeting, the retiring officers and committees shall make reports as may be desirable. Officers for the ensuing year shall be elected and shall take office on the first of January. Additionally, the Annual Medical Staff Budget will be presented for approval upon recommendation from the Finance Committee. Changes to the Medical Staff Bylaws may also be presented for review and recommendation to the Governing Board.

**Section 2. Special Meetings:** Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff and shall be called at the request of the Governing Board, Executive Committee, or any twenty-five Members of the Active Physician Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. The Executive Committee of the Medical Staff may act on behalf of the organized Medical Staff between Semi-Annual Meetings.

Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail or fax or e-mail, to each member of the Active, Medical Staff not less than seven nor more than thirty days before the date of such meeting, by or at the direction of the President of the Medical Staff except in the case of special meetings, when notice shall be given as soon as possible. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Member at his/her address as it appears on the records of the Hospital. Notice may also be sent to Members of other medical staff groups who have so requested. The attendance of a Member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

**Section 3. Proxy Vote:** Materials for proxy vote such as prior meeting minutes, proposed Medical Staff Bylaws changes, proposed Annual Medical Staff Budget, and Annual Leadership and Other Nominations shall be mailed or e-mailed to all Active voting members of the Medical Staff at least 30 days prior to the scheduled meeting. A Member may submit a written proxy vote to the Medical Staff Office for all action items in lieu of attending the meeting.

**Section 4. Quorum:** At any meeting, the majority of those present and eligible to vote shall constitute the majority for purposes of amendment of these Bylaws, Rules and Regulations; and all other actions. Those voting members who submit their proxy vote prior to the scheduled meeting will count towards the quorum requirement.

**Section 5. Agenda:**

- A. The content at any regular Medical Staff meeting may include:
1. Call to order;
  2. Acceptance of the minutes of the last regular and of all special meetings;
  3. Unfinished business;
  4. Communications;
  5. Report from the Administrator of the Hospital;
  6. Reports of departments;
  7. Reports of committees;
  8. New business;
  9. Review and analysis of the clinical work of the Hospital;
  10. Reports of medical committees;
  11. Discussion and recommendations for improvement of the professional work of the Hospital;
  12. Proposed Medical Staff Bylaws Changes;
  13. Proposed Annual Medical Staff Budget;
  14. Proposed Annual Nominations for Leadership and Other Nominations;
  15. Adjournment; and
  16. Next Meeting.

**Section 6. Minutes:** Minutes of each regular and special meeting of the Medical Staff shall be prepared by the appropriate Leader of the Medical Staff and shall include a record of the attendance of Members and the vote taken on each matter. The minutes shall be signed by the Medical Staff Leader and shall be kept with the permanent records of the Medical Staff.

**ARTICLE XII**  
**COMMITTEE AND DEPARTMENT MEETINGS**

**Section 1. Regular Meetings:** Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings to review and evaluate the clinical work of Members in the department. At regular departmental meetings, quality improvement aspects of patient care should be considered.

**Section 2. Special Meetings:** A special meeting of any committee or department may be called by or at the request of the Chair thereof, by the President of the Medical Staff, or by one-third of the committee's or department's then members, but not less than two members.

**Section 3. Notice of Meetings:** Written notice stating the place, and day of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than fifteen days before the time of such meeting, by the person or persons calling the meeting except in the case of special meetings of which notice will be given as soon as possible. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting. Meeting notices may also be sent via e-mail and it is the responsibility of the Member to read the e-mail.

**Section 4. Quorum and Attendance:** The majority of those present, but not less than two members shall constitute a majority at any meeting, with the exception of any Audit/Review Committee which will require three members to constitute the majority. All members of a committee or department are encouraged to attend all meetings of the committee and/or department to which they are assigned. The Credentials Committee, Medical Executive Committee, and Professional Practice Evaluation Committee must have a minimum of 50% of the members present to constitute the majority for a quorum.

**Section 5. Manner of Action:** The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote thereon.

**Section 6. Rights of Ex Officio Members:** Persons serving under these Bylaws as ex officio members of a committee shall have the rights and privileges of regular members; except they shall not be counted in determining the existence of a quorum and they may not vote.

**Section 7. Minutes:** Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the appropriate medical staff leader and copies thereof shall be promptly submitted to the attendees for approval, and after such approval is obtained, forwarded to the Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.



**ARTICLE XIII**  
**IMMUNITY FROM LIABILITY**

The following shall be express conditions to any Member's application for, or exercise of, Medical Staff membership or clinical privileges at this Hospital:

FIRST, that any act, communication, report, recommendation, or disclosure, with respect to any such Member, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, or in furtherance of or required by any provision(s) of these Bylaws, the Credentialing Manual, the Rules and Regulations, or state or federal law or regulation for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law;

SECOND, that the privilege described above shall extend to the Hospital, all Members of the Hospital's Medical Staff, the Governing Board, other Members, the Hospital's President and his/her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, consider or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Board or the Medical Staff;

THIRD, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure, made in furtherance of, permitted under, or required by any provision of these Bylaws, the Credentialing Manual, the Rules and Regulations or state or federal law or regulation, even where any information involved would not otherwise be deemed privileged;

FOURTH, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

- A. applications for appointment or clinical privileges;
- B. periodic reappraisals for reappointment or clinical privileges;
- C. corrective action, including summary suspension;
- D. hearings and appellate reviews;
- E. medical care evaluations, including but not limited to proctoring;
- F. utilization reviews; and
- G. other Hospital, departmental, service or committee activities related to quality patient care and professional conduct.

FIFTH, that the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a Member's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care;

SIXTH, that in furtherance of the foregoing, each Member shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph SECOND of this Article, subject to such requirements of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State;

SEVENTH, that the consents, authorizations, releases, rights, privileges and immunities provided pursuant to any provisions of the Credentialing Manual for the protection of this Hospital, its Medical Staff, appropriate Hospital officials and personnel and third parties, in connection with applications for appointment, reappointment, and clinical privileges, shall also be fully applicable to the activities and procedures covered by this Article.

The applicant specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's qualifications for clinical privileges as a Physician or Allied Health Professional. This authorization includes the right to inspect and obtain any and all communications; reports, records, and documents from said third parties. The applicant also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

To the fullest extent permitted by law, the applicant releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, its authorized representatives, and any third parties with respect to acts, communications or documents, recommendations, or disclosures involving the applicant.

**ARTICLE XIV  
GENERAL PROVISIONS**

**Section 1. Notices:** Any notice required by these Bylaws may be sent by certified mail (usually accompanied by return receipt requested) or may be hand delivered or sent via e-mail.. All notices sent by certified mail shall be presumed to have been received within three days after the notice has been mailed.

**Section 2. Conformity With Credentials Manual:** The Bylaws Manual is not intended to replace the Credentials Manual. In the event of conflict between the Credentials Manual and the Bylaws Manual, the provisions of the Bylaws shall govern.

**Section 3. Adoption and Amendments:** ; The Bylaws are developed by the organized Medical Staff. The organized Medical Staff enforces compliance with the Medical Staff Bylaws. This Bylaws Manual, except for the Medical Staff Rules and Regulations and Appendices, shall become effective after they have been recommended by the Officers of the Medical Staff, Executive Committee, voted and recommended by the Active Medical Staff and have been approved by the Governing Board. The Medical Executive Committee represents and acts on behalf of the organized Medical Staff between meetings of the organized Medical Staff.

**Section 4. Conflict Resolution:**

A. CONFLICTS BETWEEN THE GOVERNING BOARD AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Staff, in partnership with the Governing Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Governing Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Governing Board, or a designated committee of the Governing Board and Hospital Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President or the Chair of the Governing Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chair, Vice-Chair, and Secretary of the Board or other designees of the Governing Board
- The Hospital President or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Governing Board within 30 days of the initial meeting, the Medical Staff and the Governing Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Governing Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Governing Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Governing Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Governing Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Governing Board cannot resolve the conflict in a manner agreeable to all parties, the Governing Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Governing Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Governing Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chair of the Governing Board or the Medical Staff President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Governing Board, or the Hospital Administration.

#### B. CONFLICTS BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the perceived wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President, the representatives of the Medical Staff or the Chair of the Governing Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- Three voting members of the Medical Staff selected by the Medical Staff members who signed the written petition
- The Chair of the Governing Board
- The Hospital President or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Governing Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Governing Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Governing Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Governing Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chair of the Governing Board or the Medical Staff President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Governing Board, or the Hospital Administration.

## ARTICLE XV RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. Similarly, the departments and sections of the Medical Staff may also adopt such departmental and section rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Executive Committee and the Governing Board. All such rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Member in the Hospital. All such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any Executive Committee meeting at which a quorum is present and without previous notice, or at any special meeting of the Executive Committee on notice, by a two-thirds vote of those present. Such changes shall become effective when approved by the Governing Board. The Executive Committee has the ability to adopt an urgent amendment to the Rules and Regulations subject to the Conflict of Interest Policy.

Urgent Amendment: In the event that the hospital receives a written notice, demand or other similar communication from a governmental or accrediting body or similar entity or if the Hospital is put on notice that it needs to amend a rule or regulation of the Medical Staff in order to comply with any law or regulation which change cannot be accomplished within the time frames provided within the Bylaws, an urgent amendment to a rule or regulation may be pursued.

The Medical Executive Committee shall be delegated the authority to provisionally adopt and the Governing Board may provisionally approve an amendment to a rule or regulation, as may be required to comply with the law, without any prior approval of the medical staff. In such cases, the entire medical staff will be immediately notified by the Medical Executive Committee. Copies of any notice or materials requiring urgent amendment, if not otherwise confidential, will be submitted along with the written notice. The medical staff has the opportunity to retrospectively review and comment on the provisional amendment. If there is no conflict between the medical staff and the Medical Executive Committee, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the process for resolving conflict between the medical staff and the Medical Executive Committee shall be followed. If necessary, a revised amendment will be submitted to the Governing Board for its review and consideration.

Where the urgent change only involves a change to policy of the Medical Staff, the approval process referenced above does not apply but a copy of the policy amendment will be sent to all members of the Medical Staff.

**ARTICLE XVI**  
**ADOPTION, AMENDMENTS AND REVIEW**

These Bylaws may be adopted at any regular or special meeting of the Active Medical Staff, and shall become effective when approved by the Governing Board of the Hospital. These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. Copies of proposed Bylaws changes shall be sent out to the Active Staff members prior to the next regular or special Medical Staff meeting at least 30 days prior to the scheduled meeting. A proposed amendment shall be referred to the Bylaws Committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds vote of the Active Medical Staff members present and eligible to vote. In the event of a proxy vote, passage of an amendment shall require two-thirds of the majority of the votes received from members eligible to vote to recommend the amendment. Those voting members who submit their proxy vote for the recommended changes will count towards the quorum requirement.

The Medical Executive Committee represents and acts on behalf of the organized Medical Staff between meetings of the organized Medical Staff. The Organized Medical Staff may directly propose changes to the Medical Staff Bylaws, Rules and Regulations and Policies and amendments thereto, directly to the Governing Board. The Medical Staff Bylaws are adopted by the medical staff and approved by the Governing Board before becoming effective. The Governing Board complies with the Medical Staff Bylaws. Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. All changes to the Credentialing Manual (including procedures for processing applications for the granting, renewal, or revision of clinical privileges) are reviewed and recommended by the Credentials Committee and the Medical Executive Committee (acting on behalf of the entire Medical Staff) and approved by the Governing Board before becoming effective. These Bylaws, including the Credentialing Manual, the Medical Staff rules and regulations, and the department and section rules and regulations, shall be reviewed by the appropriate committee at least bi-annually to assure their continued relevance and applicability to the affairs of the Medical Staff and the Hospital

**SHADY GROVE MEDICAL CENTER  
MEDICAL STAFF RULES AND REGULATIONS**

1. Every member of the Active Medical Staff is expected to be actively interested in securing **autopsies** and quality monitoring of autopsies in the hospital. No autopsy shall be performed without prior written consent. All autopsies shall be performed by a Hospital pathologist or by a Physician to whom he/she may delegate the duty. The Medical Staff uses developed criteria for autopsies. The Hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the Medical Staff (specifically the attending physician of autopsies that the hospital intends to perform).
2.
  - A. All service or unassigned patients (i.e., a patient who does not have an attending physician on the Shady Grove Medical Center staff) presenting at the Emergency Department shall be assigned to the Department or Section concerned in the treatment of the disease which necessitated admission. All such patients shall be assigned to the appropriate Department or Section and to the Physician **on-call on the emergency room roster** for that department or section.
  - B. Each Department and Section is authorized to, and shall include in its Rules and Regulations, provision for, the establishment and functioning of an on-call roster for Emergency Department referrals, including the designation of who is responsible for preparing the roster, the frequency of preparation and rotation of the roster, the eligibility for service on the roster and any other relevant matters.
  - C. The Hospital, Medical Executive Committee or each Department or Section may require all members or members of a designated category of Medical Staff membership to accept Emergency Department roster referrals. The roster shall be devised so that Medical Staff participation rotates fairly and provides equal access to the roster among those who are deemed qualified and eligible by the Department or Section.
  - D. The Chair of each Department or Section shall be responsible for providing or finding coverage if a Member of the department resigns, is suspended or is unable to be reached.
  - E. For Departments or Sections with seven or fewer eligible physician members to provide ED On-Call Coverage, each member will be required to provide ED coverage a minimum of one day per week.
  - F. The schedule for a department or section must be published at least two months in advance.
  - G. Each physician will be responsible for contacting the Medical Staff Office in advance of changes and providing alternate coverage.
  - G. The Hospital shall supervise the Emergency Department roster system as necessary to assure conformity with this rule.
  - H. All physicians on the Emergency Room roster will be required to evaluate all patients referred by the E.D. (Emergency Department) at least once for the acute problems for which they were referred regardless of the patient's ability to pay, and regardless of the physician's HMO, IPA, etc. affiliation.
  - I. If the on-call physician has been called about the patient by the E.D. staff, or has seen the patient in the E.D., then it is that physician's responsibility to follow-up with the patient in the private office setting and that referral physician would be responsible for the patient if the patient were to return to the E.D. prior to being seen in the physician's private office. However, if the patient is given a written referral to the on-call physician's office but then returned to the E.D. prior to having been seen by the previous referral physician, then the patient will be assigned to the E.D. on-call physician on the day of the return visit.
3. All members of the Medical and AHP Staff will respond promptly to pages. 30-minute phone response time required and a 2-hour in person response time if required.

