



**Medical Staff Bylaws
2016**

ADVENTIST BEHAVIORAL HEALTH Rockville, Maryland

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, Adventist Behavioral Health is owned and operated by Adventist HealthCare, Inc., a corporation organized under the laws of the State of Maryland; and WHEREAS, one of its purposes is to serve as a psychiatric and addictive disorders hospital system providing a full continuum of patient care through inpatient, outpatient, and other ancillary facilities and services;

WHEREAS, one of the goals of the medical staff is to strive for the efficient and effective delivery of quality medical care in the Hospital, subject to the ultimate authority of the governing body of the Hospital;

WHEREAS, the best interests of the patients will be better protected by the cooperative efforts of the medical staff, the Board, and the administration;

NOW, THEREFORE, the Practitioners of this Hospital are organized, pursuant to an express delegation of authority by the Board, as a medical staff in conformity with these Bylaws, Rules and Regulations.

These Bylaws are prepared for compliance with hospital licensing laws and accreditation standards. They do not constitute a contract unless otherwise expressly mandated by DEFINITIONS.

DEFINITIONS

AVP of Operations: the individual appointed by the Board to act in its behalf in the overall management of the Hospital; the title will be as designated by the Board.

Adverse Action: an adverse professional review recommendation or adverse professional review action as defined in Article VI, Section F.

Allied Health Professional (AHP) or Health Professional Affiliate (HPA) or Affiliate: individuals, other than those defined below under "Practitioner" and other than Hospital employees, who exercise independent judgment within the areas of his or her professional competence and the limits established by the Board, the Medical Staff, and the Maryland Practice Act, who provide direct patient care services in the Hospital under a defined degree of supervision, and who must be granted Clinical Privileges through the procedures in these Bylaws to perform such Services.

Application: an application either for initial appointment or reappointment to the Medical Staff or for Clinical Privileges that has been determined by the Credentials Committee, MEC or the Board to contain all of the necessary documentation to make a recommendation.

Board: the Board that has been given the authority to act as the governing body of this Hospital.

Clinical Privileges/Privileges: specified diagnostic and therapeutic services that may be exercised by authorized individuals on approval of the Board, based on the individuals professional license, documented current competence, education, training, health status, experience, and judgment, and as set forth in the Hospital's Clinical Privileging Plan.

Days: calendar days, unless otherwise noted.

Direct Research Supervision: BHWS employee, credentialed LPV or contractor approved by IRB program as research supervisor that has the authority to evaluate research performance.

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

Hospital: means Behavioral Health & Wellness Services Rockville, MD

Human Subject: Individual with whom an investigator, whether professional or student, conduct research to obtain data or identifiable private information through intervention or interaction with individual.

IRB: an institutional review board established in accord with and for the purposes expressed in this policy.

IRB Approval: the determination of the IRB that the research has been reviewed and may be conducted at Adventist Behavioral Health within the constraints set forth by the Adventist Healthcare IRB and federal requirements.

IRB Certification: is defined as the official research project or activity involving human subjects that has been reviewed and approved by an IRB in accordance with an approved assurance.

Advisory Committee: the committee appointed by the Board to investigate impairment of Practitioners, consult with Practitioners, and, if necessary, make recommendations to the Board.

Medical Director: the chief Medico-Administrative Practitioner, appointed by the Board, whose duties and responsibilities are described herein and specifically defined by the terms of his contract with the Hospital.

Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Medical Review Hearing Committee (MRHC): the committee appointed pursuant to these Bylaws for the purpose of evaluating the evidence and making findings in a Medical Staff hearing.

Medical Staff/Staff: the organizational component of all Physicians (M.D. or D.O.) and Practitioners, including Nurse Practitioners who hold an unrestricted license in this State and who are privileged to provide patient care services in the Hospital within the scope of their licensure and approved Clinical Privileges. [Note: Psychologists are included as Staff Members.]

Medical Staff Term: not to exceed two (2) years.

Medico-Administrative Practitioner: a Practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full or part-time basis, whose responsibilities may be both administrative and clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner's direction.

Medical Staff Member or Member: a Practitioner whom has been granted and maintains Medical Staff membership and (except for emeritus staff) Clinical Privileges in good standing pursuant to these Bylaws.

Medical Student: A student in a school of medicine that is permitted to observe or participate in clinical care with supervision by a licensed physician.

Resident: A licensed physician in an ACGME approved residency that is permitted to see patients under supervision by a fellow or attending physician.

Fellow: A licensed physician in an ACGME approved fellowship that is permitted to see patients under supervision by an attending physician.

Minimal Risk: The likelihood and level of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests "Code of federal Regulations Title 45 Part Subpart a Section 46. 102"

Peer Review: The concurrent or retrospective review of an individual's behavior and performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice. With reference to Practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

Physician: an individual who has received a doctor of medical or doctor of osteopathy degree and holds current, unrestricted license to practice medicine in this State.

Practitioner: a Physician, or other individual eligible for medical staff membership, other than an employee of the Hospital, who has a current, unrestricted license issued by the State, and who is also permitted by the Hospital to provide patient care services without direction or supervision by another professional, in accordance with individually granted clinical privileges.

Prerogative: a participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee or affiliate and is exercisable subject to the conditions imposed in these Bylaws, the Rules and Regulations, and in other System, Hospital and Medical Staff policies.

President: member of the Active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital.

Research: An organized investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge “Code of Federal regulations Title 45 part 46 Subpart a Section 46.102”

Service or Unit: One of the treatment programs provided by the Hospital. Such programs, on the date of this revision of these Bylaws, include adult psychiatric, adolescent psychiatric, child psychiatric, dual diagnosis, geriatric, adult and adolescent partial program and adolescent residential programs.

Special Notice: Written notification given either by personal delivery or by certified or registered mail, return receipt requested. Refusal to accept Special Notice sent by registered or certified mail shall constitute receipt. Special Notice shall be deemed received when personally delivered or after the expiration of three (3) days in the case of registered or certified mail.

Written Notice: Refers to communications delivered by U.S. Mail, E-Mail, or Fax, or internally to the practitioner’s mailbox. Preference of mode of communication is specified by the practitioner in writing and filed with the Medical Staff Office.

System: the corporate entity operating this Hospital, all other hospitals and operating System facilities, outpatient clinics and other facilities (and subsidiaries) providing clinical services to patients in Montgomery County, Anne Arundel County and the Greater Washington metropolitan area.

System Member: all participants in a particular System, including all Practitioners, Medical Staff Members, employees, and duly authorized agents and representatives of such System.

State: Maryland.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services. Any person providing telemedicine services to Hospital patients must be appropriately licensed in the State.

Unprofessional or Inappropriate Conduct: Conduct that adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a hostile work environment for Hospital employees or other individuals working in the Hospital, or begins to interfere with the

individual's own ability to practice competently. Such conduct may include disruptive, rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

Adventist Behavioral Health Rockville, Maryland

ARTICLE 1: PURPOSES AND RESPONSIBILITIES

SECTION 1 - PURPOSES

The purposes of the Medical Staff are:

- A. To provide an organized body through which the benefits of Staff membership (mutual education, consultation, and professional support) may be obtained by each Staff Member and the obligations of Staff membership may be fulfilled;
- B. To serve as the primary means for accountability to the Board for the quality and appropriateness of the professional performance and ethical conduct of its Members as well as of all Allied Health Professionals, and to strive for quality patient care, efficiently delivered and maintained consistent with available facilities and resources, and to the degree reasonably possible as determined by the state of the healing arts;
- C. To develop a structure, reflected in the Medical Staff Bylaws, Rules and Regulations, policies, protocols, and other applicable documents, that adequately defines the responsibility and, when appropriate, the authority and accountability of each Medical Staff component;
- D. To provide a means through which the Medical Staff may provide input to the Hospital's and the System's policy-making and planning process; and
- E. To provide a means for the Medical Staff, Board, and administration to discuss issues of mutual concern.

- F. To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
- G. To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospital;
- H. To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.

SECTION 2 - RESPONSIBILITIES

The responsibilities of the Medical Staff are to account for the quality and appropriateness of patient care rendered by all Practitioners and Allied Health Professionals authorized to provide patient care services in the Hospital, through the following measures:

- A. Processing credentials in a manner that matches verified qualifications, performance, and competence with Clinical Privileges for all Medical Staff applicants and Members, and privileges and/or prerogatives for all Allied Health Professionals;
- B. Making recommendations to the Board with respect to Medical Staff appointments, re-appointments, Staff category, Clinical Privilege delineation, and as appropriate, Department, Service and/or Unit assignment and corrective action;
- C. Providing an effective mechanism to monitor and evaluate clinical performance provided by all Practitioners and outside contracted medical services;
- D. Participating in the Hospital performance improvement program generally consistent with the requirements of The Joint Commission by conducting objectively all required peer evaluation activities through Medical Staff and/or Service review, team process, and specific (committee) monitoring processes;
- E. Providing an effective utilization review program for allocation of medical services based upon patient-specific determinations of individual medical needs;
- F. Providing continuing education that is relevant to patient care provided in the Hospital as determined, to the degree reasonably possible, from the findings of quality-related activities;
- G. Initiating and pursuing corrective action as provided in these Bylaws when indicated;
- H. Accounting to the Board, through appropriate measures, for the quality and efficiency of medical care rendered to patients in the Hospital;

- I. Monitoring and enforcing the Medical Staff Bylaws, Rules and Regulations, and Hospital policies and procedures uniformly and consistently, and recommending amendments where appropriate.

SECTION 3 - ADVENTIST HEALTHCARE, INC. (AHC)

One of the purposes of the System is to maintain comparably high professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, corrective action, and procedural rights are hereby authorized, in accordance with the guidelines set forth in these Bylaws.

- A. Credentialing

The Medical Staff may enter into arrangements with facilities within the System to assist it on credentialing activities. This may include, without limitation and as permitted by state law, relying on information in other System staff members credentials and peer review files in evaluating applications for appointment and reappointment, and utilizing the other Affiliate's medical or professional staff support resources to process and assist in processing applications for appointment and reappointment. Documentation of primary source verification performed by the other System shall be kept in the Member's credentials file.

- B. Peer Review

The Medical Staff may enter into arrangements with other System facilities to assist it in peer review activities. This may include, without limitation, relying on information on other System facilities' credentials and peer review files, and utilizing the other ' medical or professional support resources to conduct or assist in conducting peer review activities. Peer Review is a forum with legally protected information.

- C. Corrective Action

The Medical Staff may work cooperatively with other System facilities at which a Medical Staff Member holds privileges to develop and impose coordinated, cooperative, or joint corrective action measures as deemed appropriate to the circumstances. This may include, without limitation, giving timely notice of emerging or pending problems, as well as notice of corrective actions imposed and/or reciprocal effectiveness of such corrective actions as provided in section 9IX and XI-11? herein.

- D. Joint Hearings and Appeals

The Medical Staff and the Board of this System are authorized to participate in joint hearings and appeals for Practitioners at other System facilities provided the applicable procedures are substantially comparable to those set forth in the Hearing and Appellate Review Procedures established in these Bylaws.

ARTICLE II: MEDICAL STAFF MEMBERSHIP

SECTION 1 - NATURE OF MEMBERSHIP

Membership on the Medical Staff of this System is a privilege that shall be granted only to professionally qualified and currently competent Practitioners (including those Practitioners under contract with the System) who:

- a. Continuously meet the qualifications, standards, and requirements set forth in these Bylaws, Rules and Regulations and the Bylaws and policies of the Hospital and the System;
- b. Are professionally qualified to provide services which need to be provided at facilities within the system as such need is determined to exist from time to time by the Board; and
- c. Comply with the provisions of these Bylaws, the Rules and Regulations of the Medical Staff, and Hospital, System, and Board policies and procedures.

Appointment to and subsequent membership on the Medical Staff shall confer on the Member only such Clinical Privileges, Prerogatives, and other rights as have been granted by the Board in accordance with these Bylaws.

No individual is automatically entitled to initial or continued membership on the Medical Staff or to the exercise of any Clinical Privilege in this System merely because he is duly licensed to practice in this or any other state, because he has previously been a Member of this Medical Staff, because he had, or now has membership or Privileges at this or another health care facility, or another practice setting, or because he is a member of any professional organization.

Subject to exceptions provided by law or stated herein, Medical Staff membership and/or Clinical Privileges shall not be denied on the basis of sex, age, race, creed, color, national origin, sexual orientation or any physical or mental impairment (if, after any necessary reasonable accommodation, the applicant complies with these Bylaws and the Rules and Regulations of the Hospital and System) but shall be related to professional ability and judgment; relevant training and experience; health status; current competence; and to the System's purposes, needs, and non-exclusive capabilities.

When the determination is based on the System's needs or its non-exclusive ability to provide the facilities, beds, and support staffing/services, consideration will be given, or as otherwise provided by law, to utilization patterns, and actual and planned allocations of physical, financial, and human resources; to general and specific clinical and support services; and to the System's specific goals and objectives as reflected in the System's short and long range plans.

It is recognized that some patient care services within the System may be provided exclusively by a limited number of Practitioners selected by the System, and who have been properly processed and granted Medical Staff membership and/or Clinical Privileges.

SECTION 2 - QUALIFICATIONS AND OBLIGATIONS OF MEMBERSHIP OR PRIVILEGES

A. General Qualifications

Only Practitioners who can comply with the following qualifications shall be eligible for staff membership:

- a. A current, unrestricted license to practice in this State who can document their background, professional experience, worthy character, education, relevant training, clinical judgment, and demonstrated current competence;
- b. Adherence to the ethics of their profession; good reputation;
- c. Their ability to work with others (Staff Members, members of other health care disciplines, System management and employees, visitors, patients, and the community in general); and
- d. Provide quality care to patients within the System in an economical and efficient manner without adversely affecting the financial viability of the System and with due regard for containing the costs of the delivery of health care services; provided, however, that (i) prudent and appropriate care of patients shall have priority over the financial viability of the System; (ii) source of System revenue or reimbursement for patients shall not be a factor in determining whether or not this qualification is satisfied; and (iii) determinations of failure to satisfy this qualification shall be based primarily (but not exclusively) on appropriate comparisons of the Practitioner's practice patterns with accepted professional practice patterns as the same may be determined and interpreted from time to time by the Medical Executive Committee and/or the Board, so as to demonstrate to the Medical Staff and Board that any patient treated by them within the System or in any of its facilities will be given care of the professional level of quality and efficiency as established by the Medical Staff and the System, shall be generally qualified for membership on the Medical Staff.

B. General Obligations

In addition to the other obligations listed in these Bylaws, each applicant, by applying for or being granted any category membership or Clinical Privileges (honorary or otherwise), thereby obligations are:

1. Adhere to the generally recognized standards of professional ethics of his profession;
2. Refrain from unlawful fee splitting or unlawful inducements relating to patient referral;
3. Comply with the medical staff rules and regulations. Failure to do so may result in disciplinary action.
4. Follow policies proposed by the standing committees of the medical staff when approved by the MEC, as they are binding on the members of the medical staff.
5. Actively participate in and regularly cooperate with the Medical Staff in assisting this System to fulfill its obligations related to patient care, including but not limited to, attending committee meetings on patient safety, pharmacy and therapeutics, peer review, and utilization management, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.
6. Collaborate with and participate in Ongoing and Focused Professional Practice Evaluation in accordance with regulations of The Joint Commission and to maintain a culture of continuing evaluation and improvement of the quality of care.
7. Provide continuous care for his patients and delegate the responsibility for diagnosis or care of patients only to a Member who has unrestricted Clinical Privileges to undertake that responsibility
8. Refrain from any unlawful harassment or discrimination against any person (including any patient, System employee, System independent contractor, Medical Staff Member, or visitor) on the basis of sex, age, race, creed, color, national origin, physical or mental impairment, financial status, ability to pay, or source of payment, and shall provide all of his patients with care at the professional level of quality and efficiency as defined by the Medical Staff and the Board.
9. Obtain appropriate informed consent;
10. Abide by the Medical Staff Bylaws, rules and regulations, System and Hospital policies;
11. Abide by all applicable rules and regulations of governmental agencies and comply with applicable standards of The Joint Commission

12. Prepare and complete adequately, and in a timely fashion, the medical and any other required records for all patients he or she admits or in any way provides care for in the Hospital or in any facility in the System;
13. Seek consultation when required by the Rules and Regulations;
14. Maintain a professional liability insurance policy with an approved carrier with policy limits of no less than \$1,000,000 per claim and \$3,000,000 aggregate per year or participate in the applicable professional liability fund/insurance plan of the State and provide the System with a current certificate of insurance. In the event that the applicant is insured under a claims made policy, he shall continue to purchase such coverage for a minimum of two (2) years following the discharge of the last patient he treats at the Hospital or at any facility in the System. The insurance must cover the types of procedures that he has Privileges to perform. He also agrees to immediately notify the AVP of Operations of any insurance policy changes or cancellation and authorize his insurance carrier to provide immediate notice of any change to the Hospital;
15. Reasonably assist the System in fulfilling its uncompensated or partially compensated patient care obligations within the areas of his professional competence and Privileges;
16. Participate in emergency service coverage and consultation panels as may be required by the Rules and Regulations;
17. Cooperate with the System in its efforts to comply with accreditation, reimbursement, and legal or other regulatory requirements;
18. Supply requested information and appear for interviews with regard to his membership or Privileges;
19. Immediately notify the President/Chief Operating Officer, who will notify the MEC and the Board of any change in the information on his application for membership or Privileges;
20. Continuously meet the qualifications for membership as set forth herein;
21. Maintain the confidentiality of all Medical Staff peer review matters, pursuant to these Bylaws;
22. Provide his patients with care at the professional level of quality and efficiency as defined by the Medical Staff and Governing Body;

23. Discharge Staff, committee, service, department, and System functions for which he is responsible by Staff category, assignment, appointment, election or otherwise;
24. Recognize the importance of communicating with appropriate department officers and/or Medical Staff officers when he obtains credible information indicating that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the wellbeing or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter;
25. Authorize the System to consult with members of the medical staffs of other hospitals and other Systems with which the applicant has been associated and with others who may have information bearing on his competence, skill, experience, character, ethical and other qualifications;
26. Consent to the Systems inspection of all records and documents that may be material to an evaluation of his professional qualifications for the Clinical Privileges he requests as well as of his moral and ethical qualifications for Staff membership;
27. Upon request and with the patient's consent (if necessary), provide to the System information from his office records or from outside sources as necessary to facilitate the call or review of the care of patients referred from within the System;
28. Release from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant and his credentials; and
29. Release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
30. Consent to the disclosure to other health care entities, medical associations, licensing boards, and other organizations any information regarding his professional or ethical standing that the System or Medical Staff may have, and release the Medical Staff and System from liability for so doing to the fullest extent permitted by law; and
31. Inform the President/Chief Operating Officer, who will notify the MEC and the Board (i.e., within 30 days) on a continuing basis of any malpractice claims, any criminal investigations, indictments, or convictions, and any limitations or sanctions imposed or proposed by any other

health care entity, licensing or drug control authorities, or the Medicare or Medicaid programs, including any voluntary relinquishment of any license, registration or Privileges.