4. **All orders including, verbal or telephone orders must be dated, timed, and authenticated promptly within 48 hours by the original person who dictated the verbal or telephone order. (New CMS requirement effective January 26, 2012)**
- A. All verbal and telephone **orders** for treatment shall be in writing.
  - B. For patient safety purposes, **verbal orders** are only authorized when it is impossible or impractical for the prescriber to write the order.
  - C. In emergent situations, only registered nurses, physician's assistants, and nurse practitioners may accept verbal orders.
  - D. **Telephone orders** may be accepted from physicians by nurses and the following employees:
    - 1) A respiratory therapist shall be allowed to take telephone orders for respiratory treatments, medication or ventilator changes.
    - 2) Physical, occupational, and speech therapists, as well as audiologists, may be permitted to take telephone orders regarding performance of treatment within their various disciplines.
    - 3) Staff dietitians shall receive dietary telephone orders.
    - 4) Pharmacists shall be permitted to take telephone medication orders.
    - 5) Laboratory personnel shall be allowed to take telephone orders regarding laboratory studies, such as blood and culture specimens.
    - 6) Radiology technologists shall be permitted to take telephone orders regarding orders for x-ray studies.
  - E. If orders are faxed from an attending physician, the burden is on the physician to confirm receipt of the order. The physician should notify the charge nurse or the nurse providing direct patient care at the time the orders are faxed.
5. In the **absence from the area of any attending Physician** by reason of vacation, meetings, etc., he/she shall name another Member of the Physician Staff to care for his patients. The Physician so designated shall be informed as to the patient's condition. The name of the Physician's replacement shall be entered in the patient's record. In case of failure to name such an associate, the chief of department or the President of the Medical Staff or the Administrator of the Hospital (in that order) shall have authority to call any Member of the Medical Staff should he/she consider it necessary.
6. No member of the Medical Staff shall serve as attending physician, perform procedures, or act as an official consultant for members of his or her **immediate family** at Shady Grove Medical Center.
7. **Mass casualty assignments:** All Physician Staff Members may be assigned to posts, either in the Hospital or in the auxiliary hospital, or in mobile casualty stations; it is their responsibility to report to their assigned stations in the event of a mass casualty. All Members of the Medical Staff of the Hospital specifically agree to relinquish direction of the professional care of their patients, service and private, as addressed in the Hospital's Emergency Preparedness Plan in cases of such emergency, including the evacuation within or out of the Hospital.
8. Except in emergency, **no patient shall be admitted to the Hospital until a provisional diagnosis** has been stated and the consent of the Administrator or his/her delegate secured. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
9. Physicians or their designees should **visit patients at least once daily** while hospitalized, with the exception of healthy newborn infants who must be seen within 24 hours of birth. Designees shall be other Physicians or Physician assistants or Nurse Practitioners if permitted by their department with appropriate privileges. If a Physician assistant or Nurse Practitioner sees a patient on a given day, the attending Physician must see the patient the following day and that documentation be made on the patients' medical records by the Physician or his/her designee at the time of his/her visit. Documentation of each visit shall be recorded on the patient's chart.

10. Except in emergencies and as per the hospital's Consent policy, a surgical or invasive intervention shall be performed only after informed consent of the patient or his/her legal representative is obtained. These interventions include, but are not limited to:
  - 1) All surgical procedures;
  - 2) Any radiological procedure involving performance of percutaneous biopsy or drainage;
  - 3) Placement of intravascular monitoring catheters, other than as an adjunct to the administration of anesthesia that has been authorized separately;
  - 4) Invasion of body cavities for the purpose of drainage, biopsy or monitoring, including Endoscopic procedures;
  - 5) Any stress test;
  - 6) Traction pins;
  - 7) Cardioversion; and
  - 8) Other medical interventions defined in hospital policy as requiring consent.
11. All **tissue removed at operation** (except excluded list) shall be sent to a Hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis; the pathologist shall sign his/her report. The preoperative diagnosis must be recorded in the medical record prior to surgery. The exclusion list will be kept for reference in the Department of Pathology and the operating suite.
12. All surgical cases scheduled at Shady Grove Medical Center will follow the **pre-op requirements** as defined by the Department of Anesthesia Standards of Care Guidelines. All tests will be ordered in the name of the attending physician and the results will be available to the attending physician. (The Pre-operative Testing Requirements for Patients who are Receiving Anesthesia Other than Local Anesthesia Policy is available on-line via the medical staff website under the resources tab or via the Hospital Intranet under the Policy and Procedures tab for SGMC.)
13. The availability of the **primary surgeon in the O.R. or Labor & Delivery Suite/department** will be based on the skill level of the individual assisting as follows:
  1. If a Physician's Assistant (P.A.) is closing skin, the primary surgeon will be physically available within the O.R. or Labor & Delivery department;
  2. If a Surgical Assistant (S.A.) is closing skin, the primary surgeon will be physically present in the O.R. Suite or Delivery Room Suite; and
  3. Once skin closure has been completed, the primary surgeon will be immediately available by telephone or pager if he/she leaves the O.R. or Labor & Delivery department prior to the patient arriving in the PACU/Recovery Area."
14. **Consultations** should be obtained when in the judgment of the attending physician the consultation may improve patient care, when high risk treatment procedures are contemplated, when unexpected complications arise; or in cases in which treatment response seems unduly delayed.
  - A. Essentials of a Consultation: A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation. The consultation shall include:
    1. the name of the consulting physician
    2. name of the requesting physician
    3. brief reason for consultation
    4. findings, opinions, and recommendations for course of the patient's care
  - B. Responsibility of Requesting Consultation: The patient's Physician is responsible for requesting consultations when indicated. It is the duty of the Medical Staff through its department chairmen and Executive Committee to make certain that Members of the Medical Staff do not fail to call for consultations as needed.
  - C. A consultation from a Physician who is credentialed to manage patients on mechanical ventilators shall be required for all patients on ventilators unless the attending Physician is so credentialed.
  - D. Consultations must be completed **in a timely manner considering the level of urgency as expressed by the attending requesting the consult.**
15. **Drugs used** shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs, with the exception of drugs for bona fide clinical investigations. Exceptions to the rule shall be well justified.



16. **Narcotics**, unless otherwise specified, shall be discontinued at noon on the third day. **Antibiotics**, unless otherwise specified, shall be discontinued at noon on the seventh day and physicians shall be notified the day prior to discontinuation. **Anticoagulants** and other dangerous or toxic drugs are to be reviewed daily by nursing service and consultation be held with the Physician on the case. Drugs should not be discontinued without notifying the Physician. If the order expires in the night, it should be called to the attention of the Physician the following morning.
17. Except in cases of true emergency, the **Courtesy Staff Members may not admit patients to the Hospital when a Physician on the Active Medical Staff has a patient on the waiting list**. A review of all such admissions will be made by the Physicians' department and reported to the Executive Committee. If an admission is not thought to constitute a true emergency, the Physician will be contacted in writing by the Executive Committee and the Physician will be expected to answer in writing such allegation within ten days. All admission privileges may be suspended by the Executive Committee until such time as the usual procedures for hearing are followed.
18. Members of the **Active Medical Staff will have first priority of admissions and operating room scheduling** over the Courtesy Staff, except in cases of true emergency.
19. Members of the Medical Staff who have fewer than twenty-five **patient contacts** per year or who are not actively participating on two committees or who are not a Chairperson of a Committee shall be placed on Courtesy Staff. Patient contacts may include:
  - a) Inpatient Admissions
  - b) Inpatient Surgeries
  - c) Inpatient Consults
  - d) Outpatient Consults/Attending (includes pre-admission documentation such as H & P or consult)
  - e) Outpatient Surgeries
  - f) Outpatient and Inpatient Diagnostic Procedures
  - g) Days on ER Call
  - h) Referrals to Hospitalists or other physicians on staff for SGAH services
  - i) Referrals to the Emergency Room, Lab, Radiology, Pathology, Rehabilitative Medicine, etc.
  - j) Departments may be more specific regarding what patient contacts may include. Please refer to specific rules & regulations of each Department.

A member of the Medical Staff may be considered for active status if the average number of patient contacts of all the members of the physician's group is more than 25 per physician per group.

Active physicians who have privileges at only Shady Grove Medical Center and no other hospital affiliations may retain active status even when they do not meet the criteria requirement for 25 patient encounters per physician per group.

20. Physicians on the **Courtesy Staff** who admit twenty-five or more patients to the Hospital per year or actively participate on two committees or who are a Chairperson of a Committee **may seek higher privileges** at the appropriate time intervals as stated in the Credentialing Manual.
21. Patients admitted for **dental or podiatric services** shall be admitted to the surgical service. There must be a Physician in attendance who is responsible for the medical care of the patient throughout the Hospital stay.
22. Each Member of the Medical Staff, in accepting the Bylaws, Rules and Regulations, gives his/her assent to the use of the **Hospital formulary**, unless otherwise specified in writing on the patient's order sheet.
23. The attending physician is the admitting physician and/or the physician who follows the patient during the main course of stay, unless otherwise specified within the medical record, e.g., transfer of service, coverage for vacation. See rule #29 regarding transfer of service. The attending physician shall be held responsible for the **completion of a complete medical record** for each patient. The record of a discharged patient shall be completed within a period of time that in no event exceeds 30 days following discharge. If a physician does not complete the deficient portion of the record within thirty days following discharge, the physician, unless justifiably excused by the Executive Committee of the Medical Staff, will be placed on the non-admitting list. The medical record shall include a history and physical, medical or surgical treatment, operative report, pathological findings, progress notes, consults if applicable, summary or discharge note with mention of follow-up, discharge or death summary if applicable, physician's signature on autopsy report, when available, and completed and signed cancer staging forms, when applicable.. No medical record will be filed until it is complete, except on order of the Medical Record Committee. Late entries or corrections shall be notated.

A. All **operative and invasive procedures** performed shall be documented by a note in the medical record immediately following completion of the procedure. This note should include **(Must document even if there was none)**:

1. the date
2. name of operating surgeon and any assistants or anesthesiologists
3. title of the procedure
4. preoperative and postoperative diagnoses
5. type of anesthesia administered
6. a listing of specimens
7. significant complications during the procedure
8. estimated blood loss
9. the degree of tolerance of the procedure by the patient
10. and the status of the patient upon arrival in the PACU

A full, detailed operative report should then be dictated within 24 hours. It is recommended that all operative reports be dictated using the hospital's transcription equipment.

B. **History and Physical requirements** are now noted under Section 5.23 of the Medical Staff Bylaws as per CMS and Joint Commission requirements.

C. Patients will be discharged on order of the attending physician. A **discharge summary** must be written or dictated for all patients with a length of stay over 48 hours. It is recommended that All discharge summaries be dictated using the hospital's transcription system. A patient who expires always requires a death summary to be dictated within 48 hours of death. The discharge and/or death summary will include:

1. identification data
2. reason for hospitalization
3. significant history
4. significant physical examination findings
5. hospital course to include any consultations, procedures performed and care, treatment, and services provided
6. condition on discharge
7. post discharge plans
8. post discharge medications

\* Note #6 through #8 are not required for a death summary. If there are plans for an autopsy, this should be included as #7.

D. Patients will be discharged on order of the attending physician. For the purposes of this Rule 23, the attending Physician is the admitting Physician and/or the Physician who follows the patient during the main course of stay, unless otherwise specified within the medical record, e.g., transfer of service, coverage for vacation. main course of stay, unless otherwise specified within the medical record, i.e., transfer of service, coverage for vacation, etc. **The record of a discharged patient shall be completed within a period of time that in no event exceeds 30 days following discharge.** If a Physician does not complete the deficient portion of the record within thirty days following discharge, the Physician, unless justifiably excused by the Executive Committee of the Medical Staff, will be placed on the medical record suspension list.

E. Any Physician who is on the **medical record suspension list** shall not be allowed to admit or treat any new patients or post any new surgical procedures. These patients must be transferred to the services of a Physician who is not on the medical record suspension list. An on-call Physician who is on the medical record suspension list shall take the responsibility of replacing himself/herself with another Physician until the suspended Physician has completed his/her records; otherwise, the suspended Physician's Medical Staff privileges will be terminated. Patients of the suspended Physicians shall be covered by an alternate Physician selected by the suspended physician. The nursing unit shall be informed of the alternate coverage. A Physician who is placed on the medical record suspension list due to a delinquent record will be required to complete the delinquent record and any incomplete record before his/her name is removed from the medical record suspension list. Physicians on the medical record suspension list for more than 90 calendar days in a year will automatically be moved to Courtesy status and be required to pay Courtesy fees. .

- F. Should the deficiency result in the responsible Medical or Allied Health Professional Staff Member being on the **non-admitting list (on medical record suspension) for a period of thirty days**, a letter will be sent to the Member via certified mail, return receipt from the Department Chair giving the Member 60 additional days to correct the deficiency. If the Member remains on the medical records suspension list (on temporary suspension) 30 days after the Department Chair letter is mailed, then the President of the Medical Staff will send a letter via certified mail, return receipt to the Member reminding them of the 30 remaining days to correct the deficiency. Failure to correct the deficiency after 90 days of temporary suspension shall result in revocation of the Member's membership and privileges in accordance with Article VII, Section 3 (a), and no additional hearing or appeal rights shall apply.
- G. The time limits set forth in this Rules shall be tolled if a physician notifies the Director of the Medical Records Department that the physician will be **unable to complete delinquent medical records due to his/her extended illness or travel out of town**. When the physician resumes practice or returns to the area, he/she shall have seven (7) days to complete all delinquent records before he/she is suspended and placed on the non-admitting list. Physicians are encouraged to complete all charts as soon as practicable and, if possible, prior to scheduled travel.
- H. Members are only entitled **to access patient information** in the Hospital which is necessary and relevant to the medical care and treatment to be rendered by the Member to his/her particular patients, for one for whom the Member is providing consultation, or for research or peer review purposes under appropriate Hospital protocols. Accordingly, no Practitioner shall review nor make use of any Hospital department, personnel, property, or equipment to discover or review patient information which is not germane to his/her care of such patient. Members may not review their personal or family member's medical records for any reason without providing the appropriate consent through the Medical Records Department's release of records process. Members who fail to comply with this subsection may not be reappointed to the Medical Staff.
- I. All **original records are the property of the Hospital** and shall not be taken away without a court order, subpoena, or statutory requirement. In case of readmission of a patient, all previous records shall be made available for the use of the attending Physician upon request, and by notifying the Medical Record Department.
- J. **Medical records of all patients shall be afforded to Medical Staff Physicians in good standing for Hospital functions and bona fide study and research approved by the Institutional Review Board**, consistent with preserving the confidentiality of personal information concerning the individual patients. All patients' records are subject to inspection by the appropriate department Chair, Medical Staff committee, and Medical Staff officers for bona fide purposes. A patient may, with his/her permission and approval of the attending physician, be used as a teaching case, e.g., chart rounds, conferences. Subject to the discretion of the Administrator, former Members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
24. **Notices** may be sent by means other than certified mail including e-mail, and failure of a physician to pick up a notice by certified mail or read an e-mail does not affect the effectiveness of the notice.
25. **Patients who arrive in the Emergency Department without a family physician** will be considered to be adults if they have attained the age of 18; such patients will be considered to be pediatric if they are 14 years old or less. Patients who are 15, 16, and 17 years old will be admitted at the discretion of the Emergency Department Physician.
26. **Admitting privileges** are defined by the medical staff delineation of privileges. (See Credentials Manual)
27. All **admissions to the Adult ICU and PACU** from outside the hospital will be evaluated in the Emergency Department prior to transfer to the Adult ICU and PACU.
28. **Transferring primary responsibility for patient care** from one Physician to another Physician shall require documentation by an order in the patient's medical record by both Physicians. The receiving physician shall agree to become the responsible Physician prior to the transfer.
29. **Transfer summaries** should be dictated prior to the transfer of the patient. It is recommended that all transfer summaries be dictated using the hospital's transcription system. Transfer summaries shall include admission and discharge diagnosis, admission examination, hospital course including pertinent tests, pending lab test, and course of treatment, and transfer and follow-up plans.