C. Urgent Temporary Privileges:

Temporary privileges may be granted for the following:

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

Temporary privileges 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 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 CVO (Credentialing Verification Organization at Shady Grove Adventist Hospital to query NPDB/FSMB/AMA/Certificates/AIM.

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 3 - CONDITIONS AND DURATION OF APPOINTMENTS AND REAPPOINTMENTS

A. Appointments and Reappointments: Initial appointments to the Medical Staff shall be made by the Board upon a recommendation from the MEC, and shall be for a period not to exceed two (2) years from the month of appointment. Reappointments shall be made by the Board upon a recommendation from the MEC, and shall commence upon the applicant's State of Maryland license expiration date, but not more than every two years.

SECTION 4 - ADMINISTRATIVE AND CONTRACT PRACTITIONERS

A. Contractors With No Clinical Duties

A Practitioner employed by or contracting with the System in a purely administrative capacity with no clinical duties or Privileges is subject to the regular personnel policies of the System and to the terms of his contract with the System (if any), or to the other terms and conditions of his employment, and he need not be a member of the Medical Staff.

B. Contractors With Clinical Duties: Medico-Administrative Officers (Other Than Medical Director)

A Medico-Administrative Officer must be a Member of the Medical Staff with delineated Clinical Privileges, achieving this status by the procedures set forth in these Bylaws. The effect of expiration or termination of a contract between a Medico-Administrative Officer and the

System on the Medico-Administrative Officer's Staff membership and his Clinical Privileges shall be determined by the terms of the contract between the Medico-Administrative Officer and the System, if any. The Staff membership and Clinical Privileges of such Medico-Administrative Officer shall not be contingent on his continued occupation of that position, in the absence of a contract providing otherwise.

C. Medical Director

The Medical Director is the Chief Medico-Administrative Officer, and must satisfy the requirements of Article III, Section 4(B) above. In addition to all other requirements for Medical Staff Membership, the Medical Director shall be board certified or board eligible in the specialty of psychiatry; have an established record of leadership and communication skills and organizational ability; have and maintain an excellent reputation as a clinician; have the willingness and capacity to work effectively within the requirements of managed care; and demonstrate a record of contributions to the development of psychiatry (as set forth in the Medical Director Standards of Performance as maintained by the System). The Medical Director's primary responsibility is to ensure the clinical excellence of the network of services provided by the System and its associated clinical operations. The specific elements of the Medical Director's job functions and responsibilities are to be set forth in either a Memorandum of Understanding between the Medical Director and the AVP of Operations (if the Medical Director is an independent contractor) or in the position description for employees (if the Medical Director is an employee). General guidelines to be utilized by the System in developing such a Memorandum of Understanding or a position description are attached to these Bylaws as Exhibit A. The Medical Director will be appointed by the Board and will be accountable to the President/Chief Operating Officer.

D. Subcontractors

Practitioners who subcontract with Practitioners who contract with the System may lose any Clinical Privileges granted pursuant to an exclusive arrangement (and their Staff membership if their contract so specifies) if their relationship with the contracting Practitioner is terminated, or the System and the contracting Practitioner's agreement or exclusive relationship is terminated. The System may enforce such an automatic termination even if the sub-contractor's agreement with the Practitioner fails to recognize this right.

ARTICLE III:

CATEGORIES OF THE MEDICAL STAFF

SECTION 1 - CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories: Active, Courtesy, Consulting, and Emeritus and Honorary. Action may be initiated to change the Staff category or terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described herein or

in the Rules and Regulations as developed and implemented by the System. Changes in Medical Staff category shall not be grounds for a hearing unless they affect the Member's Clinical Privileges.

SECTION 2 - GENERAL QUALIFICATIONS

Each Practitioner who seeks or enjoys Staff appointment must continuously satisfy the basic qualifications for membership as set forth in these Bylaws and Rules except those that are specifically waived for a particular category, and the additional qualifications that attach to the category to which he is assigned. The Board may, after recommendation from the MEC, waive any qualification in accordance with Section 4 of this Article IV.

SECTION 3 - PREROGATIVES AND RESPONSIBILITIES

A. Prerogatives

The prerogatives available to a Medical Staff Member, depending on staff category enjoyed, are:

- a. Admit patients consistent with approved Privileges;
- b. Exercise Privileges which have been approved;
- c. Vote on any Medical Staff matter including Bylaws amendment; officer selection, and other matters presented at any general or special Staff meetings and on other matters presented at department meetings;
- d. Hold office in the Medical Staff and in the department to which he is assigned; and
- e. Serve on committees and vote on committee matters.

B. Responsibilities

The responsibilities that Medical Staff Members will be expected to carry out, in addition to the basic responsibilities set forth in Article II, Section 2 herein, are to:

Contribute to the organizational and administrative Medical Staff activities, including performance improvement, risk management, and utilization management, and serve in Medical Staff department offices and on Hospital and Medical Staff committees;

- a. Participate equitably in Staff functions, at the request of a department or service chair or other Staff officer, including contributing to the System's medical education programs; serving the on-call roster and accepting responsibility for providing care to any patient requiring on-call coverage in his specialty and consulting with other Staff Members consistent with his delineated Privileges; proctoring Practitioners and fulfilling other Staff functions as may reasonably be required.

- b. Attend at least the minimum number of staff and department meetings specified in the Bylaws or in the Rules and Regulations;
- c. Accept for care and treatment a reasonable proportion of unassigned patients in need of emergency care who are unable to pay all or a portion of the costs of care.
- d. Accept, treat and transfer patients consistent with “COBRA” regulations.
- e. Practice in accordance with all State and Federal laws, rules and regulations including but not limited to “Stark Acts I & II”; CMS rules and regulations regarding seclusion and restraint, and “COBRA” laws.
- f. Document patient care and treatment in a clear manner, consistent with the CPT Code for care rendered to the patient, and in compliance with utilization review and peer review.
- g. If performing admission psychiatric evaluation, include the following elements:
 - (a) Chief Complaint
 - (b) History of Present Illness
 - Precipitating event
 - circumstances leading to admission
 - recent symptoms as well as pertinent negatives
 - psychiatric review of systems
 - (c) Justification for inpatient level of care
 - (d) Past Psychiatric History
 - (e) Hospitalizations and other episodes of treatment
 - (f) Longitudinal course of symptoms
 - (g) Past Medical History
 - (h) Current Medications
 - (i) History of medications taken and clinical response
 - (j) Mental Status Exam
 - (k) Strengths/Weaknesses
 - (l) Formulation
 - (m) Summary of positive findings
 - (n) DSM-V Diagnoses
 - (o) Initial Treatment Plan
 - (p) Estimated Length of Stay
 - Criteria for Discharge
- h. If performing admission history and physical, include the following elements within 24 hours of admission. The following providers are qualified to complete History & Physicals- Physicians and Nurse Practitioners in the General Specialties of Family Practice, Internal Medicine, Pediatrics and Surgery. Psychiatrists may complete H&P’s if they have additional board certification in any of the previously named specialties:

CHIEF CONCERN:



Indicate time available; indicate own needs

Elicited full list of patient concerns starting with presenting concern

Summarize and finalize the agenda (negotiate specifics if too many items are on the agenda)

HISTORY OF PRESENT ILLNESS: (*Listen*; use “nonfocusing” open-ended skills: silence, neutral utterances, nonverbal encouragement. *Observe nonverbal* cues, physical characteristics, autonomic

changes, accoutrements and environment. Consider *attribution*: what patient thinks is wrong; Consider *motivation*: why seeking treatment now; who is concerned/affected – patient, family, employer, etc.)

C –Characteristics (quality, severity)

L – Location and radiation

O –Onset and duration (gradual, sudden, continuous, progressive, intermittent)

S – Symptoms associated with the concern

E – Exacerbating factors

R – Relieving factors (include what the patient has tried as therapeutic maneuvers)

PAST MEDICAL HISTORY:

Allergies: verify allergies and drug reactions: allergic diseases (e.g., asthma, hay fever) drugs, foods, environmental

Medications: current/recent prescribed, over the counter, alternative therapies and health care

Medical history: screen for major diseases: diabetes mellitus, cancer, heart attack, stroke; screen for major treatments in the past (cortisone, blood transfusions, insulin, digitalis, anticoagulants); toxins and/or industrial exposures; visits to the doctor in the last year

Surgical history: surgical procedures both inpatient and outpatient and date

Hospitalizations: surgical, nonsurgical, psychiatric, obstetric, rehabilitation, other and date

Gynecological/Obstetric (female):

Menstrual history (onset of menses, cycle length, number of pads daily); pregnancy/childbearing (births, spontaneous or induced abortions); complications of pregnancy; menopause (onset); contraception (birth control pills and/or other means; hormonal preparations); sexually transmitted diseases; mammogram; last pap smear

Immunizations: tetanus-diphtheria in all patients; Measles-Mumps-Rubella in children; influenza and pneumococcal in patients with certain chronic illnesses (cardiovascular, pulmonary, metabolic, renal, hematologic, immunosuppression) and in patients over the age of 65

Diet: What did the patient eat the day before including meals and snacks; salt intake, fiber intake, caffeine intake, sugar intake in patients who have diabetes

Trauma history: prior history of injury and how injury was treated

Growth and development/childhood diseases/birth history: younger age groups

FAMILY MEDICAL HISTORY:

Summary of ages and states of physical and mental health of immediate family members (including depression or substance abuse, whether parents and siblings are alive, and causes of death)

Family members with similar symptoms and signs

Presence of chronic and/or infectious diseases in family members

Family relationships (note family interaction patterns-happy, successful, competitive, distant, dysfunctional, love, anger)

PERSONAL/SOCIAL HISTORY:

Marriage/other relationships and outcome: (spouse, partner, children, number of living children)

Household composition/living situation: alone or with others; relationships; care giving

Ethnicity

Sources of social support: friends, community, organizations, pets, spiritual beliefs or community

Personal background: education, occupation, military, travel, religion, dwelling, financial, stress

Directives for care: living will, health care Power of Attorney, CPR, transfusions, known health risks

PREVENTION/RISK FACTORS:

Prevention: recreation, exercise, firearms, seat belts, smoke detectors, current stressors, sleep, periodic health examinations

Tobacco, alcohol, recreational drugs: current use/ past use

Sexual History: sexually active, partners (male/female/both), practice safe sex; Male: History of

sexually transmitted disease (female ask in past medical history)

Occupational hazards/environmental exposures

Violence risk (Ex: Do you feel safe? Are you afraid of anyone? Has anyone hurt you?)

REVIEW OF SYSTEMS (*Within the last year have you experienced.....*):

General: change in weight; change in appetite; overall weakness; fatigue; fever, chills or sweats; anhedonia

Skin: sores; itching or rashes; color or texture changes; hair or nail changes; change in mole(s) **Endocrine:** thyroid enlargement; heat or cold intolerance; loss of libido; salt cravings; excessive thirst; enlarging hat or glove size

Hematopoietic: lymphadenopathy; enlarging glands; bleeding or bruising tendencies; frequent or unusual infections

Musculoskeletal: frequent fractures; joint pain, stiffness, or swelling; muscle pain or weakness; low back pain; difficulty moving or walking; claudication

Head and Neck: headaches; trauma; neck stiffness

Eyes: bright flashes of light; changes in vision; scintillating scotomata; floaters; diplopia; pain

Ears, Nose, Sinuses, Mouth and Throat: sore throat; painful tooth; decrease or change in sense of taste; difficult speech; hoarseness; epistaxis; change or loss of hearing; tinnitus

Breasts: pain; masses; discharge

Respiratory: cough; dyspnea; wheezing; hemoptysis; pleurisy

Cardiovascular: chest pain; orthopnea; paroxysmal nocturnal dyspnea; edema; palpitations; syncope Gastrointestinal: dysphagia; reflux; nausea; vomiting; hematemesis; eructation; flatulence; constipation; diarrhea; melena; abdominal pain; jaundice; pruritis ani

Urinary: frequency; urgency; dysuria; hematuria; nocturia; incontinence; renal stones; hesitancy **Female reproductive:** vaginal pain; discharge; sore or lesions on vagina; menometarrhagia; irregular periods; amenorrhea; hot flashes

Male reproductive: scrotal mass; hernia; scrotal pain; urethral discharge; penile sores; retrograde, bloody or premature ejaculation; erectile dysfunction

Neurologic: weakness; numbness; seizures; headaches; incoordination; alternating consciousness; sleep disorders; memory disorders; tremor; dizziness

Psychiatric: anxiety; depression; mania; intrusive thoughts; loss of good judgment and/or insight; hallucinations

Physical Examination

Vital Signs: temperature; pulse; respiratory rate; blood pressure: sitting and standing (orthostatic hypotension); weight; height; BMI

General Appearance: apparent health; developmental status; apparent physiologic age; habitus; hygiene; nutrition; gross deformities; mental state and behavior; facies; posture

Skin: color; texture; moisture; turgor; eruptions; abnormalities of hair and nails (pallor, pigmentation, cyanosis, clubbing, edema, spider nevi, petechiae)

Head: symmetry; deformities of cranium, face, or scalp (tenderness, bruits)

Eyes: visual acuity; visual fields; extraocular movements; conjunctive; sclera; cornea; pupils including size, shape, equality and reaction; ophthalmoscopic exam including lens, media, disks, retinal vessels and macula; tonometry (pallor, jaundice, proptosis, ptosis)

Ears: hearing acuity; auricles; canals; tympanic membranes (mastoid tenderness, discharge) **Nose:** nasal mucosa and passages; septum; turbinates; transillumination of sinuses (tenderness over sinuses)

Mouth and Throat: breath; lips; buccal mucosa; salivary glands; gingival; teeth; tongue Neck: range of motion; thyroid; trachea; lymph nodes; pulses

(venous distension, abnormal arterial and venous pulsations, bruits, tracheal deviation)

Lymph Nodes: cervical, supraclavicular, axillary, epitrochlear and inguinal nodes (enlargement, consistency, tenderness, and mobility)

Breasts: symmetry; (nodules including size, consistency, tenderness, mobility, dimpling; nipple discharge and lymph nodes)

Thorax and Lungs: configuration; symmetry; expansion; type of respiration; excursion of diaphragms; fremitus; resonance; breath sounds (retraction, labored breathing, prolonged expiration, cough, sputum, adventitious sounds including crackles, wheezes, rhonchi, and rubs) **Cardiovascular system:** precordial activity; apical impulse; size; rate and rhythm of heart sounds; abdominal aorta; peripheral arterial pulses including carotid, radial, femoral, posterior tibial, and dorsalis pedis pulses; (thrills; murmurs; friction rubs; bruits; central venous distension; abnormal venous pulsations)

Abdomen: contour; bowel sounds; abdominal wall tone; palpable organs including liver, spleen, kidney, bladder, and uterus; liver span; (scars; dilated veins; tenderness; rigidity; masses; distension; ascites; pulsations; bruits)

Musculoskeletal: symmetry; range of motion of joints; peripheral arterial pulses; color; temperature; (curvatures of spine; costovertebral angle tenderness; joint deformities; muscle tenderness; edema; ulcers; varicosities)

Neurologic exam: cranial nerves; station; gait; coordination; sensory and motor systems; muscle stretch reflexes; (paresthesias, weakness, muscle atrophy, fasciculations, spasticity, abnormal reflexes, tremors)

Genitourinary: female- external genitalia; vagina; cervix; cytology smear; fundus; adnexae; rectovaginal exam (vaginal discharge, tenderness)

male- penis; scrotal contents; urethral discharge; hernias; prostate

Rectum (if indicated): sphincter tone; test for occult blood; (hemorrhoids, fissures; masses)

Mental state exam: appearance; attitude; motor behavior; mood and affect; intellectual functions; thought content and processes; insight into mental functioning; judgment

*Selected abnormalities in parentheses

SUMMARY AND INTERPRETATION

1. Summary of important data
2. Initial problem list
3. Initial management plans (for each problem)
4. Signature and date of completion

C. Limitation of Prerogatives

The prerogatives set forth under each Staff category are general in nature and may be subject to limitation by special condition attached to a Practitioner's staff membership, by other sections of these Bylaws, the Rules and Regulations, or by Hospital, System, or Board policies.

SECTION 4 - WAIVER OF QUALIFICATIONS

Any qualification may be waived in the discretion of the Board upon determination that such waiver will serve the best interests of the patients and the System. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

SECTION 5 - ACTIVE STAFF

A. Qualifications

The Active Staff category shall consist of Practitioners who:

- a. Have met all the requirements set forth in Article III, Section 2 herein;

- b. Are regularly involved in caring for patients in the Hospital and/or in other facilities within the System and who have a genuine concern and interest in the System. Regular involvement in patient care, as used in these sections 5- 11, shall mean admitting inpatients or outpatients (including partial patients and intensive outpatients) on the equivalent of 8

inpatients per year. [Note: One (1) inpatient shall be equivalent to two (2) outpatients. For example, treatment of 26 patients on a total outpatient basis is considered to be a fair equivalent of 13 patients on an inpatient basis.]

- c. Graduation from an accredited medical school with a completed residency in the specialization of psychiatry or addictive disease.

B. Prerogatives

Active Staff Members assume all responsibilities and Prerogatives of membership set forth above in Section 3, including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments. When there is a bed shortage, regardless of the reason, Active Staff Members will be granted priority over the Members of all other Medical Staff categories for elective admissions.

Active Staff Members shall be eligible to vote; serve on Medical Staff and Board committees; and shall attend not less than the number of Medical Staff and committee meetings required by these Bylaws. Active Staff Members shall participate in the quality improvement, utilization review, peer review, and other management activities required of the Medical Staff and shall serve as proctors for other Practitioners when qualified and so required to do by the MEC or Bylaws.

An Active Staff Member who is not regularly involved in patient care shall be automatically transferred to the Courtesy Staff at the time of the next reappointment, unless the Practitioner does not meet the qualifications for membership for either Staff category, in which case his Medical Staff membership shall automatically expire, without the hearing and appeal rights under these Bylaws.

SECTION 6 - COURTESY STAFF

A. Qualifications

The Courtesy Staff category shall consist of Practitioners who are not regularly involved in patient care in the System and who specialize in psychiatry or addictive disease. Regular



involvement of patient care in the System will require that the Member be appointed to the Active Staff category.

Courtesy Staff Members can be staff members in good standing at another hospital in which their regular participation in quality management\improvement activities is documented and

their performance is evaluated. Courtesy Staff membership shall provide satisfactory evidence to the Credentials Committee of such membership, participation, and evaluation.

B Prerogatives

Courtesy Staff Members are not eligible to vote on Medical Staff matters, hold Medical Staff office or serve as voting members of Medical Staff. They are not required to attend meetings of the Medical Staff and service of which they are members nor any Staff or Hospital education programs.

At times of shortage of Hospital beds or other facilities including staffing as determined by the President/Chief Operating Officer, the elective inpatient admissions of Courtesy Staff Members shall be subordinate to those of Active Staff Members.

SECTION 7 - CONSULTING STAFF

A. Qualifications

The Consulting Staff category shall consist of Practitioners of good reputation who provide expertise in a specialty or sub-specialty that is not otherwise available through membership, but that is needed in the System for specific patient care needs. Consulting Medical Staff Members can be Members of the Active Staff of another hospital.

B. Prerogatives

Consulting Medical Staff Members are not eligible to vote on Medical Staff matters (except on matters presented at meetings of which they are members), to hold Medical Staff office, or to admit patients. They may attend Medical Staff meetings and meetings of Services of which



they are members, and serve on committees. They are required to abide by the Bylaws, Rules and Regulations of the Medical Staff and Board and applicable Hospital policies.

SECTION 8 - EMERITUS STAFF

A. Qualifications

The Emeritus Medical Staff shall consist of Practitioners who have demonstrated special interest in the Hospital, have rendered significant or prolonged service in the System, who desire to be relieved from routine Staff responsibilities, and who are appointed to the Emeritus Staff by the Board of Directors upon recommendation of the President, the Credentials Committee and the Medical Executive Committee. Emeritus Medical Staff granted clinical privileges must meet the general qualifications set forth herein.

B. Prerogatives

Emeritus Medical Staff Members shall have the prerogative to admit patients and to exercise such Clinical Privileges as are granted pursuant to these Bylaws.

Emeritus Medical Staff members shall not be eligible to vote on general Medical Staff issues, to hold office, to serve as Medical Staff committee chairmen or to serve on Medical Staff committees, but shall be eligible to attend general Medical Staff meetings.

SECTION 9 - HONORARY STAFF

A. Qualifications

The Honorary Staff shall consist of physicians recognized for their outstanding reputations, ~~their~~ noteworthy contributions to the health and medical sciences or previous long-standing service to the System. Honorary staff members granted Clinical Privileges must meet the general qualifications set forth herein.

B. Prerogatives

Generally, honorary staff members are not eligible to admit patients in the System or to exercise Clinical Privileges in the System. However, the MEC may grant an exception to this



rule. When it does so, the honorary staff member may exercise such Clinical Privileges as are granted to him pursuant to these Bylaws. Otherwise, the prerogatives of an honorary staff member shall be to attend Staff, committee and Service meetings and any staff or hospital education meetings. Honorary staff members shall not be eligible to vote at Service, committee or Medical Staff meetings or to hold office in this medical staff organization.

SECTION 10 - RESIDENTS, INTERNS AND FELLOWS

A. Qualifications

Residents, interns and Fellows enrolled in a residency or internship training program approved by the MEC and the Board may be permitted to provide patient care services within the System; such participation by residents and interns shall be governed exclusively by the terms and conditions of the written agreement and applicable System policies.

Residents, interns and Fellows must be licensed independent practitioners with delineated clinical privileges in order to perform patient care activities. All military residents, interns and fellows have to provide a current in good standing license from their home states to Medical Staff during their credentialing process. The visiting physician must not have a history of any disciplinary action in any other state, territory, nation, or any branch of the United States uniformed services or the Veterans Administration, and must not have any significant detrimental malpractice insurance in the jurisdiction in which he/she practices (Referring to §14–302.1). As such, a physician member of the Medical Staff must provide supervision of the resident. The resident's graduate education program shall provide written descriptions of the role, responsibilities and patient care activities the resident performs to the medical staff prior to clinical privilege delineation. The description shall include identification of the mechanisms by which the resident's supervisor and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

All Residents, interns and Fellows may perform only those services set forth in the protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the rules and regulations of the Medical Staff, Hospital or System policies. Residents, interns and Fellows, or the institution with which they are affiliated, must have a separate agreement with the System and must demonstrate such clinical capabilities as the Medical Executive Committee (Credentialing) shall deem appropriate.

All Fellows, who are LIPs with state CDS licensure and DEA certification, may perform psychiatric assessments and write orders for medications on the entity's formulary as stipulated in the Medical Staff Rules and Regulations and policies and procedures when practicing in the specialty. However, the approved Request for Delineation of Clinical Privileges form shall



stipulate those patient care activities or entries in their sub-specialty must be countersigned by the supervising LIP within 48 hours.

All military residents, interns and fellows must provide prove of liability coverage by the Federal Tort Claims Act (FTCA) ((28. U.S.C.2671 et seq.)

On a quarterly basis, the supervising LIP shall document communication with the professional graduate program pertaining to the safety and quality of patient care, and the related education and supervisory needs, of the resident. Such documentation shall be kept in the resident's credentials and delineation of clinical privileges file. Furthermore, the professional graduate education committee and the governing body shall periodically communicate about the educational needs and performance of the participants in the program. Such documentation shall be captured in the governing body minutes.

All Residents and Interns shall comply with the Medical Staff Bylaws, Medical Staff rules and regulations, and applicable Hospital and System policies.

B. Prerogatives

Residents and Interns shall attend Medical Staff meetings if required and may be appointed to Medical Staff committees, but shall have no voting rights. Residents and interns may not admit patients without the supervision of a Member of the Medical Staff.

SECTION 11- RESEARCH

A. ABH Minimal Risk Research

ABH permits research activities that have been designated as Minimal Risk by Adventist Healthcare IRB policy that supports Code of Federal Regulations Title 45 Part 46 Subpart A section 46.102

B. Research review by ABH

Research covered by this policy that has been approved by AHC IRB may be subject to further appropriate review and approval or disapproval by ABH officials. However, those BHWS officials may not approve the research if it has not been approved by an IRB (**\$46.112**)

AHC – IRB must provide ABH with a list of IRB members identified by name; earned degrees; representative capacity; indications of experience such as board certifications, licenses, etc., sufficient to describe each member's chief anticipated contributions to IRB deliberations; and any employment or other relationship between each member and the institution; for example: full-time employee, part-time employee, member of governing panel or board, stockholder, paid or unpaid consultant. Changes in IRB membership shall be reported to the ABH

department head officials and Medical Staff Services (§46.103)

C. Suspension or termination of IRB approval of research

AHC- IRB has the authority to suspend or terminate approval of research that is not being conducted in accordance with the AHC- IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate ABH Head officials in accordance to AHC- IRB policies (§46.113)

AHC-IRB shall follow up with ABH on any research progress, termination and suspension.

D. Researchers with No Clinical Duties

Researchers with no clinical duties or privileges must comply with ABH and AHC system personnel policies.

E. Researchers with Clinical Duties

Researchers with clinical duties or privileges are subject to ABH Medical Staff bylaws, policies, AHC Research and AHC system policy. All researchers with or without Clinical Duties have to comply with human resources procedures before their research start date.

All researchers have to complete ABH facility research application appropriate to their role as non-Clinical researcher or Clinical researcher applicants. All researchers must provide prove for IRB certification, CITI (Collaborative Institutional Training initiative), Curriculum Vitae (CV), signed research Conflicts of Interest and disclosure policy form and submit all appropriate documents to Medical staff. Non Clinical researchers are not members of Medical Staff, however will have to comply with ABH personnel policy and AHC system policies.

All Researchers with No Clinical /Clinical Duties will be permitted to have a view only access of EMR for human subjects participating in research. EMR access shall be appropriate to the purpose of research during the time frame of their research.

ARTICLE IV: ALLIED HEALTH PROFESSIONALS

SECTION 1 - GENERAL

Allied Health Professionals (AHPs) are health care providers other than Practitioners who hold a license, certificate, or such other legal credentials as are required by this State which authorizes the AHP to provide health care services. AHPs may be granted permission to participate in the provision of certain patient care services within the System by the MEC as delegated by the Board (see below - Section 2), but such permission shall not be construed to afford AHPs all of the rights of Medical Staff membership.

Psychologists and Nurse Practitioners are considered AHPs.

SECTION 2 - CATEGORIES OF AHPs ELIGIBLE FOR PRACTICE PREROGATIVES

The Board, at least once each Medical Staff Year, shall review and identify the categories of AHPs eligible to apply for Prerogatives in the Hospital. The Board shall also identify the Prerogatives and terms and conditions that may be granted to qualify AHPs in each category. The MEC shall make recommendations to the Board as to the categories of AHPs that should be eligible for Prerogatives and to the Prerogatives and the terms and conditions that apply to each AHP category. The System shall make available to the Medical Staff, and any interested applicant, a list of the AHP categories that are eligible for Prerogatives. An AHP in a category not identified by the Board as eligible for Prerogatives may submit a request in writing to the AVP of Operations asking for consideration by the Board. The Board shall consider such request at its annual review of the AHP categories.

SECTION 3 – QUALIFICATIONS



To be eligible for Prerogatives, an AHP must, at a minimum, meet the following requirements in addition to any requirements recommended by the MEC and the Board:

- A. Hold a current, unrestricted license, certificate or other appropriate legal credential in a category of AHP's that the Board has identified as eligible for Prerogatives.

- B. Document his background, qualifications, relevant training, education, experience, demonstrated current competence, judgment, character, and physical and mental health status, with sufficient adequacy to demonstrate that patient care services will be provided by the AHP at the professional level of quality and efficiency established by the Medical Staff and the System.

- C. Document his strict adherence to the ethics of the Medical Staff and the AHP's respective profession; his ability and agreement to work cooperatively with others in the System setting; and his willingness to commit to and regularly assist the System in fulfilling its obligations related to patient care, within the areas of the AHPs professional competence and credentials.

- D. Maintain a professional liability insurance policy with a carrier approved by the Board with policy limits of no less than \$1,000,000 per claim and \$3,000,000 aggregate per year, or such other amount as may be deemed appropriate by the Board, and provide the System with a current certificate of insurance. In the event that the applicant is insured under a claims-made policy, he shall continue to purchase such coverage for a minimum of two (2) years following the discharge of the last patient he treats within the System. The insurance must cover the types of procedures that he has prerogatives to perform. He also agrees to immediately notify the CEO of any insurance policy changes or cancellation and authorize his insurance carrier to provide immediate notice of any change to the Hospital.

- E. Comply with the provisions of these Bylaws, the Rules and Regulations, and Hospital, System, and Board policies.

SECTION – 4 PROCEDURE FOR GRANTING PRACTICE PREROGATIVE, TERMINATION AND CORRECTIVE ACTION

Applications for appointment, reappointment and Privileges for AHPs shall be submitted and processed pursuant to an Application and in the same manner as provided in Credentialing Plan Articles I and II for Medical Staff Membership and Clinical Privileges. AHPs may be individually assigned to the clinical Service or Unit appropriate to their professional training and shall be subject in general (except for staff category) to the same terms and conditions of appointment as specified herein



for medical staff appointments. Corrective action with regard to AHPs, including termination or suspension of privileges granted or of status as an AHP, shall be accomplished by the President/Chief Operating Officer, who may consult with the MEC, and in accordance with an AHP's contract with the System, if any. AHPs, upon such corrective action, shall be entitled to exercise the rights or procedures provided by Articles XI and XII. AHPs shall be subject to the automatic suspension provisions of Article XI, Section 3 and the confidentiality provisions of Article XIII.

SECTION 5 - PREROGATIVES AND RESPONSIBILITIES

A. Practice Prerogatives

The prerogatives of an AHP shall be to:

- a. Exercise Privileges granted under the supervision or direction of a Member Staff or a service in accordance with these Bylaws, medical staff rules and regulations, Hospital, System, and Board policies;
- b. Write recommendations for or prescribe care to the extent established for him in the rules of the Staff and of the service to which he is assigned, but not beyond the scope of his license, certificate or other legal credential;
- c. Serve on Staff, Service, Unit, Hospital, and System committees to the extent assigned thereto;
- d. Attend meetings of the Staff and Service to which he is assigned, when requested to do so, and attend Staff and System education programs;
- e. attend Staff and System education programs;
- f. Exercise such other Prerogatives as may, by resolution or written policy duly adopted by the Staff or by any of its services or committees or by the CEO, and approved by the Board, be accorded to System facilities as a group or to any specific category of System facilities such as the right to vote on specified matters, to hold defined offices, or any other Prerogatives for which medical education training and experience beyond that which an affiliate can demonstrate is not a prerequisite.

B. Responsibilities

Each AHP shall:

- a. Meet the same responsibilities as required for Medical Staff Members, as modified to reflect the more limited practice of the AHP;
- b. Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the System for whom he is providing services, or arrange a suitable alternative for such care and supervision;
- c. Actively participate in patient assessment activities and other quality assessment and peer review activities required of the Staff and in discharging such other Staff functions as may from time to time be required; and
- d. Satisfy the requirements for attendance at meetings which he is requested to attend of the Staff, the Service or Unit to which he is assigned and committees of which he is a member.