30. **Medical Staff Performance Improvement Policy** (See Appendix A)
31. The following personnel/clinicians are **authorized to administer medications** at Shady Grove Medical Center::
  - 1) Physicians - any medications used within practice credentials;
  - 2) Physicians Assistants - working under direction of a physician and within approved scope of practice;
  - 3) CRNAs & CRNPs - any medication used within practice credentials and within approved scope of practice;
  - 4) Nurses - medications as authorized and within the scope of license;
  - 5) Radiology Technologists - contrast media;
  - 6) Respiratory Therapists - inhalation medications;
  - 7) Physical/ Occupational Therapists - fluoromethane spray.
32. Shady Grove Medical Center does not have sufficient facilities and qualified personnel to treat, and will not admit and retain, patients with **a primary diagnosis of psychiatric illness or substance abuse**. Unless first requiring medical treatment for stabilization of medical problem, these patients will be evaluated by mental health services and transferred to an appropriate facility as expeditiously as possible. Members will obtain the appropriate psychiatric consult for patients who are emotionally ill or who become emotionally ill while in the Hospital or who suffer the results of acute alcoholism or acute drug abuse.
33. **Code of Conduct Policy** (See Appendix B)
34. **Physician Monitoring Process Policy** (See Appendix C)
35. **Physician Travel Policy** (See Appendix D)
36. **Meeting Cancellation Policy** (See Appendix E)
37. **Identification Badge (I.D.) Policy** (See Appendix F)
38. **Medical Records Suspension Fining Policy** (See Appendix G)
39. **Credentialing LIPs and Non-LIPs in the Event of Disaster** (See Appendix H)
40. **Administrative procedures may be in supplementary documents** to the Medical Staff Bylaws as long as they are not required by the Joint Commission or another regulatory body to be in the Medical Staff Bylaws.
41. Hospital policies and procedures are developed for appraisal of emergencies, initial treatment, and referral of **patients at off-campus locations** i.e. Germantown Emergency Center and The Maternity Center.
42. A doctor of medicine or osteopathy is **on duty or on call at all times**.
43. A **patient's general medical condition** is managed and coordinated by a doctor of medicine or osteopathy. A doctor of medicine or osteopathy manages and coordinates the care of any **Medicare patient's psychiatric problem** that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c) (1) (v); or a clinical psychologist.
44. The management of each patients' care, treatment, and services (including patients under the care of participants in a **professional graduate education program** is the responsibility of a licensed independent practitioner with appropriate clinical privileges.
  - a. Residents are supervised by a licensed independent practitioner with appropriate clinical privileges for all out patient care responsibilities.
  - b. Written descriptions of the roles, responsibilities, and patient care activities of the residents are provided to the organized medical staff and hospital staff. These descriptions include identification of mechanisms by which the supervisor(s) and graduate medical education program director make decisions about each participant's progressive involvement and independence in specific patient care areas.
  - c. End of program evaluations for each program participant completed by the supervising practitioner for submission to the sponsoring school are reviewed by the Graduate Medical Education Committee.

d. An annual report is provided to the organized Medical Staff and Governing Board regarding the safety and quality of care, treatment, and services provided by, and the related educational and supervisory needs of the participants in the professional graduate medical education program, as well as the overall results of the Committee's review of the program evaluations.

e. The Medical Staff will comply with all residency review citations in an appropriate and timely fashion.

45. The medical staff delegates to a **"Qualified Medical Person" to conduct examinations when an emergency medical condition exists**. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;
- Serious impairment to any bodily functions;
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
  - That there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - That the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Qualified Medical Persons" are those professionals who have been identified by the Hospital's governing body as qualified to administer a medical screening examination as set forth in the Hospital's Medical Staff Bylaws or Rules and Regulations. In all cases, a Qualified Medical Person will include physicians - M.D.'s and D.O.'s and nurse practitioners, registered nurses, physician assistants operating within their scope of practice and, where required by law, in accordance with standardized procedures. For Maternity patients, Qualified Medical Person may include registered nurses assigned to the Labor and Delivery Department pursuant to an approved standardized procedure (hereinafter "Labor and Delivery RN").

46. The Medical and Allied Health Professional Staff follow and adhere to Adventist Health Care's **Electronic Health Record and Computerized Physician Order Entry Policy**.

47. The Medical and Allied Health Professional Staff follow and adhere to Adventist Health Care's **HealthCare Work Flu Prevention Plan Policy**.

48. Intensivists will provide **coverage for patients in the Adult Intensive Care Unit** on a 24 hour, 7 day a week basis.

49. **Medical Students and Residents** must be supervised by teaching staff in such a way that the medical students and residents assume progressively increasing responsibility according to their level of education, ability and experience.

On-call schedules for teaching staff must be structured to ensure that supervision is readily available to medical students and residents on duty.

Medical Students will not write orders. The Residency Program Scope of Practice will delineate whether the residents can write orders and which orders will require counter signature by the supervising physicians.

The teaching staff must determine the level of responsibility accorded to each medical students and resident.

- 1) Assure that each program provides a curriculum and an evaluation system to ensure that medical students and residents demonstrate achievement of the six general competencies recommended by ACGME or similar program for medical students as appropriate.
- 2) Establish and implement formal written institutional policies for selection, evaluation, promotion, and dismissal of medical students and residents in compliance with the Program Requirements.

50. **Financial Procedures Policy (See Appendix I)**.

51. The Medical Staff follows the **AHC Conflicts of Interest Policy** regarding conflicts of interest. Each practitioner is required to review the policy and complete the Conflicts of Interest Disclosure Statement during initial appointment and at reappointment.

52. **Outpatient services** may be ordered and patients may be referred for all hospital outpatient services: Diagnostic testing including non interventional radiology and laboratory, Physical Therapy, Occupational Therapy and Speech Therapy by the practitioner who is responsible for the care of the patient as long as the practitioner:

- a) Is licensed in, or holds a license recognized in, the jurisdiction where he/she sees the patient;
- b) Is acting within his/her scope of practice under State law;
- c) Is authorized by the Medical Staff to order the applicable outpatient services under a written hospital policy that is approved by the Governing Board;

This includes both practitioners who are on the hospital Medical Staff and who hold medical staff privileges that include ordering the services, as well as other practitioners who are not on the hospital Medical Staff, but who satisfy the hospital's policies for ordering applicable outpatient services and for referring patients for hospital outpatient services;

- d) The hospital's registration office will verify that the ordering practitioner has a National Provider Identifier (NPI) number on-line the National Provider Registry and Maryland State license; and
- e) Practitioners ordering outpatient services who are not on the hospital's Medical Staff may be entered as the Attending physician (not Admitting physician) for the patient if they have a NPI number.

53. The Medical Staff has approved for the following clinical services to provide **Telemedicine services** at Shady Grove Medical Center: Radiology, Pediatric Neurology and Adult Neurology.

54, **Medical Staff Committees** (See Appendix J)

# APPENDIX A

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### PEER REVIEW

<b>Effective Date:</b>	<b>October 22, 2003</b>	<b>Policy No:</b>	<b>#011</b>
<b>Cross Referenced:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Med. Exec. Comm.</b>
<b>Reviewed:</b>	<b>July 25, 2007</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>11/16/04; 7/25/07; 09/24/08; 11/30/11; 10/19/16</b>	<b>Page:</b>	<b>1 of 4</b>
<b>Approved:</b>	<b>09/24/08; 11/30/11; 04/23/14; 10/19/16</b>		

#### **Purpose:**

To establish a peer review process for the medical staff that is uniform and educational.

#### **Definitions and Responsibilities:**

1. Individual practitioner – the Licensed Independent Practitioner whose performance is under review. This individual participates in the review process and provides a written response to the Peer Review Committee for all reviewed events scored as II and/or B, or higher, or for any case at the discretion of the Department Chair.
2. Peer – a Licensed Independent Practitioner with similar or like privileges.
3. Reviewer – the reviewer is a peer and will:
  - a. Review the patient's medical record.
  - b. Assign a score that reflects an objective assessment of the quality of clinical practice.
4. Department Peer Review Committee – a committee consisting of department representatives. This committee will convene monthly and/or as circumstances dictate, to perform individual case reviews as necessary. Cases are reviewed in a consistent, timely, defensible and balanced manner using the Peer Review Scorecard. Specialty expertise will be requested and considered necessary. Committee minutes will reflect findings, conclusions, recommendations, and actions taken. Minutes will also reflect if no further action is indicated.
5. Department Chair – has initial responsibility for the continuing surveillance of the professional performance of all Licensed Independent Practitioners in his/her respective department.
6. Medical Staff President – is responsible for ensuring the findings, conclusions, recommendations, and actions to improve individual and organizational performance are communicated to appropriate medical staff members and committees.
7. Professional Practice Evaluation Committee – a multidisciplinary committee chaired by the Past President of the Medical Staff consisting of past Chairs or designee with peer review experience from each medical staff department. The Chair, with a majority vote from current committee members has the ability to veto any appointment that they deem lacking proper experience to fulfill the responsibility of membership. PPEC committee will convene monthly and/or as circumstances dictate, to perform individual case reviews as necessary. This committee reviews all Level III and IV Departmental Peer Review Committee cases; and develops, implement and monitors remedial-action plans for physicians identified in those cases. Cases shall be reviewed in a consistent, timely, defensible and balanced manner. Specialty expertise will be requested as considered necessary. Committee minutes will reflect findings, conclusions, recommendations, and actions taken. The Committee may review cases without prior peer review by the Department if necessary to expedite the review.
8. The Executive Committee may recommend a change in score of a peer review case, forwarding of a case for further review or further action to be taken by the respective department against the respective provider. The Professional Affairs Sub-Committee of the Governing Board will review and approve the minutes of the PPEC. They will also review and approve any changes as recommended by the Executive Committee. The Professional Affairs Sub-Committee of the Governing Board has the authority to override the scoring of any peer review case, forward the case further review or further action to be taken by the respective department against the respective provider.

9. Quality Improvement Coordinators – have responsibility for:
  - a. Screening cases submitted for peer review through various sources.
  - b. Recording Peer Review Committee meeting minutes and typing correspondence
  - c. Providing correspondence and/or copies to Medical Staff Services for placement in The physician’s Medical Staff Credentials File, and use for OPPE.
  - e. Entering data into Physicians’ MSO database.
10. Credentials Committee – considers all peer review information at the time of reappointment and privileging.
11. Rate-Based Indicators:
  - a. Rate-based indicators are selected annually by the Department Chairs in collaboration with the Performance Improvement Department and are prioritized and approved by the PI Council.
  - b. Variance data is aggregated and analyzed by the Performance Improvement Department. Recognized trends are subjected to intensive study to determine contributing factors. Findings are reported through the Department Chair to the Peer Review Committee and to the PI Council.
12. Immunity from liability applies to the entirety of the peer review process. Please reference the Immunity from Liability Clause in the Medical Staff Bylaws for the complete reference.
13. Just Culture:
  - a. “Just Culture” is a defined set of values, beliefs, and norms about what is important, how to behave, and what behavioral choices and decisions are appropriate related to occurrences of human error or near misses. In a Just Culture, open reporting and participation in prevention and improvement is encouraged. There is recognition that errors are often system failures (not personal failures) and a focus on understanding the root of the problem allows for learning, process improvement, and changes to design strategies and systems to promote prevention.
  - b. A Just Culture is not a “blame-free” culture. Rather, it is a culture that requires full disclosure of mistakes, errors, near misses, patient safety concerns, and sentinel events in order to facilitate learning from such occurrences and identifying opportunities for process and system improvement. However, a Just Culture is also a culture of accountability in which individuals will be held responsible for their actions within the context of the system in which they occurred; such accountability may involve system improvement or individual counseling, coaching, education, counseling, or corrective action. A Just Culture balances the need to learn from mistakes with the need to take corrective action against an individual if the individual’s conduct warrants such action.
  - c. A Just Culture is one in which caregivers are cognizant of, and look for, the risks around them, report errors and hazards, make the right choices, and help design safe systems to prevent mistakes. A Just Culture is a middle ground between a blame-free culture with no personal accountability and a culture in which individuals are blamed for all mistakes. At SGAH we embrace the concept of Just Culture as our model for responding to errors and improving patient safety and care.

**Peer Review Procedure:**

1. The Quality Improvement Coordinator will screen cases from various sources and determine by Standard of Care scoring if the case needs to go to peer review or meets the standard of care and review is complete.
2. Method for selecting departmental peer reviewers, including specific circumstances:
  - a. Assignments – the use of rosters to rotate peer review duties among department members, standing assignments, or subcommittee groups formed for the purpose of conducting peer review are all acceptable methods available to the Department Chair.
  - b. Conflict of Interest – within the context of the peer review process, a conflict of interest precludes a physician from participating in a peer review determination on the performance of another practitioner. A conflict of interest may exist if the reviewing physician has direct clinical involvement in the care to be evaluated, or is in practice with the practitioner under review. In those cases the Department Chair will assign an alternate peer reviewer.