SECTION 6 - TERMINATION OF PRACTICE PREROGATIVES

An AHPs Prerogatives shall terminate automatically at the sole discretion of the AVP of Operations or President upon the occurrence of any of the following:

- a. Termination of the Medical Staff membership or Clinical Privileges of any supervising Practitioner;
- b. Termination of the relationship between the AHP and any supervising Practitioner;
- c. Suspension, revocation, expiration, voluntary or involuntary restriction, termination, or imposition of terms of probation by the applicable licensing or certifying agency of the AHPs license, certificate or other legal credential which authorizes the AHP to provide health care services;
- d. Failure of the AHP to perform properly assigned duties;
- e. Conduct by the AHP which interferes with or is detrimental to the provision of quality patient care;
- f. Failure of the AHP to maintain professional liability insurance;
- g. Termination of the supervising Practitioners contract or other relationship with the System for any reason.



- h. Termination of the contract between an AHP and the system as set forth in the terms of such contract.

SECTION -7 SYSTEM EMPLOYEES

Nothing in these Bylaws shall be construed to interfere with the System's right to terminate System employees, including Practitioners, in accordance with System personnel policies.

ARTICLE V: SERVICES

SECTION 1 - ORGANIZATION OF SERVICES

Each service shall be organized as a separate part of the Medical Staff and shall have a chairman who is selected and has the authority, duties and responsibilities as specified in **Article VII, SECTION 6(E)**.

SECTION 2 - DESIGNATION OF SERVICES

Current Services: The services on the date of the revised Bylaws are adult psychiatric, adolescent psychiatric, dual diagnosis, geriatric, adult and adolescent partial program and adolescent residential programs.

Future Services: When deemed appropriate, the Medical Staff and the Board, by their joint action, may create new, eliminate, subdivide, further subdivide or combine services.

SECTION 3 - ASSIGNMENT TO SERVICES

Each professional shall be assigned membership in at least one service, but may be granted membership and/or clinical privileges in one or more of the other services. The exercise of clinical privileges within any service shall be subject to the rules and regulations of that service and the authority of the service chairman.

SECTION 4 - FUNCTIONS OF SERVICES

SECTION 1 - ORGANIZATION OF SERVICES

Each service shall be organized as a separate part of the Medical Staff and shall have a Director who is selected and has the authority, duties and responsibilities as specified in Article VII, SECTION 6(E).



SECTION 2 - DESIGNATION OF SERVICES

Current Services: The services on the date of these revised Bylaws are adult inpatient psychiatric, adolescent inpatient psychiatric, dual diagnosis/chemical dependency, geriatric, adult and adolescent partial program and adolescent residential programs.

Future Services: When deemed appropriate, the Medical Staff and the Board, by their joint action, may create new, eliminate, subdivide, further subdivide or combine services.

SECTION 3 - ASSIGNMENT TO SERVICES

Each professional shall be assigned membership in at least one service, but may be granted membership and/or clinical privileges in one or more of the other services. The exercise of clinical privileges within any service shall be subject to the rules and regulations of that service and the authority of the service director. .

SECTION 4 - FUNCTIONS OF SERVICES

The primary responsibility delegated to each service is to implement programming and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the service. To carry out this responsibility each service shall:

- A. Collaborate as an interdisciplinary leadership team to develop and refine treatment protocols and programming that are evidence-based and/or recognized as effective for the population targeted.
- B. Provide effective mechanisms, such as identification of quality indicators, to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges in the service. Important problems in patient care shall be identified and resolved, and opportunities to improve care shall be addressed.
- C. Conduct or participate in, and make recommendations regarding the need for, continuing professional education programs responsive to findings of review and evaluation activities.
- D. Monitor, on a frequent basis, adherence to: (1) Medical Staff Rules and Regulations; (2) Hospital, System, and Board policies; (3) requirements for alternate coverage and for consultations; (4) sound principles of clinical practice; (5) fire and other regulations designed to promote patient safety.
- E. Coordinate the patient care provided by the service s professionals with nursing and patient care services and with administrative support services.

- F. Report periodically to the Medical Executive Committee/Organized Medical staff concerning: (1) findings of the service's review and evaluation activities, action taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the service and the Hospital; and (3) such other matters as may be requested from time to time by the Medical Executive Committee or that the service may deem appropriate.
- G. Meet at least monthly for the purpose of service functions, which shall include the review of service monitors that relate to patient care and clinical performance.
- H. Establish such committee as are necessary and desirable to properly perform the functions assigned to it.
- I. Participate in the System's quality assurance program.

**ARTICLE VI:
OFFICERS OF THE MEDICAL STAFF**

SECTION 1 - OFFICERS

Officers of the Medical Staff shall be

- A. By Position in the Hospital Hierarchy.
 - 1. AVP of Operations;
 - 2. Medical Director as Chairman of the Medical Executive Committee;
 - 3. Service Director(s) appointed by the President/COO and/or the Medical Director. President/COO appointments will take precedence over Medical Director Appointments but this will be done in a spirit of cooperation.
- B. By Election
 - 1. President;
 - 2. Vice President;
 - 3. Secretary/Treasurer;
 - 4. Member at Large

The structure of the medical staff shall be approved by the Governing Body. The medical staff is accountable to the Governing Body of Adventist HealthCare, Behavioral Health & Wellness Services.

SECTION 2 - QUALIFICATIONS

Officers must be Members of the Active Staff or the AVP of Operations of the institution, at the time of their nomination and election and must remain in good professional and ethical standing during their

term of office. Because of the peer responsibilities of their offices, the President and the Vice President and Medical Director shall be Physicians, with demonstrated competence in their fields of practice and ability to direct the medico-administrative aspects of Medical Staff activities. Officers must have demonstrated good interpersonal relationships with Medical Staff Members and System staff, and have indicated a willingness to accept the responsibilities of the office.

SECTION 3 - NOMINATION AND ELECTION OF OFFICERS

A. Nominations: Nominations may be made:

1. The nominating committee shall consist of at least three (3) Members of the Active Medical Staff appointed by the President/Chief Operating Officer, Medical Director, and President subject to approval of the MEC. The nominating committee shall convene at least thirty (30) days prior to the final meeting of the Medical Staff Term and shall submit to the Secretary of the Medical Staff one (1) or more qualified nominees for each office at least twenty (20) days prior to the meeting. The nominees shall be for the offices of President, Vice President, Secretary-Treasurer and At Large Member. The MEC as a whole may elect to function as the nominating committee. A slate of officers will be determined and recommended to the Medical Staff.
2. By petition. Nominating by petition requires the signature of at least thirty (30%) percent of the Active Staff Members and must be filed with the Secretary of the Medical Staff at least thirty (30) days prior to the final Medical Staff meeting. The Medical Staff shall be notified of these additional nominees at the time of this meeting; and
3. If the Medical Director is elected President then she will function in both capacities of President and Medical Director.

B. Election:

Officers shall be elected by Active Staff Members at the final meeting of the designated two-year Medical Staff Term. Election shall be by secret written vote. The candidate must be elected by a majority vote of the Active Staff Members present at the meeting. When three (3) or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote. Voting by proxy shall not be permitted.



SECTION 4 - ELECTED TERM OF OFFICE/VACANCIES

A. Term of Office:

Each officer shall serve a two-year term, beginning the first day of the Medical Staff Term following their election. Each officer shall serve until the end of his term or until a successor is elected, unless he shall sooner resign or be removed from office.

B. Vacancies in Office

A vacancy in the office of President shall be filled by the Vice President. A vacancy in the office of Vice President shall be filled by MEC as soon after the vacancy occurs as practicable. A vacancy in the office of Secretary-Treasurer will be filled by the MEC.

SECTION 5 - REMOVAL OF ELECTED OFFICERS FROM OFFICE

A. Removal

Removal of a Medical Staff officer for cause may be initiated by a two-thirds (2/3) majority vote of the Active Medical Staff eligible to vote. Removal shall also require approval of the MEC and the Board. The Board may remove any officer for cause as described in **Section 5B, below**.

B. Grounds for Removal

Each of the following conditions in itself constitutes cause for removal of a Staff officer from office:

- a. Revocation of professional license by the authorizing State agency;
- b. Suspension from the Medical Staff;
- c. Failure to perform the required duties of the office as set forth in Section 6 herein;

- d. Failure to adhere to professional ethics;
- e. Failure to comply with or support enforcement of the System and Medical Staff Bylaws, rules and regulations, and policies;
- f. Failure to maintain adequate professional liability insurance; and
- g. Failure to maintain Active Staff membership and Privileges.

SECTION 6 - RESPONSIBILITIES, DUTIES, AND AUTHORITY OF OFFICERS AND APPOINTED MEC MEMBERS

- A. The President, shall have the responsibilities, duties and authority as follows:
 - a. Attend and collaborate on the agenda of all general and special meetings of the Medical Staff;
 - b. Enforce the Medical Staff Bylaws, Rules and Regulations and appropriate Hospital and System rules and policies; implement sanctions when they are indicated; enforce the Medical Staffs compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner; and otherwise perform the duties required of the President by these Bylaws.
 - c. In collaboration with the Medical Director, appoint the Chairman and all Medical Staff Members of Medical Staff standing and ad hoc committees, except the MEC; appoint the Medical Staff Members of System and Board committees when these are not designated by position or by specific direction of the Board;
 - d. Communicate and represent the views, policies, concerns, needs, and grievances of the Medical Staff to the Board and Administration;
 - e. Aid in coordinating the activities of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff;
 - f. Advise the Board on the effectiveness of the quality management program and the overall quality of patient care in the Hospital;

- g. Advise the Board, Administration, and the MEC on matters that impact on patient care and clinical services, including the need for new or modified programs/services, for recruitment and training of professional and support staff personnel, and for staffing patterns;
- h. Develop and implement, in collaboration with the Medical Director, methods for credentials review and for delineation of Clinical Privileges, utilization review, continuing professional education programs, and concurrent monitoring of clinical practice.
- B. Vice President. The responsibilities, duties, and authority of the Vice President are as follows:
- a. Assume the responsibilities, duties, and authority of the President during the absence, whether the absence is temporary or permanent;
 - b. Serve as a member of the MEC;
 - c. Perform other functions at the request of the President;
 - d. Advise the President and MEC on matters concerning the Medical Staff.
- C. Secretary-Treasurer. The responsibilities, duties, and authority of the Secretary-Treasurer are as follows:
- a. Serve as a member of the MEC and the Bylaws Committee;
 - b. Maintain accurate and complete minutes of all Medical Staff meetings;
 - c. Give proper notice of all Medical staff meetings on order of the Medical Director, President, or other authorized person;
 - d. Assure that an answer is rendered to all official Medical Staff correspondence;
 - e. Sign checks for Medical Staff fund expenditures pursuant to his authority; and
 - f. Perform such other duties as ordinarily pertain to his office.
- D. At Large Member. The responsibilities, duties, and authority of the At Large Member are as follows:
- a. Serve as a member of the MEC;

- b. Advise the President and the MEC on matters concerning the Medical Staff;
- c. Perform other functions at the request of the President.

E. Other Officials.

1. Service Director:

Qualifications: Each Service Director shall be a member of the Active Staff

Selection: Service Directors are appointed through the collaboration of the President/CEO, the Vice-President/COO, the Medical Director, and the President of the Medical Staff.

Terms of Office: A service chairman shall serve a term consistent with the term of his contract with the System.

Duties: Each Director shall:

- (a) Account to the AVP of Operations and the Medical Director for all professional and administrative activities within his service.
- (b) Work with the interdisciplinary leadership team of the service to develop and refine treatment programs that are evidence-based and/or recognized as the standard for patients treated by the service. .. Such programs shall include a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the service.
- (c) Collaborate with interdisciplinary service leadership to monitor the daily operations of the service to in order to maximize effectiveness and identify issues to be addressed
- (d) As medical lead of the service, act, if necessary, as mediator between non-medical staff and attending physicians, provide second opinions when concerns have been raised about quality of care, communicate with families and community providers in situations in which such communications with the attending physicians are no longer productive

- (e) Be a member of the medical executive committee, give guidance on the overall medical policies of the System and make specific recommendations regarding issues related to his or her service.
- (f) Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the president of the staff, the medical executive committee, the AVP of Operations or the Board.
- (g) Participate in the System's performance improvement program.

ARTICLE VII COMPLEMENTARY ROLE OF THE ORGANIZED MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

SECTION 1 – DEFINITIONS

- A. The **Organized Medical Staff** is composed of credentialed members of the medical staff as defined in **Article III** above who have been accorded the right to vote.
- B. The **Medical Executive Committee** is a standing committee of the Medical Staff and shall consist of at least three (3) but not more than nine (9) members, including the officers of the Staff and at least one (1) other member elected by the Medical Staff, the Medical Director and President/Chief Operating Officer. Non-physician LIPs may be members of the MEC. The majority of voting MEC members shall be fully licensed physicians actively practicing in the hospital.

The Medical Director or his designate shall serve in the capacity of the Chairman of MEC. In the absence of the Medical Director or his designate, the President of the Medical Staff shall serve as Chairman of MEC in these issues followed by the Vice President, and then Secretary/Treasurer if the former cannot serve. Each voting MEC member shall have only one (1) vote.

SECTION 2 – ROLE OF THE ORGANIZED MEDICAL STAFF

- A. The organized medical staff develops medical staff bylaws, rules and regulations, and policies.

- B. The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval.
- C. The organized medical staff has the ability to adopt rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body. When such proposals are advanced, they are first communicated to the medical executive committee using established email addresses.
- D. The organized medical staff delegates authority to adopt and amend rules, regulations and policies to the Medical Executive Committee.

SECTION 3 – ROLE OF THE MEDICAL EXECUTIVE COMMITTEE

- A. Pursuant to Section 2, D above the Medical Executive Committee has authority to adopt and amend rules, regulations and policies.
- B. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff using established email addresses.
- C. If there is an urgent need to adopt rules or regulations to comply with law or regulation, the Medical Executive committee may convene an ad hoc meeting for this purpose and communicate the outcome to the Organized Medical Staff using established email addresses. Any disagreement with the Medical Executive Committee action is to be resolved using the process outlines in Section 4, below.
- D. The Medical Executive Committee fulfills the Responsibilities, Duties, and Authority specified in Article VIII, Section 2, and Paragraph B below.

SECTION 4 – RESOLUTION OF CONFLICT BETWEEN THE MEDICAL EXECUTIVE AND THE ORGANIZED MEDICAL STAFF AND REMOVAL OF COMPLETE AUTHORITY OF MEDICAL STAFF

- A. It is anticipated that the relationship between the organized medical staff and the medical executive committee would be collaborative and constructive and that there will be consensus on the adoption and amendment of rules regulations and policies.
- B. If conflict persists, the following procedure is invoked:
 - a. A special committee composed of the officers of the medical staff, as representative of the Medical Executive Committee, and no more than 3 other members of the Organized Medical Staff who are proponents of the opposing position.
 - b. The committee meets to discuss the basis of the conflict and the ramifications of each proposed position. It attempts to arrive at a consensus resolution of the issue.
 - c. The committee's resolution is presented to the organized medical staff for approval. Approval requires a majority of voting members
 - d. If the special committee is unable to arrive at a consensus, the issue is presented to the organized medical staff. Both the Medical Executive Committee and members opposing the Medical Executive Committee present their positions.
 - e. The Organized Medical Staff Votes to determine the resolution. In this vote, the Medical Executive Committee position prevails UNLESS the opposition position is supported by two-thirds of the voting members present.
- C. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee

SECTION 5- Removal of the Authority of the Executive Committee

- A. The Organized Medical Staff can remove the authority of the Executive Committee if the Organized Medical Staff does not believe that the Executive Committee is providing adequate representation.
- B. Individual members of the Organized Medical Staff shall provide requests in writing to remove the authority of the Executive Committee. These requests shall be sent to either the CEO or the Medical Director.
- C. If 20% of the Associate and Active Medical staff submits such requests, the removal of the authority of the Executive Committee shall undergo voting by the Organized Medical Staff.
- D. Vote of the Associate and Active Medical staff with two-thirds majority of the quorum is required for removal of the Medical Executive Committee's authority.
- E. Voting may occur by mail, email, or at either the notification meeting or at a regular meeting of the Department of Psychiatry and Medicine.
- F. The Governing Board will ultimately review the recommendations of the medical staff and make the final decision based on the recommendation of the Medical Staff.

G. The Board with then work with the Medical Staff to elect new officers, if needed.

ARTICLE VIII: COMMITTEES AND FUNCTIONS

SECTION 1 - GENERAL CONSIDERATIONS

- A. There shall be a MEC and other standing and special (ad hoc) committees of the Medical Staff. All committee (other than MEC) members, including the Chairman, shall be appointed and/or removed by the Medical Director in consultation with the President of the Medical Staff and the System President/Chief Operating Officer.
- B. Each committee shall submit a copy of its minutes to the MEC and shall maintain a permanent record of its proceedings, including pertinent discussion and any conclusions, recommendations, and actions.
- C. Non-Physician members participating in committee functions shall be approved by the Medical Director or AVP of Operations with the concurrence of the Committee Chairman or President.



- D. The Medical Director and the President/Chief Operating Officer, or their designees, shall serve Ex-Officio without vote, on all Medical Staff committees to which they are not expressly appointed.
- E. Whenever these Bylaws require that a function is performed:
 - a. The MEC shall perform the function or designate a sub-committee to perform it;
 - b. Or a special committee shall be formed to perform the function, in accordance with the authority delegated to it by the MEC.

All committee participants shall sign and date a Medical Staff peer review confidentiality statement acknowledging that each agrees to maintain the confidentiality of all committee matters.

SECTION 2 - MEDICAL EXECUTIVE COMMITTEE (MEC)

A Composition

The MEC shall be a standing committee of the Medical Staff and shall consist of at least three (3) but not more than nine (9) members, including the officers of the Staff and at least one (1) other member elected by the Medical Staff, the Medical Director and President/Chief Operating Officer. Non-physician LIPs may be members of the MEC. The majority of voting MEC members shall be fully licensed physicians actively practicing in the hospital.

The Medical Director or his/her designate shall serve in the capacity of the Chairman of MEC. In the absence of the Medical Director or his designate, the President of the Medical Staff shall serve as Chairman of MEC in these issues followed by the Vice President, and then Secretary/Treasurer if the former cannot serve. Each voting MEC member shall have only one (1) vote.

- B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of the MEC shall be to:
 - a. Represent and act on behalf of the Medical Staff, subject to such limitation as may be imposed by these Bylaws;
 - a. Recommend to the Board on all matters relating to appointments, reappointments, Clinical Privileges, Staff category and clinical and corrective action. When designated

- professional personnel, regardless of their source of employment, provide or are recommended to provide services within the System, the committee shall make recommendations to the Board on their qualifications to provide those services and on the degree of supervision required;
- b. Receive and act upon reports and recommendations from Medical Staff committees and Staff officers concerning quality management activities and the discharge of their delegated administrative responsibilities;
 - d. Review data related to ongoing professional practice review. Cause, through evaluation by this committee, each Medical Staff peer evaluation and quality assessment and improvement activity to be performed effectively;
 - e. Review data regarding patient satisfaction as well as narrative reports of patient's experiences and complaints. Develop measures to improve the patient experience within the system.
 - f. Review content quality of admission psychiatric evaluations and history and physical examinations. Identify practitioner specific trends and direct corrective action, if necessary, through the Peer Review and Credentialing Committees.
 - g. Coordinate the activities of, and policies adopted by, the Staff, services, and committees;
 - h. Fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients within the System;
 - i. Initiate and pursue corrective action, when warranted, in accordance with these Bylaws;
 - j. Take all reasonable steps to help assure professional ethical conduct, competence, and clinical performance on the part of all Staff Members;
 - k. Make recommendations to the Board on medico-administratively and system management matters, particularly as they relate to patient care, through the AVP of Operations and President;
 - l. Submit recommendations to the Board for changes in the Medical Staff Bylaws, rules and regulations and other organization documents pertaining to the Medical Staff;
 - m. Provide and promote effective liaison among Medical Staff, Administration, and Board;
 - n. Participate in identifying community health needs and in setting System goals and implementation of programs to meet those needs; and

- o. Promote in-house Medical Staff continuing education activities that are relevant to care and services provided in the System and, in particular, to the findings of Medical Staff peer evaluation and quality assessment and improvement activities.

C. Meetings

The MEC shall meet as often as necessary to accomplish its functions, but at least six (6) times per year.

SECTION 3 - CREDENTIALS (assumed by Medical Executive Committee) FUNCTION

A. Composition

The Credentials function shall be assumed by the MEC. If feasible, when a Practitioner other than a Physician is being reviewed, a peer representative, who is not a member of the committee, will participate for that part of the meeting.

B. Functions. The responsibilities, duties, and authority of the Credentials function shall be to:

1. Review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment, and for Clinical Privileges according to the System Credentialing Plan;
2. Review and evaluate the qualifications of designated professional personnel, regardless of their source of employment, to provide specific patient care services in the System according to the System Credentialing Plan;
- ;
3. Submit a report, in accordance with these Bylaws, to the MEC on the qualifications of each applicant for Staff membership or Clinical Privileges, and of each designated professional personnel, to provide specific patient care services. Such report shall include recommendations for Staff applicants as to appointment, Staff category assignment, and Clinical Privileges, and, for designated professional personnel, the specific services to be performed. In either case, any special conditions will be recommended at the same time;
4. Submit reports to the MEC on the status of pending Applications, including the specific reasons for any unusual delay in processing an Application or request;

5. Monitor activities implemented for evaluation of the performance of patient care, such as for those who have been granted Temporary Privileges;
6. Initiate, investigate, review, and report on corrective action matters and on any other matters involving the clinical, ethical, or professional conduct of any Practitioners assigned or referred by the President, the Chairman of the Performance Improvement committee, the MEC, or the Governing Body; and
7. Assure that separate credentials file is maintained for each Staff Member, each Practitioner with Clinical Privileges, and each designated professional personnel, including reports from quality assessment and improvement activities and of corrective actions of any degree.

C. Meetings

The Credentials function shall meet as often as necessary to accomplish its required functions, but at least quarterly.

SECTION 4 - PERFORMANCE IMPROVEMENT FUNCTION

A. Composition

The Performance Improvement function shall be performed through the Performance Improvement Committee and shall consist of the Medical Director, Chief Nursing Officer, Clinical Director, AVP of Operations, Director of Quality Improvement and Risk Management and other members of the Staff and/or services as appointed. Individuals from either the Medical staff or System staff may participate as consultants on an as-needed basis.

B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of the performance improvement committee shall be to:

1. Coordinate and integrate all quality assessment and improvement components of the quality management program to reduce/eliminate duplications, omissions, inconsistencies, and failure to effect change;
2. Require that all evaluations performed are objective (based on preset criteria or standards), are clinically rather than administratively oriented, and are designed to identify important problems/patterns of care and performance. The committee through its quality management coordinator may assist in providing suitable clinically valid criteria for use in quality assessment and improvement activities;

3. Monitor the quality management program to the extent that it is comprehensive, in that all Specialties/Units/Practitioners are evaluated through the system in place;
4. Monitor corrective action to determine if it has been taken, is effective, and is maintained. Physician-related corrective action will be the responsibility of the MEC. System-related corrective action will be the responsibility of administration. The Board will assess the Medical Staff and administration effectiveness in assuring any corrective action needed;
5. Receive, analyze, and recommend action regarding any significant findings from the Risk Management program;
6. Monitor the development of policies and procedures with respect to special treatment procedures, including restraints, seclusion, electroconvulsive therapy and other forms of convulsive therapy, psycho surgery, behavior modification procedures that use aversive conditioning and other special treatment procedures for adolescents and adults;
7. Maintain a liaison with risk management, utilization review, infection control, patient representative, and in-service education;
8. Maintain a current written continuous Performance Improvement plan;
9. Perform at least an annual evaluation of the performance improvement program to assure its comprehensiveness and effectiveness, the latter to be measured by documented improvement in patient care and clinical performance; and
10. Report at least quarterly to the MEC. The Committee Chairman should make an updating report to the Board at least quarterly, and at any time a significant quality-related problem exists.
11. Meetings occur monthly

SECTION 5 - BYLAWS, RULES AND REGULATIONS FUNCTION

A. Composition.

The Bylaws, Rules and Regulations function shall be assumed by the MEC.

B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of the Bylaws, Rules and Regulations function shall be to:

1. Cause, through ongoing review, that the Bylaws, Rules and Regulations reflect current practice, national standards of patient care, and an efficient organization of the Medical Staff to perform its functions;
2. Recommend to the MEC and the Board any changes deemed necessary or desirable in the Bylaws, rules and regulations;
3. Develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws, rules and regulations and with Hospital, System, and Board policies; and
4. Act as the Medical Staff mechanism for documenting the required annual review of the Medical Staff Bylaws, rules and regulations, making at that time, any recommendations for change.

C. Meetings

The Bylaws, Rules and Regulations Committee shall meet as often as necessary to accomplish its functions.

SECTION 6 - MEDICAL RECORD FUNCTION

A. Composition

The Medical Record function shall be assumed by the MEC.

B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority shall be to:

1. Review and evaluate medical records objectively, using prescribed work sheets, to help assure that records are adequate for:

- a. Continuity of care purposes;
 - b. Assist in quality assessment and improvement activities;
 - c. Assisting in protecting the legal interests of the patient, the System, and the responsible Practitioner. Members shall evaluate whether the records reflect an accurate and adequate documentation of medical events;
2. Address issues of medical record content, delinquency, and deficiency, and recommend needed actions, including corrective actions;
 3. Establish the format of the medical record in concert with the director of the Medical Record department, and review and advise the AVP of Operations and MEC regarding all forms to be used in the medical record (including patient treatment plans);
 4. Review and recommend approval or not, of all policies, rules, and regulations relating to medical records;
 5. Recommend any need for and the interval for microfilming medical records, and participate in decisions for computerization of medical record data; and
 6. Develop, or cause to be developed, and implement a uniform record review system that, over a reasonable period of time, causes a representative sampling of the records of all Practitioners to be evaluated.

C. Meetings.

Medical Record functions will be addressed at the MEC meetings and as often as necessary to accomplish its functions (at least quarterly).

SECTION 7 - UTILIZATION REVIEW FUNCTION

A. Composition

The Utilization Review function shall be assumed by the MEC.

- B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of the Utilization Review Committee shall be to:
1. Comply with all requirements of the utilization review plan approved by the Medical Staff and Board;
 2. Require documentation that utilization review is applied regardless of payment source;
 3. Monitor and evaluate objective clinical data regarding practice patterns and prepare such reports as may be required by the MEC or other committee;
 4. Require that focused reviews be emphasized; and
 5. Determine whether under-utilization and, when appropriate, over-utilization on practices impact adversely on the quality of patient care and recommend the appropriate action to be taken.

C. Meetings.

The Utilization Review function will be addressed at the MEC meetings and as often as necessary to accomplish its functions (at least quarterly).

SECTION 8 - MEDICAL ADVISORY FUNCTION

A. Composition.

The Medical Advisory function shall be assumed by the MEC. The Chairman of the MEC may designate a subcommittee comprised of Active members of the Medical Staff who are experienced in the area of physician impairment or addictive diseases.

B. Responsibilities, Duties, and Authority.

This subcommittee may receive inquiries and reports on the health, well-being, or impairment of Medical Staff Members and, as it deems appropriate, may investigate. For matters involving individual Medical Staff Members, the committee may provide such advice, counseling, or referrals as seem appropriate. These activities shall be confidential. The committee does not have disciplinary authority; however, if information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff Member poses an

unreasonable risk of harm to hospitalized patients, the information may be referred for corrective action. The committee may provide suggestions and advice to other appropriate committees or officers regarding reasonable safeguards concerning Physicians continued practice within the System while undergoing treatment. The committee may also consider general matters related to the health and well-being of the Medical Staff, including educational programs or related activities in coordination with other appropriate committees.

C. Meetings.

The Committee shall meet as often as necessary to accomplish its functions. It shall maintain only such records of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the MEC. Any records regarding individual Practitioners shall be kept strictly confidential and maintained independently from any general records of the committee.

SECTION 9 - PHARMACY AND THERAPEUTICS FUNCTION

A. Composition.

The Pharmacy and Therapeutics function is a standing function of the MEC.

B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of are to take all reasonable steps to:

- a. Cause an objective evaluation of the clinical use of all drugs (by individual or category of drug) in the Hospital;
- b. Cause a well-controlled formulary to be established and implemented to help control drug use in the System. The committee will evaluate and make recommendations to the MEC as to which drugs should be added to and deleted from the formulary. Requests for formulary changes from individual Medical Staff Members may be submitted to the committee in writing, to include the rationale for the change. The committee's action shall be transmitted to the requesting Practitioner by the committee Chairman;
- c. Monitor and evaluate the prophylactic, therapeutic and empiric use of drugs, and evaluate all significant untoward reactions to drugs, all in an effort to assure that drugs are provided appropriately, safely, and effectively. In addition, the

committee shall strive to assure the adequate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic in-service training for nursing service personnel;

- d. Evaluate all significant medication errors;
- e. Evaluate initially, or when changes are made, and at least annually, standing and routine orders in use;
- f. Assist in the formulation of and approve all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the System;
- g. Make recommendations to the MEC on protocols proposed for the use of investigational or experimental drugs in the System; and
- h. Maintain records of any and all findings, conclusions, reports, recommendations and actions taken.

C. Meetings.

The Pharmacy and Therapeutics functions will be addressed at the MEC meetings and as often as necessary to accomplish its functions (at least quarterly).

SECTION 10 - INFECTION CONTROL FUNCTION

A. Composition.

The Infection Control function shall be assumed by the MEC.

B. Responsibilities, Duties, and Authority. The responsibilities, duties, and authority of shall be to prevent, investigate, and control infection in the System by:

- a. Maintaining surveillance of System infection potentials;
- b. Developing a system for identifying, reporting, and analyzing the incidence and major causes of System-acquired infections;

- c. Developing and implementing, through administration and the Medical Staff, a preventive and corrective program designed to minimize infection hazards, and to include an employee health program;
 - d. Actively promoting the adequate application of general policies relating to infection control for all units/areas of the facilities in the System, to include, but not limited to, isolation procedures and techniques, sterilization procedures, the safe disposal of infectious or contaminated wastes, prevention of cross-infection through equipment use;
 - e. Causing the objective ongoing evaluation of the clinical use of all antibiotics in the System, whether the drugs are prescribed prophylactically, empirically, or therapeutically, and whether administered to inpatients or outpatients. The committee shall recommend action for any required practice change to the MEC and shall follow-up through the quality management committee to be sure the approved change has occurred. The committee shall recommend and/or approve criteria for use in all facets of antibiotic use evaluation.
- e. Instituting any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel. When the situation is considered urgent, the committee Chairman or a physician member of the committee may institute

the control measure immediately and will be assisted by System personnel in doing so. The President and AVP of Operations shall be notified as soon as any urgent control measure is instituted and shall be consulted prior to the institution of any non-urgent measure. The attending Practitioner shall be notified as soon as possible; however, when the patients attending Practitioner does not consider the measure necessary (e.g., the need to isolate a patient), the decision of the committee Chairman or member, following established infection control policy, shall prevail.

C. Meetings.

The Infection Control Function shall meet as often as necessary to accomplish its functions, but at least quarterly.

SECTION 11 – PATIENT SAFETY/RISK MANAGEMENT FUNCTION

A. Composition.

The patient safety/risk management is a standing function of the Medical Executive Committee. It shall consist of at least the Quality Improvement and Risk Management Director, representatives from nursing, pharmacy dietary, and housekeeping departments, the Medical Director, and the Assistant Medical Director. This function is a standing function of MEC.

B. Responsibilities, Duties, and Authority.

- a. Establish, monitor, and review the Hospital's safety policies and procedures.
- b. Evaluate the results of routine walkthroughs to assess good safety standards;
- c. Plan, direct, and evaluate all fire and disaster drills as outlined in the Hospitals fire and disaster plans;
- d. Review and assess all incident reports and make recommendations to the Performance Improvement Committee to reduce the potential for future incidents; and
- e. Develop, plan, and evaluate programs of continuing professional education which is designed to keep the Medical Staff informed of significant new developments in the delivery of patient care.
- e. Review the proceedings of the other hospital functions dealing with risk issues (Falls, Pharmacy and Therapeutics, AWOL, Infection Control) in order to (1) discern patterns contributing to adverse events (2) develop improvements in policies, procedures, or organizational structures in order to maximize safety and minimize risk, and (3) report findings and seek input from the Medical Executive Committees.
- f. Oversee the process of Root Cause Analyses relating to adverse effects that occur within the system to discern patterns contributing to adverse events and develop improvements in policies, procedures, or organizational structures in order to maximize safety and minimize risk.

C. Meetings



The Committee shall meet as often as necessary to accomplish its functions, but at ten months per calendar year.

SECTION 12- PEER REVIEW FUNCTION

A. Composition

- a. The Peer Review Committee is a standing function of the Medical Executive Committee. It is composed of the Medical Director, the President of the Medical Staff, up to three other members of the active medical staff, the Director of Quality Management or designee.

B. Responsibility, Duties, Authority

- a. Implement Professional Practice Evaluation/Peer Review Policy by:
 - 1) Monitoring ongoing professional practice patterns
 - 2) Reviewing risk management data and identifies practitioner quality measures
 - 3) Soliciting observations and impressions of hospital staff
 - 4) Reviewing cases in which clinically significant adverse events occurred
 - 5) Overseeing and coordinating Focused Professional Practice Reviews per Hospital Professional Practice Evaluation/Peer Review Policy
 - 6) Provide suggested areas for system-wide improvement, addressable by focused project teams and other quality improvement activities

C. Meetings

- a. The Committee shall meet as often as necessary to accomplish its function, at least on 10 occasions per year.