- c. External Peer Review - external peer review is obtained under the following circumstances:
  - If no other peer can perform the review, due to conflict of interest.
  - On the recommendation of the Professional Practice Evaluation Committee or the Medical Executive Committee.
3. Department Chair
  - a. The QI Coordinator may refer cases to the Department Chair who may determine the standard of care was met and close the case.
  - c. Whenever the Department Chair is unable to determine if the standard of care is met they will refer the case to the department level peer review.
4. The Department Peer Review conducts an intensive individual case review of the patient's medical record.
  - a. Causal analysis is determined for all reviews assigned an Outcome Score of 'B' 'E' or 'F' and documented on the Peer Review Committee Score Card.
  - b. Findings and recommendations for further action are reported to the Department Chair and Medical Executive Committee.
  - c. Written notification of case review determinations:
    - Action and follow-up, as determined by the Peer Review Committees, is in a written response or documented meeting of the Department Chair or Professional Practice Evaluation Committee with the individual practitioner.
    - All correspondence is confidential. Certified / Return Receipt U.S. mail is the mechanism for notification of peer review findings.
    - Physicians reviewed and scored a "I" without the direct involvement of that physician will not receive written notification that their case was reviewed.
    - Copies of letters and notifications of peer review determinations are filed in the Medical Staff Office in the individual practitioner's confidential Performance Improvement file.
5. The peer review process and determinations must be objective and supported by accepted contemporary practices of the specialty practiced by the physician under review. Review determinations must be:
  - a. Consistent – all cases meeting the above-stated criteria will undergo peer review conducted in accordance with this defined procedure.
  - b. Defensible – The conclusions reached during the peer review process are supported by a rationale that specifically addresses the issues for which the peer review was conducted, including, as appropriate, reference to the literature and relevant clinical practice guidelines.
  - c. Balanced – Minority opinions and views of the individual under review are to be considered and recorded.
  - d. Useful – The results of peer review activities are to become part of the physician's profile and to be used for credentialing and privileging decisions and, as appropriate, in performance improvement activities.
  - e. Ongoing – The peer review conclusions are tracked over time, and actions based on peer review conclusions are monitored for effectiveness by the Department Chairs, Medical Executive Committee and the Credentials Committee.
  - f. Timely – The following time frames are general guidelines within which the peer review process should be conducted. Completion of any individual case review should not exceed 4 months unless special circumstance exist.
6. A defined, multidimensional scoring system is used to provide a consistent "language" from which data is collected and evaluated for recognition of opportunities for improvement.

Standard of Care Scores:

- I = Standard of care met, no problem with process or documentation.
- II = Standard of care met but documentation inadequate to support standard of Care.
- III = Controversy among physician reviewers whether standard of care was met.

IV = Standard of care not met.

Outcome Scores:

A = No effect on outcome

B = Minor effect on outcome: problem allowed disease or symptoms to progress, temporary  
Or reversible.

C = Major adverse outcome: death attributable to natural disease progression

D = Major adverse outcome: known, documented complication of procedure/disease process

E = Major adverse outcome: problem resulted in reduction of longevity, functional quality of  
life, or adverse reaction by medical action or inaction.

F = Major adverse outcome: death attributable to acts of omission or commission.

7. A Causal Analysis is performed for all reviews assigned an Outcome Score of 'B' 'E' or 'F' and is documented on the Peer Review Scorecard as:
  1. Error in Diagnosis- Based on the information available to the physician, it appears that the patient was incorrectly diagnosed.
  2. Error in Judgment- The decisions made by the physician with regard to the patient's medical management are not appropriate for the diagnosis or status of the patient at the time of the occurrence.
  3. Error in Technique- Techniques employed by the physician do not meet the standard of care.
  4. Patient Non-Compliance- Patient did not follow the treatment plan indicated by their diagnosis as prescribed by the physician
  5. Natural Progression of Patient's Disease- Occurrence is related to the natural progression of the patient's disease.
  6. Hospital System or Process Failure- System or process failure involved in the occurrence contributed to the outcome.
8. The Department Chairs report Peer Review Committee findings, and present any cases with educational value at their respective Department Meetings. The Department Meeting minutes will reflect findings, conclusions, recommendations, and actions taken.
9. The Professional Practice Evaluation Committee develops, implements, and monitors remedial-action Plans with the approval by the Medical Executive Committee.
10. Physicians will be apprised on a regular basis of their performance based on the guidelines set forth in the Peer Review Policy and Procedures. Data aggregation and analysis will be presented to the physician to support the information presented in the regular assessment of physician performance.

# APPENDIX B

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### CODE OF CONDUCT

**Effective Date:** 10/24/07

**Cross Referenced:**

**Reviewed:** 11/12/07

**Revised:** 11/28/07; 09/24/08; 11/30/11; 10/19/16

**Approved:** 09/24/08; 11/30/11; 10/19/16

**Policy No:** #002

**Origin:** Med. Exec. Comm.

**Authority:** Med. Exec. Comm.

**Page:** 1 of 5

#### I. Policy Statement

1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.
2. This Policy outlines collegial and educational efforts that can be used by Medical Staff leaders to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the Corrective Action Process in the Bylaws Manual.
3. This Policy also addresses sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.
4. In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.
5. All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.

#### II. EXAMPLES OF INAPPROPRIATE CONDUCT

To aid in both the education of Medical Staff members and Allied Health Professionals and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

- threatening or abusive language directed at patients, nurses, Hospital personnel, Allied Health Professionals or other physicians (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies incompetence);
- degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;
- profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;
- inappropriate physical contact with another individual that is threatening or intimidating;
- defamatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual, outside of appropriate Medical Staff and/or administrative channels;

- inappropriate medical record entries impugning the quality of care being provided by the Hospital, Medical Staff members or any other individual;
- imposing onerous requirements on the nursing staff or other Hospital employees;
- refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Manual, and Medical Staff and Department/Section Rules and Regulations and Medical Staff Clinical Practice Expectations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs); and/or
- “sexual harassment,” which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:
  - (a) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;
  - (b) Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
  - (c) Physical: unwanted physical contact, including touching, interference with an individual’s normal work movement, and/or assault; and
  - (d) Other: making or threatening retaliation as a result of an individual’s negative response to harassing conduct.
- creating or contributing to a hostile work environment. Examples include, but are not limited to the following:
  - (a) Verbal: using threatening language
  - (b) Visual/Non-Verbal: throwing objects and using threatening gestures

**III. GENERAL GUIDELINES/PRINCIPLES**

1. Issues of conduct by members of the Medical Staff or Allied Health Professionals (hereinafter referred to as “practitioners”) will be addressed in accordance with this Policy.
2. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address complaints about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Executive Committee or the President of the Medical Staff or the elimination of any particular step in the Policy for necessary immediate action.
3. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the Professional Review Committee (“PRC”) (or its designee), the practitioner’s counsel, partners or other department members shall not attend any of the meetings described in this Policy. The PRC is composed of the Chief Medical Officer and the President and Vice President of the Medical Staff.
4. The Medical Staff leadership and Hospital Administration shall make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of inappropriate conduct and prompt action as appropriate under the circumstances.

**IV. REPORTING OF INAPPROPRIATE CONDUCT**

1. Nurses and other Hospital employees who observe, or are subjected to, inappropriate conduct by practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, shall notify any member of the PRC. Any practitioner who observes such behavior by another practitioner shall notify any member of the PRC (or its designee) directly.
2. The individual who reports an incident shall be requested to document it in writing via the hospital's online incident reporting program via the Intranet. If he or she does not wish to do so, the supervisor or PRC member may document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.
3. The documentation should include:
  - (a) the date and time of the incident;
  - (b) a factual description of the questionable behavior;
  - (c) the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have 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 behavior as it relates to patient care, personnel, or Hospital operations;
  - (g) any action taken to intervene in, or remedy, the incident; and
  - (h) the name and signature of the individual reporting the matter.
4. The supervisor/PRC member shall forward the report to the PRC.

**V. INITIAL PROCEDURE**

1. The PRC or designee shall review the report and may meet with the individual (or their designee) who prepared it and/or any witnesses to the incident to ascertain the details of the incident.
2. If the PRC or designee determines that an incident of inappropriate conduct has likely occurred, the PRC or designee has several options available to it, including, but not limited to, the following:
  - notify the practitioner that a complaint has been received and invite the practitioner to meet with one or more members of the PRC to discuss it;
  - refer the incident to the department/section chair to be addressed at the discretion of the PRC;
  - send the practitioner a letter of guidance about the incident;

- educate the practitioner about administrative channels that are available for registering complaints or concerns about quality or services, if the practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the practitioner, as appropriate;
  - send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing; and/or
  - have a PRC member(s), or the PRC as a group, meet with the practitioner to counsel and educate the individual about the concerns and the necessity to modify the behavior in question.
3. The identity of an individual reporting a complaint of inappropriate conduct will generally not be disclosed to the practitioner during these efforts, unless the PRC members agree in advance that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Credentials Committee or Executive Committee pursuant to the Bylaws Manual.
4. If additional complaints are received concerning a practitioner, the PRC may continue to utilize the collegial and educational steps noted in this Section as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

**VI. Referral to the Executive or Credentials Committee**

1. At any point, the PRC may refer the matter to the Executive Committee or Credentials Committee for review and action. The Committee shall be fully apprised of the actions taken by the PRC or others to address the concerns. When it makes such a referral, the PRC may also suggest a recommended course of action.
2. The Executive or Credentials Committee may take additional steps to address the concerns including, but not limited to, the following:
- require the practitioner to meet with the Board Chair or other Board members;
  - require the practitioner to meet with the full Executive Committee or Credentials Committee;
  - issue of a letter of warning or reprimand;
  - require the physician to complete a behavior modification course;
  - impose a "personal" code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner's adherence to it; and/or
  - suspend the practitioner's clinical privileges for less than 30 days.

The imposition of any of these actions does not entitle the practitioner to a hearing or appeal. Please refer to the Medical Staff Bylaws Article VII: Remedial Action and Article VIII: Rights to Hearing and Appeal.

3. The Executive Committee may also direct that a matter be handled pursuant to the Health Policy.
4. At any point, the Executive Committee may also make a recommendation regarding the practitioner's continued appointment and clinical privileges that does entitle the practitioner to a hearing as outlined in the Credentials Policy, or may refer the matter to the Board without a recommendation. If the matter is referred to the Board, any further action, including any hearing or appeal, shall be conducted under the direction of the Board.

## VII. Sexual Harassment Concerns

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

1. A meeting shall be held with the practitioner to discuss the incident. If the practitioner agrees to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's file. This letter shall also set forth those additional actions, if any, which result from the meeting.
2. If the practitioner refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the Executive Committee for review pursuant to the Bylaws Manual.
3. Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the PRC (or its designee(s)). If the investigation results in a finding that further improper conduct took place, a formal investigation in accordance with the Credentials Policy shall be conducted. Should this investigation result in an action that entitles the individual to request a hearing under the Bylaws Manual, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

# APPENDIX C

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### PHYSICIAN MONITORING PROCESS

<b>Effective Date:</b>	September 9, 1996	<b>Policy No:</b>	#003
<b>Cross Referenced:</b>	n/a	<b>Origin:</b>	Med. Exec. Comm.
<b>Reviewed:</b>	11/10/03; 6/27/07; 11/30/11; 10/19/16	<b>Authority:</b>	Med. Exec. Comm.
<b>Revised:</b>	6/27/07; 09/24/08	<b>Page:</b>	1 of 2
<b>Approved:</b>	09/24/08; 11/30/11; 10/19/16		

#### PURPOSE:

To assure consistent use of the monitoring process; to facilitate objective management by the Medical Staff President and Department Chairmen.

#### POLICY:

Physician monitoring can be conducted at two levels: Informal and Formal.

INFORMAL MONITORING: peer review committee monitor

- Physician monitor can be conducted at peer review committee level with focused review of a particular physician's cases as defined by the Committee.
- No notification to physician is required.
- Physician's privileges are not affected in any way.
- The process is informal and for internal QI purposes.
- Results may trigger a formal monitor.

FORMAL MONITORING:

- A physician may be put on formal monitoring based on a recommendation by the Professional Practice Evaluation Committee, Credentials Committee, Health Committee or Medical Executive Committee after it receives supporting data from the Department.
- When a Professional Practice Evaluation Committee, Credentials Committee, Health Committee or Medical Executive Committee approves a formal monitoring, the following must be included:

Start Date

End Date

Type of Monitor

Departments affected by the monitor which are to be notified (Quality Improvement and Medical Staff Services are notified immediately)



- The physician will be notified in writing by the Department Chairman, President of the Medical Staff, or appropriate committee chairperson that he/she has been placed on formal monitor and the details of the monitor.
- Types of formal monitoring may include; but are not limited to:
  1. Video of procedure
  2. Retrospective chart review: performed by Review Committee, QI staff or Department Chair or external review
  3. Contemporaneous review by physician committee membership or QI staff
  4. Proctoring
  5. Mandatory second opinion before posting case/treating patient
  6. Other
- Completion of Formal Monitoring:
  1. At the end of the monitor period, if the results presented to the Medical Executive Committee of the monitoring are unsatisfactory, the Medical Executive Committee decides further course of action.
  2. If results are satisfactory, it will be so documented by the Medical Executive Committee in their minutes and all parties will be notified by the Department Chairman, President of the Medical Staff, or appropriate committee chairperson that the monitor is closed.
  3. If there is insufficient activity during the monitor period by the physician to make an adequate evaluation, the period of time for monitoring may be extended by the Medical Executive Committee until sufficient activity has occurred and information has been collected to make an appropriate determination.
  4. If no activity occurs during monitor period, this information will be put into reappointment process.

Any action which restricts clinical privileges must be reported to the Maryland Board of Physicians regardless of their duration. However, such action is not reportable to the National Member Data Bank unless privileges are restricted for more than 30 days.

**\*\*NOTE:** If the physician to be monitored is a member of the Professional Practice Evaluation Committee, Credentials Committee, Health Committee or Medical Executive Committee, he/she will be excused from the room while discussion is held. If the physician to be monitored is the Department Chairman, the information will be given directly to the President of the Medical Staff.

# APPENDIX D

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### PHYSICIAN TRAVEL

<b>Effective Date:</b>	<b>August 12, 2002</b>	<b>Policy No:</b>	<b>#008</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Med. Exec. Comm.</b>
<b>Reviewed:</b>	<b>June 27, 2007; 11/30/11</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>1/21/04; 5/27/04; 6/27/07; 09/24/08</b>	<b>Page:</b>	<b>1 of 5</b>
	<b>10/19/16</b>		
<b>Approved:</b>	<b>09/24/08; 11/30/11Λ; 10/19/16</b>		

#### Policy

Shady Grove Medical Center Medical Staff may provide assistance and reimburse for necessary and reasonable travel and entertainment expenses incurred while attending conferences, workshops and seminars that offer information that is pertinent to meeting the needs hospital and medical staff.