SECTION 12 - TERM, REMOVAL, AND VACANCIES



Unless otherwise provided, a committee member shall continue as such until the end of his normal period of appointment and until his successor is elected or appointed. A Medical Staff committee member, other than one serving Ex Officio, may be removed by a majority vote of the MEC. An administrative staff committee member may be removed by action of the President/Chief Operating Officer. Vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.

ARTICLE IX:

MEETINGS

SECTION 1- GENERAL STAFF MEETINGS

A. Regular Meetings

Regular meetings of the Medical Staff shall be held once per year. The annual general Medical Staff meeting shall be the last meeting before the end of the designated Medical Staff Term. The agenda of such meetings may include cumulative reports by Staff officers and by committees of the review and evaluation of the work done. Elections for Staff office will be held at the final meeting. The President shall preside at all general meetings of the Medical Staff.

B. Order of Business and Agenda.

The order of business and agenda of a general Staff meeting will be determined by the AVP of Operations and Chairman of the Committee of the Whole, the Medical Director and the President. The peer review and evaluation of patient care and clinical performance will be as referred by the Medical Executive Committee.

C. Special Meetings.

Special meetings of the Medical Staff may be called at any time by the President, the Board, the MEC, or at least [one-half ($\frac{1}{2}$)] of the Active Staff Members. The President shall call a special meeting within seven (7) days of his receipt of written request for same.

- a. Written or printed notices stating the place, day, and hour of any special meetings of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Staff not less than three (3) nor more than ten (10) days before the date of such meetings, by or at the direction of the President. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each Staff Member at his address as it appears in the records of the System. 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.

- b. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 2 - COMMITTEE MEETINGS

- A. Medical Staff committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.
- B. A special meeting of any Committee, or clinical Service may be called by or at the request of the chairman or chief thereof, by the President, Medical Director, or AVP of Operations or by one-half (½) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.
- C. Notice of Committee Meetings.
 - a. Notice of regular meetings may be given orally.
 - b. For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day, and hour of the meeting shall be given to each member not less than five (5) days before the time of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the System, with postage prepaid.
- D. The attendance of a member at a meeting shall constitute a waiver of notice of such meetings.

SECTION 3 - QUORUM

- A. General Staff Meetings (Regular or Special).
 - a. The presence of one-third (1/3) of the voting Members of the Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of amendment to these Bylaws, rules and regulations and the election of Staff officers; and the presence of twenty-five

(25%) percent of such Members shall Constitute a quorum for the transaction of all other business.

- b. In the event that a quorum is not present at any regular or special meeting, those members present may meet as a subcommittee of the whole. Any action taken by those present, acting as a subcommittee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

B. Committee Meetings.

Twenty-Five (25%) percent of the voting members of a committee shall constitute a quorum at any meeting.

SECTION 4 - MANNER OF ACTION

- A. Except as otherwise specified in these Bylaws, the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group.
- B. Action may be taken without a meeting of a committee, by a writing setting forth the action so taken and signed by a majority of the Members entitled to vote thereat.

SECTION 5 - MEETING MINUTES

Minutes of all meetings shall be prepared by the secretary of the meetings and shall include a record of attendance and the vote taken on each matter. The minutes shall record a brief discussion of all problems discussed, indicating any recommendations made and forwarded, conclusions reached, and actions taken, The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC and the quality management committee. A permanent file of the minutes of each meeting (and the actions taken without an actual meeting) shall be maintained.

SECTION 6 - ATTENDANCE REQUIREMENTS

- A. Regular Attendance. Each Member of the Active Staff shall be required to attend the following:
1. One of the two required biannual Medical Staff meetings;
 2. At least fifty (50%) percent of all other general Staff meetings convened pursuant to these Bylaws; and
 3. At least fifty (50%) percent of all meetings of any committee of which he is a member.
- B. Absence from Meetings.
1. A Member who is compelled to be absent from any Medical Staff, committee meeting shall provide promptly verbal notice to the presiding officer thereof the reason for such absence. Unless excused for good cause, failure to meet the foregoing attendance requirements during the designated Medical Staff Term shall be grounds for corrective action by the MEC, in accordance with Article XI of these Bylaws. Corrective action may include revocation of Medical Staff membership.
 2. Failure of an Active Staff Member to attend the required number of general Medical Staff meetings, or medical committee meetings, unless excused as described above for just cause, shall automatically place the Member on the Courtesy Staff for the following year.
 3. The meeting attendance record of each Practitioner shall be maintained as part of the minutes of the Medical Staff meeting.
 4. No more than six (6) excused absences per year will be authorized for not attending committee and Medical Staff meetings, except for extenuating circumstances.
- C. Special Appearance.
1. A Practitioner whose patients clinical course of treatment is scheduled for discussion at a general Medical Staff or committee meeting shall be so notified in writing by the Chairman of the meeting at least ten (10) Days prior to the meeting. The notification shall indicate the time and place of the meeting, a statement of the issue(s) involved and, whenever apparent or suspect deviation from standard clinical practice is involved, the fact that the Practitioners appearance is mandatory.

2. Failure of a Practitioner to attend any meeting with respect to which he was given notice that his attendance was mandatory, shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioners Clinical Privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Board, if necessary, pursuant to Articles XI and XII. In all other cases, if the Practitioner shall make a timely request for postponement supported by an adequate excuse that his absence will be unavoidable, such presentation may be postponed by the President, or by the MEC if the President is involved, until not later than the next regular Staff, committee meeting; otherwise the pertinent clinical information available shall be presented and discussed as scheduled.

SECTION 7 - NONVOTING EX-OFFICIO MEMBERS

Individuals serving under these Bylaws as nonvoting Ex-Officio members of a committee shall, unless otherwise specified, have all other rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum.

SECTION 8 - MEETING AS A COMMITTEE-OF-THE-WHOLE

Notwithstanding any other provision of these Bylaws, whenever the Medical Staff meets, it shall be considered to be meeting as a committee of the whole Medical Staff.

SECTION 9 - CONDUCT OF MEETINGS

All meetings shall follow an acceptable form of parliamentary procedure, such as Roberts Rules of Order, in the conduct of meeting business.

ARTICLE X: PHYSICIAN HEALTH

The scope of this article applies to all members and affiliate members of Adventist HealthCare Behavioral Health and Wellness's Medical Staff.

In recognition of the obligation of the medical staff to protect patients from harm, the purpose of this section is to provide a process that provides education about physician health, addresses the prevention of physical, psychiatric or emotional illness, and rehabilitation of physicians and other members of the medical staff who suffer from a potentially impairing condition.

A. Policy

The Medical Staff at Adventist Health Care, BHWS shall assure the following:

- a. That its members and other staff receive education about illness and impairment recognition issues that are specific to members of the medical staff;
- b. That members of the medical staff are able to self-refer for confidential diagnosis, treatment and rehabilitation of physical, psychiatric or emotional illness;
- c. That other staff are able to confidentially refer members of the medical staff for appropriate diagnosis, treatment and rehabilitation of or for physical, psychiatric or emotional illnesses;
- d. That the confidentiality of the physician seeking referral or referred for assistance is maintained, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- e. That the credibility of the complaint, allegation or concern about a member of the medical staff is evaluated in a timely manner by the medical staff;
- f. That affected members of the medical staff are appropriately monitored until the rehabilitation or any disciplinary process is complete; and,
- g. That the medical staff leadership is immediately notified in instances in which a physician is providing unsafe treatment.

B. Education – Medical staff

At least annually, the Medical Director will provide the Medical Staff with comprehensive education about illnesses and impairment recognition issues specific to members of the medical staff. This education in-service will be approved in advance by the Medical Executive Committee, will be provided in a general meeting of the medical staff, and will also be distributed in written form to any

member that is not in attendance.

C. Education of other staff

At least annually, the Medical Director will assure that all persons within the organization are provided with appropriate information, approved by the Medical Executive Committee, about illness and impairment recognition issues specific to physicians. This education may be provided through distribution of educational material to the various departments or other means.

D. Referrals for Assistance

1. Self-Referral

Employee Assistance Program- An employee member of the medical staff may self refer for assistance with issues including, but not limited to: Physical health concerns; emotional problems; issues related to loss or death; psychiatric illnesses, such as depression; and financial problems.

As required in these Bylaws, a member of the medical staff must report any illness or condition – including any physical illness, substance use problem, and any psychiatric illness – to the Medical Director in the event that the illness or condition may substantially and adversely impact upon the staff member’s ability to safely execute the duties associated with the staff member’s clinical privileges.

2. Referrals by BHWS staff

Other individuals within the organization are encouraged to refer members of the medical staff for assistance, as needed. The confidentiality of the referring staff will be maintained, is so requested.

a. No evidence of substantial current or imminent impairment in functioning

A staff member may choose to speak directly with the medical staff member in order to suggest that the member take steps to prevent a problem from expanding to the degree that it may lead to impairment in functioning. An appropriate recommendation may include the suggestion that the medical staff member contact an assistance program.

b. Substantial Current Impairment in Functioning Evident, or There is Reasonable Concern that Impairment May Be Imminent

The staff member should promptly alert the immediate supervisor of the medical staff member. The staff member may also notify the Medical Director or the Vice President of Clinical Services if the

staff member believes that the immediate supervisor has not addressed the problem within a reasonable time period. If there is reason to believe that the nature and degree of the impairment is such that it poses an imminent risk to patient safety, and if the staff member's immediate supervisor is not immediately available, the AVP of Operations should be notified immediately.

E. Role of Medical Staff Leadership

1. Duty to Evaluate

All complaints, allegations and concerns about a member of the medical staff that are referred to the staff member's supervisor – including self-referrals- shall be promptly and thoroughly investigated by the supervisor. If the supervisor is not a member of the medical staff, and before any formal action is taken, the supervisor must consult with the Medical Director in the event the complaint, allegation or concern involves professional conduct or competence of the staff member.

2. Actions by Leadership

Following an evaluation, and in the event that the existence of a problem is confirmed, the Medical Director shall take any reasonable action that may be deemed necessary to assist the staff member. If the matter involves patient safety, those actions that are reasonably necessary to assure patient safety shall be taken immediately. These actions may be taken in any order and in any combination (as permitted by these Bylaws) and include, but not limited to:

- a. Personally counseling or instructing the staff member
- b. Referral to private treatment provided and counselor
- c. Referral to the Employee Assistance Program
- d. Referral to an appropriate agency for medial or psychiatric evaluation
- e. Progressive disciplinary action
- f. Suspension from Duty
- g. Emergency suspension of clinical privileges

G. Referral to the Medical Executive Committee

As noted above, the supervisor of a medical staff member must take any reasonable action that may be deemed necessary to assist the staff member and to assure patient safety. In addition to the execution of these action, including any immediate actions that may be reasonably necessary to assure patient safety, the supervisor must notify the Medical Executive Committee, through the Medical Director, by the close of the next day, anytime that the supervisor finds (1) that a medical staff member provided unsafe treatment; and (2) that a medical staff member is impaired by a physical, emotional, mental or substance abuse problem; or the member's behavior has adversely impacted upon patient care and safety, or could reasonably be expected to adversely impact upon patient care and safety in the future.

H. Actions by Medical Staff Leadership

The Medical Executive Committee, upon self-referral by a member or upon notification by a supervisor that a member of the medical staff may be impaired, the Medical Executive Committee shall

- a. Conduct or direct any additional investigation or inquiry that may be needed to determine what, if any, additional reasonable actions may be necessary to assist the medical staff member and assure patient safety.
- b. Take any additional reasonable actions that may be necessary to assist the staff member; and immediately take any additional actions that are found to be necessary to assure patient safety.
- c. Impose disciplinary action by the medical staff only if such action is both necessary and permissible under the Bylaws. Such actions must be taken in a manner consistent with provisions of the Bylaws. Formal disciplinary action against a medical staff member need not necessarily be taken when the nature of the problem is susceptible to other measures or corrective actions (except for as specifically state by the Bylaws or applicable law.)
- d. Report to the Maryland Board of Physician Quality Assurance those findings and actions that must be reported in accordance with Bylaws and applicable law.)

I. Monitoring

It shall be the duty of the medical staff member's supervisor to monitor the affected staff member and the safety of patients until the staff member's rehabilitation or any disciplinary process is complete. As part of the monitoring process, the supervisor may elect to request periodic reports and updates from any treatment provider or counselor in the event that it may be reasonably determined that such reports are required in order to assure patient safety. If the matter has been referred to the medical staff leadership, leadership shall assure that the affected staff member and the safety of the patients are monitored I a manner consistent with the safety needs of the patients.

J. Confidentiality

Supervisory personnel and medical staff leadership shall at all times assure the confidentiality of the affected medical staff member, except as required by law, ethical obligation, or when the maintenance of confidentiality would threaten patient safety.

ARTICLE XI: CORRECTIVE ACTIONS

SECTION 1 - ALTERNATIVE TO CORRECTIVE ACTION

A. Responsibility for Routine Monitoring and Education

Under certain circumstances, routine monitoring and education of Practitioners may be an appropriate alternative to corrective action. It shall be the responsibility of the Medical Director working with the assistance, as appropriate, of the chairman of each department, to design and implement effective programs to monitor and assess the quality of professional practice in his unit; and to promote quality practice in his unit by: (1) providing education and counseling; (2) issuing letters of instruction, admonition, warning or censure, as necessary; and (3) requiring routine monitoring when deemed appropriate.

B. Procedure

1. In order to assist Practitioners to conform their conduct or professional practice to the standards of the Medical Staff and Hospital, the Department Chief may make informal comments or suggestions either orally or in writing. A summary of such statements will be kept in the Members credentials file. Such comments or suggestions shall be subject to the confidentiality requirements of all Medical Staff peer review information and may be issued with or without prior consultation with either the affected Member or the Department or Section committee. Such comments or suggestions shall not constitute a restriction of Privileges and shall not give rise to the hearing and appeal rights under these Bylaws.
2. Following discussion of identified concerns with a Member, the Service or Department Chief may authorize the Medical Director to issue a letter of instruction, admonition or warning to the Member or to require the Member to be subject to routine monitoring for such time as shall appear reasonable. The term "routine monitoring" as used in this Section shall mean review of a Members practice for which the Members only obligation is to provide reasonable notice of patient admissions, procedures or other patient care activity. All Members of the Medical Staff, regardless of status, shall be subject to potential routine monitoring. The discussions of such actions with individual Members shall be informal, but shall be treated as a confidential matter pursuant to the confidentiality standards set forth herein. Such actions shall not constitute a restriction

of Privileges, shall not be considered to constitute corrective action and shall not give rise to the hearing and appeal rights under these Bylaws. Written letters of instruction, admonition or warning or routine monitoring required pursuant to this Section shall be reported to the MEC promptly after such actions are taken.

SECTION 2 - CORRECTIVE ACTION

A. Grounds: Initiation

Whenever the activities or the conduct of any Practitioner (1) fails to meet and satisfy the qualifications and criteria for staff status; (2) is disruptive to the operations of the System;(3) constitutes fraud or abuse; (4) is detrimental to the quality of patient care at the System; (5) is detrimental to the Hospital's (or any facilities or entities within the System) licensure or accreditation; (6) is detrimental to System or Medical Staff efforts to comply with any professional review organization, third-party Payer (private or governmental), or utilization review requirements; (7) is in violation of the Medical Staff Bylaws, rules and regulations, or policies of the System, Medical Staff or any committee thereof; (8) is in violation of the ethics of his profession; or (9) is believed to constitute criminal conduct, corrective action may be requested against such affected Practitioner (Affected Practitioner) as such term is defined in Article XII, Section F(1) by any officer of the Medical Staff, the Board, the President/Chief Operating Officer, or the chairman of any standing committee ("requesting party"). All requests for corrective action shall be in writing, shall be submitted to the MEC through its Chairman, and shall set forth the specific conduct constituting the basis for the request. Corrective action shall be initiated only based on the reasonable belief that such action is in the furtherance of the effective and efficient delivery of quality health care services and relates to competence or professional conduct of a Practitioner which affects or could reasonably affect the health or welfare of a patient or patients.

B. Investigation

The MEC, before taking action on the request, shall conduct such investigation as it deems necessary, which may, at its discretion, include informal interviews with the requesting party and the Affected Practitioner (each out of the presence of the other), informal interviews with or reports from other persons, and chart reviews, if applicable. Neither the investigation nor any other activities of the MEC in acting upon a request for corrective action shall constitute a hearing; they shall be informal, and none of the hearings and appeal rights under these Bylaws shall apply. A concise record of such interview shall be made. Except as may be required by state law, the Affected Practitioner is not entitled to legal representation at this stage.

C. Time for Taking Action; Notice; Right to Hearing

Within sixty (60) days after receipt by the MEC of a request for corrective action, or within such reasonable additional time as the MEC deems necessary, the MEC (or its designees) shall take action upon the request. Within five (5) days after taking action, the MEC shall give written notice to the Affected Practitioner and the Board stating which of the actions set forth in this Section the MEC has taken or recommended. If the action is of a type requiring notice as described in the Article in these Bylaws governing hearings and appeals, the notice shall comply with the applicable Sections of such Article. In no event shall the Practitioner be entitled to the rights under Article XII when the only action of the MEC was to issue a letter of admonition or reprimand.

D. Possible Actions

The action of the MEC on a request for corrective action may be to: (1) reject the request; (2) issue a letter of warning, admonition, or reprimand; (3) impose terms of probation or require proctoring, co-admitting, or consultation; (4) recommend reduction, suspension, proctoring, co-admitting, consultation, or revocation of Clinical Privileges; (5) recommend that an already imposed summary suspension of Staff membership or Clinical Privileges be terminated, modified, or sustained; (6) recommend that the Practitioner's staff membership or Privileges be suspended or revoked; or (7) take or recommend other actions deemed appropriate by the MEC.

E. Notice to AVP of Operations

The Chairman of the MEC shall promptly notify the AVP of Operations in writing of each request for corrective action received by the MEC and the date of its receipt, and shall keep the AVP of Operations fully informed of all communications, meetings, and actions in connection with each request.

F. Procedural Rights

Any action by the MEC pursuant to Article XI, Sections (D)(3)-(7), or any combination of such actions, shall entitle the Practitioner to the procedural rights in Article XII, and the matter shall be processed in accordance with the provisions of such Article.

G. Board Action

At any time that it believes corrective action may be warranted, or following a written request for corrective action, the Board, or its designee, may initiate it. Before initiating such corrective action, the Board, or its designee, shall consult with the President and with the MEC.

Thereafter the Board, or its designee, may direct the MEC to conduct an investigation or otherwise initiate corrective action on its own. In the event the MEC fails to take action in response to a direction from the Board, or its designee, the Board, or its designee, may conduct an investigation or otherwise initiate corrective action proceedings. If applicable, such proceedings shall afford the Affected Practitioner the hearing and appeal rights described in these Bylaws. The Board shall inform the MEC in writing of any action taken pursuant to this section.

H. Complaints of Harassment or Discrimination

In cases of complaints of harassment or discrimination by any patient or person in the System, an expedited initial review shall be conducted by the President (or his designee) or the Medical Director, the President/Chief Operating Officer, or a Board member, or by an attorney for the System. Reviews conducted by an attorney for the System would not be a Medical Staff proceeding. The information gathered from an attorney's review may be referred to the MEC if it is determined that corrective action may be initiated against a Medical Staff member, and all further review would be conducted as Medical Staff proceedings.

I. Use of Membership/Privileges

The Affected Practitioner shall retain the use of his membership and Privileges pending final action by the Board unless such membership or/and Privileges are otherwise suspended as provided in this Article.

SECTION 3 - SUMMARY SUSPENSION OR RESTRICTION

A. Grounds; Persons Authorized to Act

Whenever a Practitioner's (1) conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee or other person present in the hospital, or (2) where the failure to take such an action may result in an imminent danger to the health of any individual, or (3) whenever there are reasonable grounds to believe his conduct requires prompt action for any of such reasons, the chairman of the Medical Executive Committee, the Medical Director, the President/Chief Operating Officer, the Medical Executive Committee, the Board, or any Board

committee, shall have the authority to take summary professional review action. Prior to exercising its authority, the Board or its designee(s) must make reasonable attempts to contact the President. Summary action by the Board which has not been ratified by the President within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances. Summary professional review action may consist of the following: (a) a suspension of all or a part of a Practitioner's Clinical Privileges, (b) a suspension of a Practitioner's Staff status, (c) the imposition of conditions or limitations on the exercise of Clinical Privileges, (d) or a combination of actions.

B. Effective Date: Notice

A summary suspension or restriction shall become effective immediately upon imposition, and the person or body imposing same shall promptly give Special Notice of the suspension or restriction to the suspended Practitioner, stating by whom it was imposed and the reasons for same. The Special Notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended Practitioner, whichever occurs first. The Special Notice, or a written confirmation of it, shall inform the suspended Practitioner: (a) of his right to an informal interview upon his written request under **Section 3(C)**; (b) that if a summary suspension or restriction remains in effect longer than thirty (30) Days, the action will be reported pursuant to state law and to the National Practitioner Data Bank. If the suspension or restriction is terminated when the MEC takes further action under **Section 3(D)**, the Practitioner will be entitled to the hearing and appeal rights under these Bylaws, a copy of the Special Notice shall promptly be delivered to the President/Chief Operating Officer, the MEC, and the Board.

C. Investigation

The MEC (or its designee), before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one (1) meeting of the MEC, and may include a informal interview with the suspending party (if other than the MEC). An informal interview with the Affected Practitioner (out of the presence of the suspending party, if other than the MEC), may be held if the Affected Practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him. The MEC's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or committees. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these Bylaws shall apply.

D. Further Action: Time

As promptly as possible, but no later than fourteen (14) Days after the date of the suspension, the MEC shall take further action with respect to the suspension, and may modify, continue for a

definite or indefinite period, or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these Bylaws. Within five (5) days, the MEC shall give written notice of its further action to the suspended Practitioner, the AVP of Operations and the person or body who imposed the suspension or restriction (if other than the MEC).

E. Rights to Hearing

Following the decision of the MEC regarding further action, the provisions of Article XII shall govern the hearing and appeal rights under these Bylaws.

F. Alternate Patient Coverage

Immediately upon the imposition of a summary suspension or restriction, the President (or Medical Director) shall provide for alternate medical coverage for the patients of the suspended Practitioner remaining in the Hospital at the time of such suspension, if the appropriate Privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternative coverage.

SECTION 4 - AUTOMATIC SUSPENSION AND EXPULSION

The following shall result in automatic suspension of or expulsion from Medical Staff membership and/or Clinical Privileges and shall not entitle the affected Medical Staff Member to the hearing and appeal rights specified in these Bylaws, unless otherwise expressly provided.

A. Medical Records

Practitioners must complete their patients' medical records within thirty days (30) of each patient's discharge. Medical records that the Practitioner fails to complete within the 30 day period will be considered delinquent. The Medical Records department supervisor shall notify Practitioners in writing of incomplete medical records nearing delinquent status and that they will be subject to monetary fines in accordance with Medical Staff Policy on Delinquent Medical Records.

B. Licensure

Whenever a Practitioners license or other legal credentials authorizing practice in this State is revoked, not renewed, restricted, suspended or made subject to any probationary provisions by the applicable licensing and certifying agency, his Medical Staff membership and Clinical Privileges shall be automatically revoked or otherwise restricted pursuant to the scope of such restriction effective upon receipt by the System of notice thereof. In the event a temporary restraining order or other type of court order or legal restriction is placed on a Practitioner by a court, his Privileges shall be automatically restricted or suspended consistent with the terms of the court order until final resolution of the matter.

C. DEA Certificate

A temporary suspension of a Practitioners Privileges to prescribe or obtain controlled substances or other medications at or through the System or any of its facilities shall be immediately imposed by the AVP of Operations upon the receipt by the System of notice that such Practitioners right or license to prescribe or obtain controlled substances or medications has been suspended, revoked or otherwise restricted by the applicable governmental agency. Such automatic suspension shall include only those controlled substances or medications suspended or revoked by the governmental agency and shall be effective until the governmental agency reinstates the Practitioners right or license in question, unless the MEC determines otherwise and so notifies the Affected Practitioner. If a Practitioners right or license to prescribe or obtain controlled substances or medications is subject to an order of probation or other restriction, the Practitioners Privileges to prescribe or obtain controlled substances or other medications at or through the System or any of its facilities shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation or other such restriction.

D. Loss of Malpractice Insurance

For failure to maintain the required amount of professional liability insurance and to provide evidence of such coverage as required under these Bylaws, rules and regulations or Hospital policy, a Practitioners membership and Clinical Privileges shall be automatically suspended and shall remain so suspended until the Practitioner provides evidence to the MEC that he has secured professional liability coverage in the amount required. Failure to provide such evidence within forty-five (45) days after the date the automatic suspension became effective shall be deemed a voluntary resignation from the Medical Staff.

E. Felony Indictment or Conviction

A Practitioner who has been indicted, convicted of, or pled "guilty" or pled "no contest" or its equivalent to a felony or misdemeanor involving a charge of moral turpitude in any jurisdiction shall be automatically suspended by the President or President/Chief Operating Officer. Such suspension shall become effective immediately upon such indictment, conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

F. Performance Improvement and Peer Review Inquiries

Practitioners have an obligation to timely and satisfactorily respond to inquiries from Medical Staff committees and their designees on issues relating to the Practitioners qualifications, character, behavior, ethics, health status, case management, or the Practitioners compliance with the Bylaws, rules and regulations and policies of the Medical Staff and Hospital. The Committee Chairman shall send a letter to the Practitioner requesting a response within thirty (30) days. If the Practitioner fails to timely respond, the President shall send a notice advising that failure to comply within seven (7) days shall result in an automatic ten (10) day suspension of membership and all Privileges. Such suspension shall continue until the inquiring person or body confirms that a satisfactory response has been received. With the exception of emergency care which only the Practitioner is qualified and available to render, and the care of patients already hospitalized at the time of the suspension, such suspension shall include all admitting and Clinical Privileges. Unverified emergency admissions shall not be used to bypass such restriction. Failure to satisfactorily comply within six (6) months of the date of the suspension, shall be deemed a voluntary resignation from the Medical Staff and relinquishment of all Privileges.

Quality management and peer review require the active maintenance of licensure and malpractice insurance, DEA and State controlled substance abuse licensure, where applicable. Failure to supply required copies with 45 days of notification will result in suspension of privileges. Failure to provide such documentation within sixty (60) days of suspension will result in voluntary resignation of privileges.

G. Failure to Satisfy Special Appearance Requirement

A Practitioner who fails to satisfy the provisions of the Bylaws regarding Special Appearance (Article IX, Section 6(C)) shall be immediately and automatically suspended from exercising all or a part of his Clinical Privileges in accordance with the provisions of Article XII, Section 4.

H. Failure to Comply With Government and Other Third Party Payer Requirements

The MEC shall be empowered to determine that compliance with certain specific third party payer, government agency, and professional review organization rules or policies is essential to

System and/or Medical Staff operations, and that compliance with such requirements can be objectively determined. A Practitioner may be automatically suspended for failure to comply with such requirements, and such suspension shall be effective until Practitioner complies with such requirements.

I. Automatic Termination

If a Practitioner is suspended for more than ninety (90) days and is not reinstated by the Board, his membership (or the affected Privileges, if a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require a new Application and compliance with the appointment procedure set forth in Article III.

J. Notice

Unless otherwise specified in this Section, the AVP of Operations shall immediately notify the Affected Practitioner and the President in writing, either by personal delivery or certified mail, return receipt requested, of any suspension or expulsion under this Section. Such notice shall set forth the effective date of and the reason(s) for the suspension or expulsion.

**ARTICLE XII:
HEARING AND APPELLATE REVIEW PROCEDURES**

SECTION 1 - GENERAL PROVISIONS AND DEFINITIONS

A. Review Philosophy

The purpose of this Article is to permit the Medical Staff and the System to resolve issues related to professional practice and qualifications for Medical Staff membership and Clinical Privileges fairly, expeditiously and with due regard for both the need to protect patients and the interests of Practitioners, and at the same time protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Board from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board to create a hearing process which provides for the least burdensome level of formality in the process and still provides a fair review and to interpret these Bylaws in that light.

B. Exhaustion of Remedies

Each applicant, Practitioner, and Member agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing and appeal under this Article. The absence of an interlocutory appeal process for reviewing any alleged violation of the Bylaws or the affected Practitioners fair procedure rights does not warrant judicial intervention.

C. Intra-Organizational Remedies:

The hearing and appeal rights established in these Bylaws are strictly judicial rather than legislative in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of these Bylaws, rules and regulations, or Hospital or System policies. However, the Board may, in its discretion, entertain challenges to the merits or substantive validity of these Bylaws, rules and regulations, or System policies and decide those questions. If the only issue in a case is whether a bylaw, rule or policy is lawful is meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must first submit his challenges to the Board and only thereafter may he seek judicial intervention.

D. Joint Hearings and Appeals

The Medical Staff and Board are authorized to participate in joint hearings and appeals and in System wide corrective action in accordance with the provisions of this **Article XII, Section 2.**

E. Substantial Compliance

Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating or challenging the action taken.

F. Definitions - For the purposes of this Article, the following definitions shall apply.

Affected Practitioner: means the Medical Staff Member, Practitioner, or applicant for membership with respect to whom any of the actions specified in **Article X, Section 3(A)** below have been taken or recommended, and whose membership or Privileges may be affected thereby.

Initiating Body: means the person, committee, or body (which will generally be the MEC) that, pursuant to these Bylaws, initiated the action or made the recommendation that resulted in a hearing being requested.

Parties or party: means, unless clearly indicated otherwise by particular context, collectively or individually as the case may be, the Affected Practitioner, the MEC, and/or the Initiating Body (if other than the MEC).

Notice: means a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his address as it appears in the records of the Hospital. Copies shall be as effective as the original for the purpose of giving notice. Any such notice shall be deemed effective on the date it was first received or three (3) days after it was mailed first-class postage prepaid, whichever occurs first.

G. Settlements

At any time following receipt of notice of a recommendation or action which would entitle a Practitioner to request a hearing under this Article, the Practitioner may ask the initiating Body to discuss voluntary settlement or resolution of the matter. Upon such request and subject to the Practitioner's waiver of time requirements in order to allow such discussions to proceed, the MEC may authorize one or more of its Members to conduct confidential discussions with the Practitioner; provided, that the MEC shall not be obligated to conduct such discussions if it concludes that the request is interposed primarily for delay or that a settlement is not feasible.

If the Practitioner and the Initiating Body reach a written agreement which could settle the matter, the Initiating Body shall promptly notify the AVP of Operations and the Governing Body. Any such written settlement agreement shall include an acknowledgment by the Practitioner that he voluntarily waives his hearing and appeal rights under these Bylaws, that the settlement is entered into voluntarily and that he will waive all claims relating in any way to the matter against all Medical Staff and Hospital personnel. Any such proposed settlement shall be subject to Board approval.

SECTION 2 - SYSTEM CORRECTIVE ACTION, JOINT HEARINGS AND APPEALS FOR SYSTEM MEMBERS

A. System wide Corrective Action

1. Notice of Pending Investigations/Joint Investigations. The President and the AVP of Operations each shall have the discretion to notify their counterpart officers at other Systems whenever a request for corrective action has been received. In addition, the MEC may authorize a coordinated investigation and may appoint other System's Medical Staff Members to assist in the coordinated investigation. The President and the AVP of Operations are authorized to disclose to another System's peer review body (or an authorized representative of that body) information from System and Medical Staff records to assist in the other System's independent or joint investigation of any Practitioner. The results of any joint investigation shall be reported to each System's peer review body for its independent determination of what, if any, corrective action should be taken.
2. Notice of Actions. In addition to the discretionary reporting and joint investigation provisions set forth herein, the President and/or the AVP of Operations are authorized to inform his or her counterpart officer at any other System where the Practitioner is known to hold privileges whenever any of the following actions has been taken:
 - a. Summary suspension of Clinical Privileges should be reported promptly upon imposition (other than automatic suspensions for failure to complete medical records).
 - b. Other corrective actions may be reported at any time the President or AVP of Operations determines such a report to be appropriate, and should be reported promptly upon final action by the Board.

The effect of such action on the involved Practitioner's Privileges at another System shall be determined by the medical staff bylaws or other applicable policies of that other System; or if there are no applicable bylaws or policies, the information shall be deemed transmitted for the receiving System's independent review and action. The President and AVP of Operations are authorized to disclose to another System's peer review body (or an authorized representative of that body) information from the System and Medical Staff records regarding such a Practitioner or AHP.

3. Effect of Actions Taken by Other Entities. Except as provided in Section 2(A), whenever the President or MEC receives information about an action taken at another System and involving a Practitioner or AHP holding Privileges at the System, the President or MEC shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Practitioner or AHP was summarily suspended or restricted at the other System, any person authorized under these Bylaws to impose a summary action is authorized to immediately impose a comparable suspension or restriction at this System, subject to review by the MEC.

B. Joint Hearings

Whenever a Practitioner who is a Staff Member of the Adventist System is entitled to a hearing because a coordinated, cooperative, or joint credentialing or corrective action has been taken or recommended, a single joint hearing may be conducted in accordance with hearing procedures that have been jointly adopted by the involved entities, provided such procedures are substantially comparable to those set forth in Article XII, Section 3 and further provided at least one member of the Hearing Committee is a Member of this System's Medical Staff.