#### Guidelines

##### I. OUT OF TOWN TRAVEL AND MEETINGS

###### 1. Prior Authorization of Travel

- a. Travel request and/or Advance Request should be submitted to the Medical Staff Office not less than 14 days in advance of travel to allow adequate time for obtaining meeting registration, travel reservations and lodging accommodations and, if necessary, and expense advance.
- b. Approval for travel must be obtained from the President of the Medical Staff or designee. The approval authority is to verify that the business trip is necessary, in the best interest of the Medical Staff and Shady Grove Medical Center, and that sufficient budget is available.

###### 2. Travel Arrangement

- a. All airline travel should be booked at the lowest class fare to accommodate the travel, but not higher than full coach fare while accommodating the traveler's departure and arrival requirements. The system designated firm/agency or travel planners should be used to secure lowest fares available.
- b. Corporate discount rate programs are to be used when available. This includes designated car rental companies and hotel offering corporate rates to Adventist HealthCare. The designated travel planners will be aware of these programs.
- c. Travel arrangements should be made as early as possible to take advantage of all discounts or conference rates, particularly discounts available on early airfare reservations.
- d. "Frequent Flyer" benefits such as upgrades to first class, reduced fares, and companion discounts which are earned from frequent travel may be used for business or personal purposes. Medical Staff will not be reimbursed if "Frequent Flyer" benefits are used for a business trip.

###### 3. Vehicle Use

###### a. Airporter/Limo vs. Taxi

Cost effective transportation for airport/hotel transfer should be used whenever possible.

###### b. Rental Cars

- 1) Rental cars may be used to conduct Medical Staff business out of town when required or to avoid excessive cost or loss of time that may be incurred through the use of other means of transportation. Reservations should be made in advance using Premier corporate discounts.
- 2) Rental cars should be returned to the renting location if drop off charges are applicable. The gas tank should be refilled prior to returning the car.

4. Travel Meals

Receipts for meals must be submitted for actual meal cost reimbursement up to \$100.00 per day (including traveling companions). Without receipts, the traveler will be reimbursed at a daily per diem allowance of \$25.00 per day.

5. Tips and Gratuities

Reasonable tips and gratuities for porters, maids, meals and taxis are reimbursable and should be included as part of the cost of business travel.

6. Telephone/Fax/Internet

Medical Staff will be reimbursed for business calls and for a reasonable number of personal phone calls (generally one per day) while traveling on Medical Staff business. Toll free or watts lines should be used when possible.

7. Parking

Airport parking should be in long term and economy lots rather than short term/valet lots.

8. Lodging

a. Advance Reservations

Hotel reservations should be made in advance through the travel or convention planners to obtain the best possible rates. In room movie charges are not reimbursed.

b. Late Arrivals/ No Shows

Rooms will be guaranteed for late arrival but it is the travelers responsibility to call either the hotel or the travel agent's 800 number if travel plans change. No show charges will be the traveler's responsibility.

II. Reimbursement

1. All expense reimbursements will be submitted to the Medical Staff office and approved by the President of the Medical Staff or designee.
2. Medical Staff will use their own funds or personal credit cards for approved business expenses (including airfare), then obtain reimbursement according to the procedures outlined in this policy.

3. Documentation of expenses: All reimbursements claimed must be for actual expense and Appropriately documented (other than for the daily meal per diem allowance). Evidence of expenditure must be attached such as receipts, hotels statements, credit cards vouchers, airline ticket stubs, etc. Business meals reimbursed must indicate person entertained and business purpose. Miscellaneous cash expenditures of over \$15.00 must be accompanied by a receipt.
4. Documentation and receipts will be maintained in the Medical Staff Office.

III. Other

1. Traffic Citations and Fine

Traffic fines are the responsibility of the traveler and are not reimbursable.

2. Company Credit Cards

Company credit cards will not be issued or used.

3. Non-Reimbursable Expenses

Expenses that are not directly related to Medical Staff/Hospital are considered personal expenses and are not reimbursable. Also not reimbursable are expenses not directly incurred by the employee. These include, but not limited to:

- a. Travel expenses for companions including spouse and family members not required to formally participate in company activities.
- b. Personal items such as clothes, reading materials, toiletries, shoe shines, etc. or loss of personal property.
- c. Expenses paid for by another source, such as travel paid for by a professional trade association.

Shady Grove Medical Staff  
Travel/Meeting Authorization and Advance Request

REQUEST AUTHORIZATION FOR THE FOLLOWING TRAVEL

NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
(ONE REQUESTER PER FORM)

DESTINATION \_\_\_\_\_ DEPARTURE DATE \_\_\_\_\_ RETURN DATE \_\_\_\_\_

PROGRAM NAME \_\_\_\_\_ PROGRAM DATE (S) \_\_\_\_\_

PURPOSE OF TRIP \_\_\_\_\_

ESTIMATE  
Estimated total cost of travel including  
registration, travel, meals, lodging, etc.

Registration (attach documentation) ..... \_\_\_\_\_  
Transportation  
Air..... \_\_\_\_\_  
Auto \_\_\_\_\_ mi. x \_\_\_\_\_ @ = \_\_\_\_\_  
Hotel \_\_\_\_\_ days x \_\_\_\_\_ @ = \_\_\_\_\_  
Other \_\_\_\_\_  
Per Diem..... \_\_\_\_\_  
Total Expenses..... \_\_\_\_\_

Check Request:

Notes: A. Registration check payable to: \_\_\_\_\_ Amount \_\_\_\_\_  
 Mail check directly: \_\_\_\_\_  
B. Advance payable to: \_\_\_\_\_ Amount \_\_\_\_\_

Requester's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Authorizations:

Travel and expense advance approved (Before Attendance)  
President of Medical Staff designee \_\_\_\_\_ Date \_\_\_\_\_

Instructions

**Before Trip:** \*Requester will complete top portion of the authorizations, estimate the costs, sign and date the Request and then forward to Medical Staff Office.

**After Trip:** \*Requester will attach original of this form to the completed Expense Report for the trip and will Forward to the Medical Staff Office for processing and approval by President of Medical Staff Or designee.



## APPENDIX E

### SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

#### MEETING CANCELLATION

<b>Effective Date:</b>	<b>January 13, 2003</b>	<b>Policy No:</b>	<b>#010</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Medical Staff</b>
<b>Reviewed:</b>	<b>June 27, 2007</b>	<b>Authority:</b>	<b>MEC</b>
<b>Revised:</b>	<b>1/13/03; 5/27/04; 09/24/08; 11/30/11</b>	<b>Page:</b>	<b>1 of 1</b>
<b>Approved:</b>	<b>09/24/08; 11/30/11</b>		

#### PURPOSE:

To provide a mechanism to notify medical staff members of meeting cancellations in the event of Inclement weather.

#### POLICY:

1. Meetings at Shady Grove Medical Center scheduled before 9:00 a.m. will follow the Montgomery County School closings or delays as publicized through the television, radio, or any other public media.
2. All other meetings after 9:00 a.m. will be held or rescheduled at the discretion of the Committee Chair or President of the Medical Staff.
3. Collaborative decision will be made between the Physician Chair and Hospital Administrator for hospital committees that begin prior to 9:00 a.m.
4. An E-mail notice will be sent to the affected members to inform them of the meeting cancellation if at all possible.

# APPENDIX F

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### Identification Badge (I.D.) Policy

<b>Effective Date:</b>	<b>11/16/04</b>	<b>Policy No:</b>	<b>#012</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Medical Staff</b>
<b>Reviewed:</b>	<b>June 27, 2007; 10/19/16</b>	<b>Authority:</b>	<b>MEC</b>
<b>Revised:</b>	<b>09/24/08</b>	<b>Page:</b>	<b>1 of 1</b>
<b>Approved:</b>	<b>09/24/08; 10/19/16</b>		

#### PURPOSE:

Given heightened security as well as good procedure and hospital policy, it is imperative that every member of the medical and allied health professional staff visibly wear his or her I.D. badge at all times while on the hospital premise.

#### POLICY:

1. The first offense will result in a verbal reminder by the person noting the problem with a written report on occurrence wizard.
2. The second report of a missing I.D. badge will result in a letter outlining the fine to be imposed.
3. Any further reports will result in a fine of \$100 for the first fine/3<sup>rd</sup> offense. Each additional incident will increase by \$100 per incident, i.e. \$200/4<sup>th</sup> offense; \$300/5<sup>th</sup> offense, etc.
4. The first offense will result in a verbal reminder by the person noting the problem with a written report on occurrence wizard.
5. The second report of a missing I.D. badge will result in a letter outlining the fine to be imposed.
6. Any further reports will result in a fine of \$100 for the first fine/3<sup>rd</sup> offense. Each additional incident will increase by \$100 per incident, i.e. \$200/4<sup>th</sup> offense; \$300/5<sup>th</sup> offense, etc.



# APPENDIX G

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### Medical Record Suspension Fining Policy

<b>Effective Date:</b>	12/8/03	<b>Policy No:</b>	#014
<b>Cross Reference:</b>	n/a	<b>Origin:</b>	Medical Staff
<b>Reviewed:</b>	5/9/05; 6/22/07; 07/22/09	<b>Authority:</b>	MEC
<b>Revised:</b>	07/27/05; 6/22/07; 09/24/08; 07/21/10; 07/20/16	<b>Page:</b>	1 of 1
<b>Approved:</b>	12/8/03; 5/25/05; 07/27/05; 6/22/07; 09/24/08; 07/21/10; 6/22/16: 7/20/16		

#### PURPOSE:

To ensure physician compliance with completion of medical records within 30 days of patient discharge as required by State regulations and JCAHO.

#### POLICY:

- Beginning August 1, 2005, to remove a medical record suspension a physician must complete all available medical records and will be charged according to a Chart Days Calculation.  
  
Chart Days = # of delinquent charts x # of days on suspension. Fines will be calculated as follows: Chart Days <10 = no fine; 10 - <20 = \$5 and each increment of 10 will increase the fine by \$5 per chart (see grid below).
- The fine must be paid at time of record completion in order to be removed from suspension list. Check should be made payable to SGMCM Medical Staff.
- All monies/check should be hand delivered by the Medical Records Department to the Medical Staff Office on a daily basis along with a list of who has paid.
- A physician who has more than three suspensions within a calendar year will be referred to the department chair for appropriate remediation. If the practitioner has an additional three suspension, then he/she will be referred to the Credentials Committee for further action. Physicians on the suspension list more than 90 calendar days in a year will automatically be moved to Courtesy status and be required to pay Courtesy fees.
- Medical Staff Officers, Department Vice and Section Chairs as well as Medical Directors on suspension for 30 days or more in a calendar year for any reason shall not be eligible to hold a leadership role for the Medical Staff. If a members is currently in a leadership role, then they must step down from their position if they are suspended for 30 or more days in a calendar year for any reason.
- Reappointment will not be processed if the physician has any outstanding fines.
- If a physician can prove that a medical record/chart or dictation is complete, then they will be taken off the suspension list and not have to pay the fine.
- Any letter sent to a physician employed by a contracted group shall be copied to the Medical Director of that group as well as the Department Chairman if these are different.
- The President of the Medical Staff has the authority to adjust or remove a fine if circumstances warrant said adjustment.

#### **Example: Fining Table per Chart**

0 - <10 = \$0	40 - <50 = \$20
10 - <20 = \$5	50 - <60 = \$25, etc.
20 - <30 = \$10	<b>(1/2 of lower # = \$fine)</b>
30 - <40 = \$15	

# APPENDIX H

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### Credentialing Physicians and Allied Health Professionals in the Event of Disaster

<b>Effective Date:</b>	<b>October 14, 2002</b>	<b>Policy No:</b>	<b>#009</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Credentials Comm.</b>
<b>Reviewed:</b>	<b>June 27, 2007; 10/19/16</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>April 21, 2004; 10/30/08; 07/21/10</b>	<b>Page:</b>	<b>1 of 3</b>
<b>Approved:</b>	<b>10/30/08; 07/21/10; 10/19/16</b>		

#### Purpose

During a disaster, when the Hospital Emergency Operations Plan (Code Yellow – Disaster Plan) has been activated and Shady Grove Medical Center (SGMC) is unable to handle the immediate patient needs, the Hospital President, the President of the Medical Staff or their designees(s) at the time the Disaster is implemented has the option to grant disaster privileges to Physicians and Allied Health Professionals who volunteer their services but are not members of the Hospital's Medical or AHP Staff. On a case-by-case basis at his/her discretion following review of the volunteer's application for disaster privileges. The Hospital's Chief Medical Officer will determine the type(s) of medical and technical staff needed to assist with the disaster. At a minimum, the following procedures shall be followed before consideration is given to granting such disaster privileges.

#### Procedure

- A. Any physician, dentist or podiatrist who is not a member of the medical staff, or any allied health professional from an SGAH approved category who is not on the allied health staff of SGAH who presents themselves as volunteers to render their services during a disaster shall be processed accordingly.
- B. Physicians shall be directed to the Medical Staff Office where they will need to present a valid, government-issued photo identification issued by a state or federal agency (for example, driver's license or passport). In addition, the Hospital must obtain for each volunteer at least one of the following:
  1. Proof of current licensure\certification to practice medicine;
  2. A current picture hospital ID card that clearly identifies professional designation;
  3. Primary source verification of the medical license;
  4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
  5. Identification indicating that the individual has been granted authority to render patient care in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
  6. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

- C. The Physicians shall complete and sign a “Physicians Disaster Privileges Volunteer Form,” along with the “Application For Disaster Volunteer Privileges” and “Authorization Form” giving the following information:
1. Full Name
  2. Birth date and Place
  3. State, Number and Expiration Date of Medical License
  4. Number and Expiration Date of DEA Certificate
  5. Name and Expiration Date of Professional Liability Insurance Carrier
  6. List of their Primary and other Current Affiliations
  7. Social Security number
  8. Name of Medical School and Graduation Year
- D. Allied Health Professionals – AHPs shall be directed to the Medical Staff Office where they will need to present a valid, government-issued photo identification issued by a state or federal agency (for example, driver’s license or passport). In addition, the Hospital must obtain for each volunteer at least one of the following:
1. License/Registration/Certification
  2. Hospital Picture I.D.
  3. DMAT/MRC/ESAR-VHP
  4. State/Federal Authorization
- E. The Allied Health Professionals – AHPs shall complete and sign a “Non-LIP Disaster Volunteer Practitioner Data Form” giving the following information:
1. Full Name, Address, Phone, and E-mail
  2. Identification Information
  3. Any Credentials Information (if applicable)
  4. Brief Summary of Qualifications/Experience/Areas of Expertise
- F. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), primary source verification shall be done as soon as possible. In this extraordinary circumstance, the following shall be documented: why primary source verification could not be performed within 72 hours; evidence of a demonstrated ability to continue to provide adequate care, treatment, and service; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure is not required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

- G. A file shall be prepared for each individual practitioner to contain their credentials and other relevant information.
- H. Each Volunteer granted Disaster Privileges shall wear and be identified by a colored ID badge holder with lanyards which indicates their name, specialty, date/time registered, date/time verified and date/time of expiration of approval of disaster privileges. See I.D. Badge Forms.
- I. The Medical Staff oversees the professional practice of volunteer license independent practitioners. Within 72 hours, the Incident Commander, the Chief Executive Officer, the Chief of Staff or their designees(s), or the Emergency Room Physician on duty has the option to continue disaster privileges on a case-by-case basis at his/her discretion based on information obtained regarding the professional practice of the volunteer. When disaster privileges are granted, a supervising physician will be assigned to evaluate the practitioner by direct observation and/or documentation review and will within 72 hours complete and submit an "Evaluation of Practitioner Volunteer During a Disaster" form. The evaluation results will be used to determine if the volunteer practitioner will cease providing care, treatment, or service. The volunteer practitioner will cease to provide care, treatment, or service if any one of the following criteria are met:
- Implementation of the emergency management plan ceases;
  - The capability of the organization's staff becomes adequate to meet patient care needs.
- J. A list of patients treated by the volunteer shall be maintained in the practitioner's file.

**Exhibits:**

- A -Physicians and AHPs Disaster Privileges Volunteer Form
- B - AHP Application For Disaster Volunteer Privileges
- C - Authorization Form
- D – Allied Health Professional Disaster Volunteer Practitioner Data Form
- E – Evaluation of Practitioner Volunteer During a Disaster
- F – Record of Patients Seen by Practitioner During Disaster to be Clinically Reviewed Following the Disaster
- G – MSO Verifications Log
- H – I.D. Badge Forms

**Reference Joint Commission Standards:**

- EM.02.02.13
- EM.02.02.15
- MS.01.01.01 EP 17

## Exhibit A

# PHYSICIANS AND AHP DISASTER PRIVILEGES VOLUNTEER FORM

Volunteer practitioners must present a valid government-issued photo I.D. and one of the following before being permitted to apply for volunteer privileges:

1. Proof of current licensure\certification to practice medicine;
2. A current picture hospital ID card that clearly identifies professional designation;
3. Primary source verification of the medical license;
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
5. Identification indicating that the individual has been granted authority to render patient care in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
6. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

---

I, \_\_\_\_\_, certify that I am licensed\certified as a \_\_\_\_\_, in the State of \_\_\_\_\_, license # \_\_\_\_\_.

I certify that I have the training, knowledge and experience to practice in the specialty of \_\_\_\_\_ . I hereby volunteer my medical services to Shady Grove Medical Center (SGMC) during this disaster and agree to practice, as directed and under the supervision of a member of the Medical Staff of SGAH.

I acknowledge that my disaster privileges at this hospital may be discontinued based on information obtained regarding my professional practice through the credentialing process and/or as a volunteer physician if so determined by the Hospital President, President of the Medical Staff or their designees or the Emergency Room Physician on duty based on evaluation of my performance. I also acknowledge that my privileges at this hospital shall immediately terminate once the disaster has ended, as notified by the hospital.

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Date

The information as provided by the practitioner has been reviewed and verified, to the extent possible. On this basis, this practitioner is hereby granted disaster privileges to treat patients presenting to SGAH during this disaster.

\_\_\_\_\_  
Hospital President, President of the Medical Staff or Designee

\_\_\_\_\_  
Date

**Exhibit B**

**Physicians APPLICATION FOR  
DISASTER VOLUNTEER PRIVILEGES**  
*(To Be Completed By the Physician)*

Date: \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

\_\_\_\_\_ Prof. Title: \_\_\_\_\_  
Last Name First Middle Initial

Specialty: \_\_\_\_\_

MD\Other State Prof License\Certif. #: \_\_\_\_\_

Type: \_\_\_\_\_ Expires: \_\_\_\_\_

DEA # \_\_\_\_\_ Expires: \_\_\_\_\_

Malpractice Ins. Carrier: \_\_\_\_\_ #: \_\_\_\_\_ Expires: \_\_\_\_\_

Current Primary Affiliation\Hospital: \_\_\_\_\_

Other Affiliations: \_\_\_\_\_

Other Affiliations: \_\_\_\_\_

Other Affiliations: \_\_\_\_\_

MD\Other State Driver's License #: \_\_\_\_\_ Expires: \_\_\_\_\_

Practitioner's Address: \_\_\_\_\_

Medical\Professional School & Date Grad: \_\_\_\_\_

Social Security # \_\_\_\_\_ Date and Place of Birth: \_\_\_\_\_

---

Signature of Practitioner

## Exhibit C

By applying to Shady Grove Medical Center for Medical Staff Disaster Emergency Clinical Privileges:

1. I authorize the agents and employees of Shady Grove Medical Center and/or the members of the Hospital's Medical Staff to obtain any and all information they deem appropriate to conduct a proper evaluation of my professional qualification for Medical Staff membership and/or clinical privileges at the Hospital, including, but not limited to, consultation with representative of any and all hospitals and institutions which I currently have and/or previously had clinical privileges, past or current employers, third-party payers, peers, receptors, my health care providers, state and feral licensing agencies (including but not limited to the Maryland Board of Physicians, and professional liability insurance carriers. I authorize and request that all such persons and entities release all such information to the agents and employees of Adventist HealthCare and/or the members of the Hospital's Medical and Affiliate Staff;
2. I authorize and consent to the release by Shady Grove Medical Center, its representatives and agents, and/or the members of the Hospital's Medical Staff to any other hospital and institutions at which I currently have and/or previously have had clinical privileges, past and current employers, third-party payers, health plans, state and federal licensing agencies (including but not limited to the Maryland Board of Physicians), and professional liability insurance carriers, upon request, any information the Hospital and/or its Medical Staff may have requested concerning me, provided such release of information is in good faith;
3. I release from liability, to the fullest extent permitted by law, Shady Grove Medical Center, all Shady Grove Adventist Hospital representatives and agents, all member of the Hospital's Medical Staff, and all individuals and organizations who may provide any information and/or documents relative to this application or any other review and evaluation of my character, fitness, professional competence, physical or mental condition, professional activities, ethics, and other qualifications for clinical privileges;
4. I understand that any misrepresentations or omissions on this form may constitute grounds for denial of my request.

All information on this form is true to the best of my knowledge, information, and belief.

\_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Print Name

\_\_\_\_\_

Date

## Exhibit D

# Allied Health Professional (AHPs) Disaster Volunteer Practitioner Data Form

(To Be Completed by the Allied Health Professional)

### Instructions

1. The volunteer practitioner is to complete the information – where indicated – on this form. The completed form is to be turned into the Personnel Pool representative.
2. If possible, copies of the practitioner's photo identification and credentials should be made and stapled to this form.

### DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### VERIFICATION OF IDENTITY *(check and complete that which applies)*

\_\_\_\_\_ Drivers License: State: \_\_\_\_\_ License #: \_\_\_\_\_

\_\_\_\_\_ U.S. Passport Number: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

### CREDENTIAL PROVIDED *(check and complete that which applies)*

\_\_\_\_\_ License / Registration / Certification: State: \_\_\_\_\_ Number: \_\_\_\_\_

\_\_\_\_\_ Hospital Picture ID: Name of Hospital: \_\_\_\_\_

\_\_\_\_\_ DMAT / MRC / ESAR-VHP: Number: \_\_\_\_\_

\_\_\_\_\_ State / Federal Authorization: Name of Agency: \_\_\_\_\_

\_\_\_\_\_ Identification by Staff Member: Name: \_\_\_\_\_

### BRIEF SUMMARY OF QUALIFICATIONS / EXPERIENCE / AREAS OF EXPERTISE

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Volunteer Practitioner

\_\_\_\_\_  
Date

\*\*\*\*\* DO NOT WRITE BELOW THIS LINE. FOR ORGANIZATION USE ONLY \*\*\*\*\*

Staff Member Assigned to Mentor Volunteer Practitioner: \_\_\_\_\_

Signature of Personnel Pool Representative: \_\_\_\_\_ ID Badge / Tag Given: \_\_\_\_\_

Date Primary Source Verification of License / Registration / Certification Obtained: \_\_\_\_\_

Primary Source Verification Obtained by: \_\_\_\_\_ Copy Attached: \_\_\_\_\_



## Exhibit E

# EVALUATION OF PRACTITIONER VOLUNTEER DURING A DISASTER

The following practitioner volunteer must be evaluated within 72 hours regarding his/her performance during a disaster situation. Please complete the form and return it to the Hospital President, President of the Medical Staff or their designee.

Volunteer Physician Name: \_\_\_\_\_ Dates Affiliated: \_\_\_\_\_

Evaluator: \_\_\_\_\_

**Please rate the following:**

	<b>Satisfactory</b>	<b>Unsatisfactory</b>	<b>Don't Know</b>
Clinical knowledge	θ	θ	θ
Clinical competence/judgment	θ	θ	θ
Emotional stability	θ	θ	θ
Work habits/technical skills	θ	θ	θ
Patient care/thoroughness	θ	θ	θ
Relationship with peers/staff	θ	θ	θ
Availability	θ	θ	θ
Professional attitude	θ	θ	θ
Character	θ	θ	θ
Record keeping	θ	θ	θ

**Please indicate the types of injuries this practitioner has managed during this incident.**

\_\_\_\_\_

\_\_\_\_\_

3. With your knowledge of this practitioner's patient care activities during this incident, do you consider him/her competent to continue as a practitioner volunteer?    θ Yes    θ No

**SUMMARY RECOMMENDATIONS**

Continue providing care, treatment, or service during this disaster situation.  
Cease providing care, treatment, or service.

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

_____	_____	_____
Supervising Practitioner Signature	Title	Date

**I agree:**

_____	_____	_____
Hospital President, Medical Staff President Or Designee	Title	Date

## Exhibit F

### RECORD OF PATIENTS SEEN BY PRACTITIONER DURING DISASTER TO BE CLINICALLY REVIEWED FOLLOWING THE DISASTER:

The following patients were seen\reated during this emergency by \_\_\_\_\_.  
Print Name

Dates – From: \_\_\_\_\_ To: \_\_\_\_\_

---

Signature of Practitioner

Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
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Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____

**Exhibit G**

**MSO Verifications Log:**

License Verified on: \_\_\_\_\_ by: \_\_\_\_\_  
DEA # Verified on: \_\_\_\_\_ by: \_\_\_\_\_  
Malpractice Ins. Verified on: \_\_\_\_\_ by: \_\_\_\_\_  
Affiliation: \_\_\_\_\_ Verified on: \_\_\_\_\_  
Affiliation: \_\_\_\_\_ Verified on: \_\_\_\_\_  
Affiliation: \_\_\_\_\_ Verified on: \_\_\_\_\_  
Affiliation: \_\_\_\_\_ Verified on: \_\_\_\_\_  
NPDB Query Date: \_\_\_\_\_ Report Recd Date: \_\_\_\_\_  
OIG Report Verified on: \_\_\_\_\_ by: \_\_\_\_\_

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Verified by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Medical Staff Services

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VERIFICATION NOT COMPLETE Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

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IF VERIFICATION NOT COMPLETE BY Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
(72 HOURS) then:

- 1) Repeat verification attempt within \_\_\_\_\_
- 2) Repeat verification attempt within \_\_\_\_\_
- 3) Repeat verification attempt within \_\_\_\_\_







Verified by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Medical Staff Services

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VERIFICATION DENIED BY: \_\_\_\_\_  
Medical Staff Services

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

## Exhibit H

 <p><b>Medical Staff Volunteer Disaster Privileges</b></p> <hr/> <p style="text-align: center;">NAME/CREDENTIALS</p> <hr/> <p style="text-align: center;">SPECIALITY</p> <hr/> <p style="text-align: center;">DATE/TIME REGISTERED</p> <hr/> <p style="text-align: center;">DATE/TIME VERIFIED</p> <hr/> <p style="text-align: center;">DATE/TIME EXPIRES</p>	 <p><b>Medical Staff Volunteer Disaster Privileges</b></p> <hr/> <p style="text-align: center;">NAME/CREDENTIALS</p> <hr/> <p style="text-align: center;">SPECIALITY</p> <hr/> <p style="text-align: center;">DATE/TIME REGISTERED</p> <hr/> <p style="text-align: center;">DATE/TIME VERIFIED</p> <hr/> <p style="text-align: center;">DATE/TIME EXPIRES</p>
 <p><b>Medical Staff Volunteer Disaster Privileges</b></p> <hr/> <p style="text-align: center;">NAME/CREDENTIALS</p> <hr/> <p style="text-align: center;">SPECIALITY</p> <hr/> <p style="text-align: center;">DATE/TIME REGISTERED</p> <hr/> <p style="text-align: center;">DATE/TIME VERIFIED</p> <hr/> <p style="text-align: center;">DATE/TIME EXPIRES</p>	 <p><b>Medical Staff Volunteer Disaster Privileges</b></p> <hr/> <p style="text-align: center;">NAME/CREDENTIALS</p> <hr/> <p style="text-align: center;">SPECIALITY</p> <hr/> <p style="text-align: center;">DATE/TIME REGISTERED</p> <hr/> <p style="text-align: center;">DATE/TIME VERIFIED</p> <hr/> <p style="text-align: center;">DATE/TIME EXPIRES</p>
 <p><b>Medical Staff Volunteer Disaster Privileges</b></p> <hr/> <p style="text-align: center;">NAME/CREDENTIALS</p> <hr/> <p style="text-align: center;">SPECIALITY</p> <hr/> <p style="text-align: center;">DATE/TIME REGISTERED</p> <hr/> <p style="text-align: center;">DATE/TIME VERIFIED</p> <hr/> <p style="text-align: center;">DATE/TIME EXPIRES</p>	 <p><b>Medical Staff Volunteer Disaster Privileges</b></p> <hr/> <p style="text-align: center;">NAME/CREDENTIALS</p> <hr/> <p style="text-align: center;">SPECIALITY</p> <hr/> <p style="text-align: center;">DATE/TIME REGISTERED</p> <hr/> <p style="text-align: center;">DATE/TIME VERIFIED</p> <hr/> <p style="text-align: center;">DATE/TIME EXPIRES</p>

# Appendix I

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### FINANCIAL PROCEDURES

**Effective Date:** September 10, 2007

**Reviewed:**

**Revised:** 04/25/12; 10/19/16

**Approved:** 09/10/07; 04/25/12; 10/19/16

**Policy No:** #015

**Origin:** Finance Comm.

**Authority:** Med. Exec. Comm.

**Page:** 1 of 1

#### I. Policy Statement

The Medical Staff account is maintained and reconciled by the Medical Staff Secretary/Treasurer with oversight by the Adventist HealthCare Finance Department.

#### II. Monthly Reconciliation

The monthly bank statements are reviewed by the Medical Staff Secretary/Treasurer and are reconciled with the QuickBooks records. The entire account is also reconciled with the Adventist HealthCare Accounting Department monthly report. Any discrepancies are investigated and resolved. The Medical Staff Coordinator has no role in reconciliation of the account.

Deposits to the medical staff account are managed through the Medical Staff office. These are recorded in QuickBooks.

#### III. Checks

Checks are written by the Medical Staff Coordinator and must be signed by two individuals. In most cases these are the Medical Staff Secretary/Treasurer and the Shady Grove Medical Center Chief Financial Officer though the Medical Staff President and Vice President may also sign checks. Checks may not be signed by the Medical Staff Coordinator.

Medical Staff fees and dues are billed through the Medical Staff Coordinators at the time of medical or allied health professional staff appointment or reappointment. The Medical Staff Executive Assistant deposits the checks and records them in QuickBooks. This process is reviewed monthly by the Medical Staff Secretary/Treasurer at the time of account reconciliation.

# APPENDIX J

## COMMITTEES

### Executive Committee

- A. Composition: The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, the Chair of each clinical department, including anesthesia, pathology, radiology and emergency medicine, In-house Physician Representative, Adult Medical Hospitalist, and four members-at-large elected by the Active Medical Staff. The members-at-large are chosen from the Active Physician Staff and may include other licensed independent Members. The President of the Hospital shall be an ex officio member without vote. The administrative officers for nursing, finance, performance improvement/medical staff, and operations, and members of the Governing Board may be invited guests. The vice Chair of any department can, in the absence of the Chair, attend the Executive Committee meetings and exercise the Chair's right to vote. The Executive Committee shall meet as needed to conduct business as outlined below. Members of the Executive Committee will be assigned as follows to the committees of the Executive Committee:
1. Finance: Chair shall be the Secretary of the Medical Staff and include at least one member-at-large. The Finance Committee shall meet periodically and shall be responsible for: (1) the preparation of an annual budget for submission to the Medical Staff for approval; and, (2) the administration of Medical Staff funds.
  2. Performance Improvement Council: Two members of the Medical Executive Committee are members and facilitate the Hospital Performance Improvement Plan and meetings. The members of the Performance Improvement Council shall be the President of the Medical Staff and the Hospital's President (who shall serve as co-chairmen), Vice President of the Medical Staff, Hospital's Vice President, Members of the Hospital Administration as identified in the Hospital PI Plan. The relationship between the medical staff and the PI Council is defined and the PI Council duties are defined in the Hospital PI Plan. The organized Medical Staff through the PI Council provides leadership in activities related to patient safety.
- B. Duties: The duties of the Executive Committee shall be:
1. to represent and to act on behalf of the organized Medical Staff between meetings of the organized Medical Staff, subject to such limitations as may be imposed by these Bylaws;
  2. to coordinate the activities and general policies of the various departments;
  3. to appoint the members of all committees unless otherwise specifically provided in these Bylaws, and to receive and act upon department, committee, and other assigned groups reports;
  4. to appoint an American Medical Association (AMA) representative.
  5. to implement policies of the Medical Staff not otherwise the responsibility of the departments;
  5. to provide liaison between the Medical Staff and the Hospital's President and the Governing Board;
  6. to recommend action to the Hospital's President on matters of a medico-administrative nature;
  7. to make recommendations on Hospital management matters to the Governing Board;
  8. to be accountable to the Governing Board for the medical care rendered by the Medical Staff to patients in the Hospital;
  10. to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
  11. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
  12. to review the credentials of all applicants and to make recommendations for Medical Staff membership, assignments to department and delineation of clinical privileges and recommend to the Governing Board;
  13. to review periodically all information available regarding the performance and clinical competence of Members of the Medical Staff and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges to the Governing Board and request additional evaluations/information of practitioner's privileges through the medical staff process in instances where there is doubt about an applicant's ability to perform privileges requested;
  14. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members of the Medical Staff, including the initiation of and/or participation in Medical Staff remedial or review measures when warranted;
  15. involved in hospital-wide performance improvement activities; and
  16. to make recommendations to the Governing Board regarding the Medical Staff structure.
  17. to make recommendations to the Governing Board regarding the processes used to review credentials and delineate privileges;
  18. to review actions on reports of the medical staff committees, departments, and other assigned activity groups;
  19. to provide oversight in the process of analyzing and improving patient satisfaction on behalf of the organized medical staff; and to provide leadership in activities related to patient safety on behalf of the organized medical staff.

20. The duties of the Executive Committee can be expanded or limited through a Bylaws amendment.

C. Selection and Removal of Members

1. Each Member of the Medical Executive Committee shall be a Member of the Active Medical Staff who has demonstrated leadership ability for the position.
2. Each Member of the Medical Executive Committee, excluding chairmen of the Departments of Anesthesia, Pathology, Radiology and Emergency Medicine, shall be elected for a one-year term, subject to approval of the Governing Board.
3. Removal of a Member of the Medical Executive Committee during his/her term of membership may be initiated by a two-thirds majority of the Medical Executive Committee, but no such removal shall be effective unless and until it has been ratified by the Governing Board.

**Breast Program Leadership Committee**

The Breast Program Leadership Committee is a sub-committee of the Cancer Committee. The membership and responsibilities of the Breast Program Leadership Committee follow those outlined in the most current National Accreditation Program for Breast Cancer (NAPBC). The committee shall meet at least quarterly and report to the cancer Committee.

**Cancer Committee**

The Cancer Committee is a multidisciplinary standing committee. The committee provides leadership with duties as described in the most current version of the Commission on Cancer (CoC) American College of Surgeons, Cancer Program Standards. The Cancer Committee shall meet at least quarterly, maintain a record of its activities, and report to the Medical Executive Committee.

**Credentials Committee**

- A. The Credentials Committee is a standing committee, which shall consist of at least four Past Presidents of the Medical Staff and at least three members-at-large each of whom has held active staff privileges for at least five years. Members-at-large shall serve a maximum of ten years on the Credentials Committee. The Immediate Past President of the Medical Staff may serve as Chair. Chairperson of the Committee shall alternate every two year leadership cycle. In the first year, the Credentials Chair will be the Immediate Past President. In the second year, the Credentials Chair will be the Vice President. It shall meet as needed and submit a written report for recommendation by the Executive Committee to then be forwarded to the Governing Board for approval.
- B. The duties of the Credentials Committee shall be:
1. To investigate the credentials of all applicants for membership and to make recommendations to the Executive Committee and the Governing Board;
  2. To investigate any breach of ethics that is reported;
  1. To review any records that may be referred by the Executive Committee, Medical Record Committee, and Performance Improvement Committee or any Department Chairperson and to arrive at a decision regarding the performance of the Medical Staff Member involved, or to refer the case to the Executive Committee; and
  2. To review all information available regarding the competence of Medical Staff Members, and as a result of such reviews, to make recommendations for the granting of privileges, reappointment and the assignment of members to the various divisions and departments as provided in the Credentialing Manual.
  3. Acts as the Health Committee as necessary. (See Credentials Manual Appendix D – Health Policy for further information).

### **Critical Care Committee**

The Critical Care Committee is a multi-departmental Committee and shall consist of members from the Departments of Medicine (to include at least two cardiologists and two pulmonary/critical care physicians), Family Practice, Surgery, Anesthesiology, and Emergency Medicine Hospital Staff representatives shall include: the Nurse Managers of the Adult ICU and PACU, the Director having oversight of the Adult ICU and PACU, representatives of Respiratory Therapy, Pharmacy, Infection Control, and the Cardiac Cath Lab, and such other members as may be designated by the President of the Medical Staff. The Committee shall establish and oversee policies for the Adult ICU and PACU, to receive information about and make recommendations concerning Performance Improvement projects in the two units, to deal with triage policy and implementation in times of high utilization, and to convey these recommendations and findings to the Medical Executive Committee. The Committee shall meet at least quarterly.

### **Endovascular Committee**

The Endovascular Committee is a committee of the Medical Staff. Membership shall include physicians who perform catheter-based vascular procedures in the interventional suite or the operating room, from the departments of interventional radiology, cardiology, and vascular surgery. The purpose of this committee will be to formulate and review the standards of patient safety and quality of care for endovascular interventions. The committee will meet bimonthly and as needed.

The committee will address this mandate by, but not limited to, the following:

- a) establish and review criteria for credentials;
- b) write and review procedure protocols and policies;
- c) monitor procedure outcomes;
- d) peer review;
- e) review use of resources, equipment procurement;
- f) write and review policy for clinical trials; and
- g) participate in service line planning.

The committee will meet bimonthly and as needed.

### **Ethics Committee**

- A. The Ethics Committee at Shady Grove Medical Center shall be a standing committee of the Hospital, and will fulfill all responsibilities appropriate for such committees. The purpose of this committee is primarily to offer aid and assistance to all members of the care-giving Hospital community as well as all patients of the Hospital. This assistance shall consist of guidance and recommendations relative to bioethical questions raised by any care-giver and/or any patient within the Hospital. Requests for meetings with the committee may also be initiated by next of kin of any patient or such patient's guardian or close friend or no next of kin are available. Recommendations by the committee will be noted in the patient's chart but are not binding.
- B. The committee shall also serve to formulate policy in bioethical matters and shall also serve as a source of education for the medical staff and nursing staff in matters and shall also serve as source of education for the medical staff and nursing staff in matters dealing with bioethical issues.
- C. The Ethics Committee is a standing committee and shall consist of five physician members (one of whom shall serve as Chair), an attorney, a community representative, a social worker, a nurse, and a representative from pastoral care. Physicians or nurses will participate on an ad hoc basis depending upon their participation in a given patient's care and can also serve to offer objective expert opinion even if not involved in direct care of the patient being discussed. The committee shall meet every two months and/or on an as needed basis should any bioethical issues require emergent attention.
- D. Requests for bioethical consultations can be addressed to any member of the committee. It is recommended that the Chair of the committee be consulted first when possible.
- E. The aforementioned constituency of the committee may at any time be modified after discussion among the members of the committee.
- F. All committee meetings will be recorded and a summary of the minutes shall be mailed to each member of the committee and to the Medical Staff Services Office prior to the subsequent meeting. An agenda will be forwarded to members of the committee in advance of the subsequent meetings.

### **Infection Control Committee**

- A. The Infection Control Committee is a Hospital committee, and shall have a physician chairperson and representatives from the Department of Medicine, from the Department of Pathology, from the Department of Surgery, and from the Department of Pediatrics. The Vice President of Nursing Service, the Hospital Administrator, a representative of the Hospital laboratory and the Infection Control Officer shall also be members of this committee. The function of this committee is to investigate and control Hospital infections and to make recommendations to the Medical Staff as needed and appropriate Hospital personnel.



- B. Duties: The Infection Control Committee shall be responsible for the surveillance of the potential sources of all Hospital infections; shall monitor, investigate and control Hospital infections, shall promote a preventative and corrective program designated to minimize infection hazards; and shall supervise infection control in all phases of the Hospital's activities in accordance with current accreditation standards, including:
1. operating rooms, delivery rooms, recovery rooms, emergency rooms, and special care units;
  2. sterilization procedures by heat, chemicals or otherwise;
  3. isolation procedures;
  4. prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
  5. testing of Hospital personnel for carrier status;
  6. disposal of infectious material; and environmental and patient wastes;
  7. reviewing of food handling practices;
  8. reviewing of laundry practices;
  9. identification of sources of airborne infection;
  10. supervision of culturing of autoclaves and sterilizers; and
  11. other situations as required by the Executive Committee.
- C. Meetings: This committee shall meet at least quarterly, shall keep minutes and shall report at least quarterly to the Executive Committee of the Medical Staff, the Administrator, and the Director of Nursing Services.
- D. Physician members of the Medical Staff will abide by decisions of the Infection Control Committee when there is a question as to the appropriateness for isolation of patients.
- D. The committee Chair or his/her representative shall have final authority in emergency situations regarding protection for the patient with respect to contagious and infectious diseases.

### **Institutional Review Board Committee**

The Institutional Review Board(s) ("IRB") at Adventist HealthCare ("Adventist") is charged with protecting the rights and welfare of human subjects recruited to participate in research activities at Adventist facilities. The responsibility of assuring that research is conducted in an ethical manner is shared by Adventist, the IRB, Adventist committees, the investigators who conduct the research and their research staff, as well as the individuals who enroll in the research process.

The IRB maintains a cooperative and coordinating relationship with the Medical Executive Committee on protocols conducted at (enter entity name).

- A. Responsibilities and Authority of the IRB. The responsibilities and authority of the IRB shall be to:
1. Protect the rights and welfare of human subjects recruited to participate in research activities at (enter entity name) by reviewing and approving human research in a manner consistent with federal regulations, state and local laws, and institutional guidelines and policies;
  2. Routinely update the Medical Executive Committee regarding the status of research projects involving human subjects being conducted at (enter entity name) through the timely distribution of monthly IRB meeting minutes and relevant IRB correspondence, once approved by the IRB;
  3. Conduct initial and continuing review of research, approve, require modification to, or disapprove proposed human subject research, and has the responsibility and authority to suspend or revoke its approval of ongoing research, if necessary. While research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials at (enter entity name), those officials may not approve research that has been disapproved by the IRB.
- B. Responsibilities of the Medical Executive Committee. The responsibilities and duties of the MEC shall be to:
1. Aid in IRB membership recruitment, as requested by IRB Staff and Institutional Officials;
  2. Take all reasonable steps to help assure professional ethical conduct, competence, and clinical performance on the part of all Medical staff members who serve as research team members;
  3. Aid in evaluating complaints and allegations of research noncompliance and determine, after a preliminary analysis, if allegations have merit;
  4. Initiate and pursue remedial action, when requested by IRB Staff and Institutional Officials;
  5. Promote continuing education activities that are relevant to research ethics and human research protections provided at Adventist;
  6. Aid in the development of needed joint policy/procedures that pertain to the human research protection program at Adventist;
  7. Aid IRB Staff in the review and evaluation of the qualifications of Medical Staff personnel to perform patient care

- services necessary for research protocol conduct;
8. Ensures the quality of care provided by SGAH Medical Staff members to patients participating research approved by the IRB.

### **Labor and Delivery Committee**

- A. The Labor and Delivery Committee is a multi-departmental committee and shall consist of the Chair of the Ob/Gyn Department, at least two obstetricians, the Chair of the Anesthesia Department, and one pediatrician, the Medical Director of the Nursery, a representative from Hospital Administration, the Nurse Manager from Labor and Delivery, Director of Maternal/Child Health and a representative Physician assistant.
- B. The duties of this committee are to discuss issues pertinent to the Labor and Delivery Department such as:
  1. Coordination of activities between the departments involved in providing care to laboring patients.
  2. Equipment recommendations.
  3. Facility utilization and expansion.
  4. Any other matters relative to the Labor and Delivery Department.
- C. The committee shall meet at least quarterly and report to the Executive Committee and the Department of Obstetrics and Gynecology.

### **Medical Education Committee**

The Medical Education Committee is a standing committee and shall consist of a minimum of five members and a maximum of ten members. All departments are eligible to serve. The Chair shall be selected from any department of the medical staff for a term of three years. The Chair will be an existing member of the committee. The hospital administrator will be a non-voting member of the committee. Committee members will serve terms of one, two or three years for transition, with no more than one-third of the committee's members rotating annually.

- A. Duties of the committee: The committee shall originate and supervises all of the educational activities of the hospital for graduate medical education. This will include planning and evaluation of continuing medical educational activities as well as maintenance of accreditation status.
- B. Programs may include medical topics of interest to the medical staff and may include findings of performance improvement activities.

### **Medical Record Committee**

- A. The Medical Record Committee is a Hospital committee and shall consist of a physician chairperson and and at least two physician members and members of the Medical Record Department. The Medical Record Committee shall meet bi-monthly.
- B. The duties of the Medical Record Committee shall be:
  1. Forms
    - a. To evaluate and recommend changes to medical record forms and policies to ensure compliance with regulatory and patient care standards;
    - b. to assure that the medical records and consent forms reflect current practice;
    - c. To assure changes in hospital forms are communicated to physicians and staff affected.
  2. Medical Record Completion
    - a. To assess compliance and determine ways to ensure compliance;
    - b. To monitor electronic access to the medical record.
    - c. To assess compliance of delinquent record keeping and take action for non-compliance for medical staff and clinical staff.
    - d. To evaluate compliance with content of History and Physicals, Discharge Summaries, and Operative Reports and take action for non-compliance for medical staff and clinical staff.
  3. Medical Components
    - a. To supervise and coordinate the development of new components of the medical record.
    - b. To review content or proposed forms and approve forms for inclusion in patient medical record, until the Electronic Medical Record is implemented.
  4. Education
    - a. Develop programs to educate staff on requirements of medical records on new forms and procedures and on medical record keeping.
    - b. To set up remedial programs for staff found to be out of compliance on medical record keeping.

### **Neonatal Intensive Care Committee**

The Pediatric/Neonatal Intensive Care Committee shall discuss common or specific issues relating to the operation of and quality of care delivered to all Pediatric Inpatient Services and to help formulate and update policies relative to the care delivered and the evaluation and improvement of quality of care. The membership shall include but not be limited to, the Medical Director of Pediatrics (chairperson); 3 members of the Department of Pediatrics which must include a Neonatologist and Pediatric Hospitalist; the Director of Pediatric Surgery; a member of the Department of Anesthesia; Nursing Director of Pediatrics, a Nurse Manager and Educator, and a specialty nurse Member; a member from respiratory therapy, physical/occupational and rehabilitation medicine, pharmacy, child life, radiology, laboratory and pastoral care services. Both the membership and scope of the committee should be expandable if necessary to meet published guidelines for Neonatal Intensive Care Units. Policies and other recommendations of the Committee shall be reported to the Department of Pediatrics and thence to the Medical Executive Committee, for evaluation and comment prior to implementation. The committee shall meet no less often than bi-monthly.

### **Nominating Committee**

The Nominating Committee is a standing committee and shall consist of the Vice President, who shall serve as chairperson, and all department chairpersons.

### **Pharmacy, Therapeutics & Nutrition Support Committee**

A. The Pharmacy, Therapeutics & Nutrition Support Committee is a standing committee and shall consist of one voting member from the Departments of Anesthesia, Section of Cardiology, the Departments of Internal Medicine, Family Practice, a Pediatric or Neonatal Intensivist, the Departments of Pediatrics, Ob/Gyn, Surgery, and Emergency Medicine, and one member-at-large, and the Pharmacy Manager. The Nurse Administrator, a dietitian, a nurse, a pharmacy clinical coordinator, and financial administrator shall serve as ex-officio members. The Pharmacy & Therapeutics Committee shall meet monthly and report to the Medical Executive Committee.

A chairperson from the physician representatives shall be appointed by the President of the Medical Staff. A pharmacist should be designated as secretary. The committee may invite to its meeting persons within or outside the organization who can contribute specialized or unique knowledge, skill, and judgment.

B. Duties: This committee is to be both advisory and educational and is responsible for the clinical use of drugs for the development of policies and procedures for managing drug use and drug administration and for managing the formulary system. The committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff for complete current knowledge on matters related to drugs and drug use. It will also perform the following specific functions:

1. serve in an evaluative, educational, and advisory capacity to the Medical Staff and administration in matters pertaining to the use of drugs (including investigational drugs);
2. develop a formulary of drugs accepted for use in the organization and provide for its constant revision based on objective evaluation of the drug's therapeutic merit, safety, and cost;
3. recommend drugs to be stocked on patient care units and other services;
4. prevent unnecessary duplication in stocking drugs;
5. establish programs and procedures that help ensure safe and effective drug therapy;
6. participate in Performance Improvement activities related to distribution, administration and use of medications;
7. monitor and evaluate adverse drug reactions and make appropriate recommendations to prevent their occurrence;
8. initiate or direct drug use evaluation programs and studies, review the results of such activities, and make appropriate recommendations to optimize drug use;
9. advise the pharmacy department in the implementation of effective drug distribution and control procedures; disseminate information on its action

### **Surgical Services Operations Council Charter**

#### **Scope**

A Surgical Services Operations Council has been established by the Hospital with support and approval of its Medical Staff as an interdisciplinary working group/team allowing a forum for planning, process oversight, and evaluation of the operations and quality of Shady Grove Medical Center Surgical Services. The Council will work to achieve the Shady Grove Medical Center's objectives related to the surgical services program.

The Surgical Services Operations Council is a multidisciplinary council whose purpose is to provide leadership and oversight of the surgical program and its process improvement efforts. The Council's objective is to support delivery of safe, efficient, state-of-the-art care to patients and lead Shady Grove Medical Center as a renowned center of excellence for hospital inpatient and ambulatory surgical services.

The Surgical Services Operations Council's scope is to:

- Serve as the leadership body with full accountability for safety, cost effectiveness and efficiency
- Coordinate medical staff and hospital activity within Surgical Services
- Bridge the relationship between nursing, surgeons, anesthesiologists, gastroenterologists and the hospital and its departments as it relates to Surgical Services improvements and operations
- Serve as a forum to facilitate multidisciplinary communication and a means to resolve interdisciplinary issues
- Provide a vision defining a "World Class" surgical program improving patient care and customer service
- Effectively manage change by
  - Reviewing and assessing quality data and determining areas for continuous improvement
  - Bringing proven improvements and new techniques and methodologies safely into production
    - Reviewing recommendations from consultants' reports
    - Appointing and overseeing design teams
    - Providing regular communications to facilitate approval and implementation by all process stakeholders
- Establish and enforce policies and procedures for Surgical Services
- Monitor outcomes on a regular basis
- Assure adequate, safe and efficient surgical services operations by coordinating requests to the Executive Staff for capital budget requests as they relate to equipment, staff, supplies or other tangible assets needed to accomplish the goals of the Service.

### **Authority**

The Chief Executive Officer of Shady Grove Medical Center has delegated the operation of the Surgical Services program to the Surgical Services Operations Council. The Surgical Services Operations Council communicates to the departments of Surgery, Anesthesiology, Gastroenterology, OB/Gyn as well as to the Medical Executive Committee, Executive committee, other departments and councils/committees as needed.

The Surgical Services Operations Council has responsibility for appointing process improvement design teams, reviewing, evaluating and approving the recommendations of the teams for implementation and establishing guidelines for standard operational procedures. The Council will review aggregated quality data and will be able to act upon process issues discovered by this data. Potential issues or suspected trends related to physician performance will be referred to the appropriate Departments for peer review activity, evaluation and action.

Council members serving as sub-group representatives have the responsibility and authority to act on behalf of their respective sub-group(s) for operational matters. Issues related to the practice of medicine will be referred to the individual Departments. The Surgical Services Operations Council serves as an information conduit to the executive level and other groups represented by Council members. The responsibility for communication with medical staff and hospital council/committees is the responsibility of the Chair of the Council and may be designated to other Committee members. Minutes of meetings will be taken and sent to the Medical Executive Committee. Quality and safety data reviewed along with assessment and actions taken will be sent to the Hospital Process Improvement Committee.

The Committee establishes guidelines for standard operational procedures. The Committee delegates the responsibility for the day to day operation and monitoring of the surgery program to the Director of Surgical Services. Issues regarding patient safety and requiring immediate attention may be referred to the Council Chair, the appropriate Department Chair, or the Chief Medical Officer for appropriate action for resolution. Situations needing immediate resolution for which no guidelines exist may be referred to the Council Chairman, the chair of Anesthesia and the Director of Surgical Services or designees in their absence. A minimum of two members need to participate in such urgent decisions. Issues requiring action will be presented at the next Committee meeting for review.

### **Membership**

Membership on the Surgical Services Operations Council shall consist of the following:

- Chair of Surgery (Council chairman)
- Chair of Anesthesia
- Chair of OB/GYN
- Section chief of General Surgery
- Section chief of Orthopedic Surgery
- Chair of Gastroenterology
- Director of Surgical Services
- SGMC executive responsible for surgical services

- 4 at-large members from the medical staff, one of which must represent OB/Gyn. These members will be nominated from a nominating committee consisting of three of the above appointed members and voted upon at the October Medical Staff nominating committee meeting.

All of the above are voting members with equal vote. At large members will be limited to 5 year terms.

Additional individuals (surgeons, anesthesiologists, gastroenterologist, staff members, ancillary department management, etc.) will be invited to attend and participate on either a regular or ad hoc basis as required. Any interested party may request an agenda item and an invitation to attend. As visitors to the Council, they will not be entitled to vote.

### **Decision Making**

While the Council will strive for consensus, a supermajority of 75% of voting members will be necessary for decision-making regarding matters that require the approval of the Surgical Governance Council. A quorum of 9 members must be present for such votes.

### **Meeting Schedule**

The Surgical Services Operations Council will meet monthly at 7:30 a.m. on the fourth Thursday of each month.

### **Transfusion/Apheresis Committee**

- A. The Transfusion/Apheresis Committee is a standing committee which shall consist of three members from the Department of Medicine/Family Practice, Surgery, Anesthesia, Ob/Gyn, and Pathology. Meetings shall be held quarterly or more frequently as agreed upon by the members of the committee.
- B. The duties of the committee shall be:
1. to review all transfusion reactions occurring during the month or period since the last meeting;
  2. to discuss problems related to blood utilization and transfusion practice at the Hospital, as brought to the attention of the committee;
  3. to provide educational programs and materials to the medical, nursing, and technical staffs related to blood components, blood utilization, and good transfusion practices; and
  4. to submit a written report to the Executive Committee to be made a part of the permanent record at least annually.

### **Undergraduate and Graduate Medical Education Committee (UGMEC)**

Purpose: The Undergraduate and Graduate Medical Education Committee (UGMEC) is an institutional committee charged with the responsibility of developing policies, monitoring the compliance and advising on all aspects of the residency programs.

Membership: The UGMEC's voting membership includes the Designated Committee Chair, and other members of the medical staff.

Meeting Schedule: UGMEC meetings are conducted on a quarterly basis. The UGMEC meets in February, May, August, and November on an annual basis. Minutes are forwarded to the Medical Executive Committee.

Function: The UGMEC is the organized administrative system that ensures the institution's compliance with Institutional Requirements. Responsibilities include but are not limited to:

- 1) Establishing policies and procedures regarding the quality of education and work environment for medical students and residents at our institution.
- 2) Reviewing and determining training needs, establishing training priorities and making recommendations that would improve the medical student and residency program.
- 3) Establishing and implementing formal written policies and procedures regarding the medical students and residents' responsibilities and monitoring the medical student and residents' compliance with the program.
- 4) As a participating ACGME accredited program rotating site, establish formal written policies regarding duty hours.
- 5) Assure that the program provides appropriate supervision for all medical students and residents that is consistent with proper patient care, the educational needs of medical students and residents, and the applicable Program Requirements.

### **Utilization Management Committee**

- A. The Utilization Management Committee is a Hospital committee and shall have a physician chairperson and a representative from each clinical department and section, the Hospital Administrator (or designate), a hospital employed social worker and the Utilization Management Coordinator. The function of this committee shall be to maintain a high level of efficiency in the utilization of Hospital beds. This shall be a fact-finding committee and will make recommendations to the appropriate committee or departments for action.
- B. Duties of this committee are as follows:
1. Utilization Review Studies: The Utilization Management Committee shall conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services and all related factors which may contribute to the effective utilization of Hospital and medical services. Specifically, it shall analyze how under-utilization and over-utilization of each of the Hospital's services affects the quality of patient care provided at the Hospital, shall study patterns of care and obtain criteria relating to average or normal lengths of stay by specific disease categories, and shall evaluate systems of utilization review employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the Hospital. The Committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimum utilization of Hospital resources and facilities commensurate with quality patient care and safety.
  2. Written Utilization Review Plan: The committee shall also formulate, oversee and maintain the written utilization review plan for the Hospital. Such plan, as approved by the Medical Staff and Governing Board, must be in effect at all times.

**Special Committees and Miscellaneous:** Special committees shall be appointed by the President of the Medical Staff from time to time as may be required to properly execute the duties of the Medical Staff. Such committees shall confine their work to the purpose for which they were appointed. Where not specified, in standing committees of three members, at least one, and if more than three members, at least two, shall be reappointed annually to assure continuity of committee function.

**Committees Generally:** All of the committees formed pursuant to these Bylaws are responsible for evaluating and seeking to improve the quality of health care provided in the Hospital.