In the event there is such a joint hearing, the recommendation of the Hearing Committee shall be reported to this System's Board for final action.

C. Joint Appeals

The procedures may also call for joint appeal rights, provided such procedures are substantially comparable to those set forth in Article XII, Section 7 and, further, provided that at least one member of the Appeal Board is a representative of this System's Board.

D. Effect of Joint Hearings/Appeals

A joint hearing and/or appeal in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Practitioner pursuant to these Bylaws.

E. Provision for Separate Hearing

Notwithstanding the foregoing, if a Practitioner can demonstrate to the Medical Executive Committee (in the case of a hearing based on a recommendation of the Medical Executive Committee) or the Board (in the case of a hearing based on a recommendation of the Board or in the case of an appeal) prior to the initiation of a joint hearing and/or appeal that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual Practitioner's circumstances, the Medical Executive Committee or Board may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges at this System, in accordance with this System's Hearing and Appellate Review Provisions.

SECTION 3 - THE HEARING PROCESS

A. Grounds for Hearing/Adverse Actions

Except as otherwise provided in these Bylaws, the taking or recommending of any one or more of the following actions, unless taken in compliance with a policy decision of the System, shall constitute an adverse professional review action and/or adverse professional review recommendation (an Adverse Action) and grounds for a hearing pursuant to this Article:

1. Denial of Staff membership, reappointment, and/or Privileges (except for Temporary Privileges, unless otherwise required by state law);
2. Revocation, suspension, restriction, involuntary reduction of Staff membership and/or Privileges for more than thirty (30) days;
3. Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to staff status, or the granting of new Privileges, or imposed because of insufficient activity, or proctoring or consultation that does not restrict the Practitioner's Privileges);
4. Summary suspension of Medical Staff Membership and/or Privileges during the pendency of corrective action and hearings and appeals procedures.

5. Non-reinstatement of Staff status and/or Privileges after a leave of absence or within 30 days after curing an event of default which gave rise to an automatic suspension under Sections 4(A) and 4(H) of Article XII.
6. Any other disciplinary action or recommendation that must be reported to the State licensing authority.

B. Notice of Adverse Action or Recommended Action

Whenever any of the actions constituting grounds for a hearing as set forth in Section 3(A) above has been taken or recommended, the Initiating Body shall give written notice to the Affected Practitioner within five (5) days of the Initiating Body's decision.

The notice shall:

1. Describe what action has been taken or recommended;
2. State the reasons for the action (a statement of charges will be provided in the event a hearing is properly requested);
3. Advise that the Practitioner has the right to request a hearing and, that such request must be in writing and received by the AVP of Operations within thirty (30) days after the Affected Practitioner's receipt of the Notice of Adverse Action;
4. Contain a summary of the Practitioner's rights in the hearing; and
5. State that the action, if finally adopted, will be reported to the appropriate licensing entity and to the National Practitioner Data Bank.

C. Request for Hearing

Whenever the MEC has given notice of action that constitutes grounds for a hearing as described in **Section 3(A)** above, the Affected Practitioner shall have thirty (30) days following the date such notice was given within which to request a hearing. A request for a hearing shall be in writing and delivered to the AVP of Operations within the applicable time period set forth above. Failure of the Affected Practitioner to request a hearing within the time and in the manner set forth in this subsection shall be deemed an acceptance by such party of such action or recommendation and a waiver by such party of all hearing and appeal rights under these Bylaws. The matter shall thereupon be forwarded to the Governing Body for its final decision

in accordance **with Article XII, Section 7**. The AVP of Operations shall give notice to all parties of any such waiver and acceptance.

D. When Practitioner Entitled to a Hearing A Practitioner shall be entitled to a hearing only upon request and only after:

- a. An adverse professional review recommendation by the MEC;
- b. An adverse professional review action by the Board contrary to a favorable recommendation by the MEC; or
- c. An adverse professional review action by the Board in the absence of a recommendation by the MEC.

In addition to the above, a Practitioner shall be entitled to appellate review (but not a hearing) under the following circumstances:

- a. After an adverse professional review action of the Board contrary to a favorable recommendation by a hearing committee; provided, however, a Practitioner shall not be entitled to such an appellate review if the adverse professional review action by the Board is taken after an appellate review is requested by the MEC;
- b. After an adverse professional review recommendation of a hearing committee.

E. Notice of Hearing

Upon receipt of a proper request for hearing, the AVP of Operations shall deliver the request to the MEC, stating the date it was received by the President/Chief Operating Officer. The MEC shall, within thirty (30) days after receipt by the AVP of Operations of the request, schedule a date for a hearing. The MEC shall, not less than thirty (30) days prior to the date of the hearing, give notice to the parties of the time, place, and date thereof, and shall deliver a copy of these Bylaws to the Affected Practitioner. The date of commencement of the hearing shall not be less than thirty (30) days from the date of the notice of hearing nor more than sixty (60) days from the date of receipt of the request for a hearing by the President/Chief Operating Officer, except that when the request is received from a Member who is under suspension, the hearing shall commence as soon as reasonably practicable, but not later than forty (40) days from the date of receipt by the AVP of Operations of the request for hearing. In such instances, the notice of hearing shall be provided within a reasonable time prior to the date of commencement. The

parties and the MRHC shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable.

F. Statement of Charges

As a part of, or together with, the Notice of Hearing, the MEC shall state the acts or omissions with which the Affected Practitioner is charged, including, if applicable, a list of chart numbers under question, if any, and the reasons for the action or recommendation. Amendments to the Statement of Charges may be made from time to time, but not later than the close of the case by the Medical Staff representative at the hearing. Such amendments may delete, modify, or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given to the Affected Practitioner, the hearing officer, and each party. If the Affected Practitioner promptly gives written request to the Medical Review Hearing Committee, he shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original notice. The Medical Review Hearing Committee shall give prompt notice to the parties of each such postponement.

G. Medical Review Hearing Committee (MRHC) or Arbitrator: Appointment Removal, and Qualifications

Promptly after a hearing has been properly requested, the MEC shall determine if the hearing shall be held before: (1) an arbitrator or arbitrators selected by a process mutually acceptable to the Practitioner and the MEC; or (2) before a panel referred to as a Medical Review Hearing Committee. Should the MEC determine that a Medical Review Hearing Committee shall be used, he shall promptly appoint such a MRHC and its Chairman to act as the peer review group in the hearing. The MRHC shall consist of not less than three (3) nor more than seven (7) members, at least the majority of whom shall be Physicians who shall be licensed to practice medicine but need not be Members of the Medical Staff. When feasible, the MRHC shall include at least one (1) individual practicing in the same specialty as the Affected Practitioner. They may have knowledge of the matters to be heard, but each shall be willing to hear the matters objectively and without prejudice. They shall not have acted as accusers, investigators, fact finders or initial decision-makers in connection with the same matter; shall gain no direct financial benefit from the outcome; and shall not be in direct economic competition with the Affected Practitioner.

H. Hearing Officer

The AVP of Operations may appoint a hearing officer to conduct the hearing. The Hearing Officer may be a member of the State bar, and should be familiar with the law applicable to hospital administrative proceedings. Such attorney shall not, however, be regularly utilized by

the System for legal advice regarding its affairs and activities. The Hearing Officer shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing and shall not act as a prosecuting officer or advocate. The Hearing Officer shall act as advisor to the MRHC as to procedural matters, including the drafting of its decision and report, but he shall not be entitled to vote. In the alternative, the President/Chief Operating Officer, after consulting the MEC, may appoint a medical hearing officer to conduct the hearing. The medical hearing officer may be a Member of the Medical Staff but may not be in direct economic competition with the Affected Practitioner. He should be familiar with the applicable medical issues and with medical staff administrative proceedings. He shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. He shall decide all procedural matters and make his report and recommendation. All references to the "Hearing Officer" and to the "MRHC" shall refer to the medical hearing officer if one is appointed. If a hearing officer is not appointed, the Chairman of the MRHC shall conduct the hearing and rule on procedural matters, and all references to the "Hearing Officer" shall be deemed to refer to the Chairman of the MRHC or the arbitrator, as appropriate.

I. Postponements and Extensions

After the appointment of the MRHC and before the commencement of the hearing, postponements beyond the times required by these Bylaws may be requested by any of the parties, and shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause. The MRHC shall promptly give notice to the parties of each such postponement.

J. Medical Staff Representative

After a hearing has been properly requested, the MEC shall promptly appoint a Medical Staff Member to present the case on behalf of, and otherwise represent, the Initiating Body. The MEC may, in its sole discretion, remove or replace the Medical Staff representative at any time.

K. Failure to Request Hearing

A Practitioner who fails to request a hearing within the time and manner specified herein waives his rights to such hearing and any appellate review to which he might otherwise have been entitled.

SECTION 4 - HEARING PROCEDURE

A. Time and Place

Upon receipt of a request for hearing, the Hearing Officer shall schedule a hearing and, within thirty (30) days of receipt of such a request, give written notice to the Practitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall be set for not less than 30 days, nor more than 60 days, from the date the Hearing Officer received the request for hearing. The date, time, and place of the hearing may be extended and/or changed at the request of Practitioner and upon the Hearing Officer consent upon a showing of good cause.

B. Pre-hearing Exchange of Information and Discovery

The Hearing Officer shall consider and rule upon any dispute or controversy concerning a request for access to information. The Hearing Officer may impose any safeguards, including the denial or limitation of discovery to protect the peer review process and justice. When ruling upon requests for access to information and determining the relevancy thereof, the hearing officer shall, among other factors, consider the following:

- a. Whether the information sought may be introduced to support or defend the charges;
- b. The exculpatory or inculpatory nature of information sought, if any, i.e., whether there is a reasonable probability that the results of the hearing would be influenced significantly by the information if received into evidence;
- c. The burden imposed on the party in possession of the information sought, if access is granted; and
- d. Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

At the request of either party, the parties must exchange at least ten (10) days before the hearing: (1) lists of witnesses expected to testify at the hearing; and (2) copies of all documents expected to be introduced at the hearing. Failure of a party to produce these materials, or to update them, at least ten (10) days before the commencement of the hearing, shall constitute good cause for the hearing officer to grant a continuance, or to bar or otherwise limit the introduction of any

documents not provided to the other party or testimony from witnesses not identified pursuant to this provision.

It shall be the duty of the Practitioner and the Initiating Body to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such Pre-hearing decisions shall be raised on the record at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

C. Failure to Appear

Failure of the Affected Practitioner to appear at the hearing shall be deemed to constitute the Affected Practitioner's voluntary acceptance of the recommendation or action involved and waiver of all hearing and appeal rights under these Bylaws, unless the MRHC finds good cause for such failure, based upon written request by the Affected Practitioner or his representative.

D. Representation

The Practitioner who requested the hearing shall be entitled to be accompanied by and represented at the hearing by an attorney or other person chosen by the Practitioner, at Practitioner's expense. If the Practitioner desires to be represented by an attorney at any hearing, his request must so state. The MEC, when its action has prompted the hearing, shall appoint a Medical Staff member or a Board member or an attorney to represent its position at the hearing, to present the facts in support of its position and/or adverse professional review recommendation or action, and to examine witnesses. Counsel to the System or the Practitioner shall have the right, upon the request of his client, to be present as an observer at any hearing, even if such counsel's client has elected not to be represented at the hearing.

E. Record of the Hearing

The MRHC proceedings shall be taken and transcribed by a court reporter, and a copy of the transcript of each session shall be available for purchase by either party. Each party shall be responsible for payment of all costs and charges associated with any transcript that it requests.

F. Oath of Witness

The MRHC may, in its discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.

G. Organization and Conduct of Hearing Process

Unless otherwise expressly provided in these Bylaws, the hearing shall be conducted as follows:

1. The parties shall have a reasonable opportunity to voir dire the MRHC members and the hearing officer, and the right to challenge the appointment of any MRHC member or the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality or hearing panels and hearing officers in proceedings of this type;
2. The Medical Staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove;
3. The Medical Staff representative shall then present the facts upon which he is relying, by calling the witnesses and presenting the written evidence to support the case. He may call any person or opposing party, who is present, in support of the case;
4. At the close of the Medical Staff representatives case, unless the MRHC believes that the action or recommendation being reviewed was clearly not supported by the Medical Staff representatives presentation (in which case the hearing may terminate by such a ruling at this point), the Affected Practitioner or his representative shall make an opening statement and shall make a case presentation of evidence and testimony. He may call any person or opposing party, who is present, in support of the case;
5. Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the hearing officer as to order, time, relevance, and repetition;
6. Upon the close of all presentations and evidentiary rebuttals and within fourteen (14) days after the close of the hearing, the parties shall be entitled, subject to reasonable

limitation by the Hearing Officer, to submit a written proposed findings of fact and recommendations;

7. Upon the close of all presentations, rebuttals, statements, and argument, the hearing officer shall declare the hearing finally adjourned, and all persons other than the MRHC and hearing officer shall thereupon leave the hearing. The MRHC shall thereafter, at the convenience of its members but subject to the provisions of Section 5 below, deliberate in order to reach its decision;
8. Liberality may be exercised in accommodating the schedules of witnesses, MRHC members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the hearing officer after consultation with the MRHC regarding such matters shall be final (subject to party or any other person) who disrupts a hearing after being warned by the hearing officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the hearing officer, leave the hearing. Unless directed otherwise for good cause by the Hearing Officer, the hearing shall proceed in the absence of such excluded person. If such excluded person is the Affected Practitioner or a witness, he shall have the right to submit to the MRHC, not later than ten (10) days after such exclusion (unless extended by the hearing officer for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties.

H. Burden of Proof

1. At the hearing, the Initiating Body shall have the initial duty to present evidence for such case or issue in support of its action or recommendation. The Practitioner shall be obligated to present evidence in response.
2. An applicant for membership and/or Privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he is qualified for membership and/or the denied Privileges. The Practitioner must provide information which allows for adequate resolution of reasonable doubts concerning his current Qualifications for membership or Privileges.
3. Except as provided for applicants for membership and/or Privileges, throughout the hearing, the Initiating Body shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence that its action or recommendation was warranted.

I. Admissible Evidence; Judicial Rules of Evidence Shall Not Apply



The general rule of evidence shall be that any relevant matter, whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law. The MRHC shall have the discretion to recognize any matters, either technical or scientific, including statistical data, relating to the issues under consideration, which are common knowledge in the general medical community and/or any medical specialty.

SECTION 5- DECISION AND REPORT OF MRHC; NOTICE

Within twenty-one (21) days after final adjournment of the hearing, the MRHC shall render and deliver to the AVP of Operations a written report and decision. The decision and report shall be based on evidence produced at the hearing, including any recognized matters and logical and reasonable inferences that may be drawn. The decision and report shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. It shall include sufficient detail to enable the parties and the Board to determine the basis for the MRHC's decision on each issue contained in the Statement of Charges. It shall also contain a description of the appellate rights provided under these Bylaws. The President/Chief Operating Officer, within five (5) working days after receiving the decision and report, shall send a copy of them to the parties.

SECTION 6 - BOARD ACTION AFTER MRHC DECISION

The Board shall take no action regarding the underlying matter or the decision and report of the MRHC, until after the expiration of the time for requesting appellate review under Section 7, provided that if an appellate review is properly requested under Section 7, the Board shall take no action except in compliance with the procedures and provisions of this Article. If an appellate review is not timely requested, the Board shall make its final decision in accordance with Section 7.

SECTION 7 - APPEAL TO BOARD

A. Time for Requesting Appeal

Within ten (10) days after the giving of notice to the parties of the decision of the MRHC, either the Affected Practitioner or the Initiating Body, may request an appellate review by the Board. The request shall be in writing and must be received by the AVP of Operations within the applicable time period set forth above. The AVP of Operations shall immediately deliver copies

of such request to the Board and to the other parties. The request shall set forth the ground(s) for appeal as noted under Section C. If an appellate review is not requested as set forth in this paragraph, all parties shall be deemed to have waived all rights to appeal.

B. Nature and Effect of Appellate Review

The appellate review shall be by the Board or a committee thereof and all references to the "Board" shall include such committees. Appellate review shall consist of a review of the prior proceedings and decision in the matter being reviewed, an appellate review meeting, deliberations, review of any further recommendations, and a final decision. In its final decision the Board may affirm, modify or reverse the decision of the MRHC. No person or entity that participated in bringing the charges or in officially reviewing the matter shall participate in the appellate review process, even if such removal leaves the Board with less than a quorum.

C. Grounds for Appeal. The grounds for appeal are limited to the following:

- a. Substantial and prejudicial failure of the MRHC or the MEC to comply with these Bylaws or to afford due process or a fair hearing;
- b. The action or recommendation that prompted the hearing, or any substantial part was arbitrary or capricious;
- c. The MRHCs decision or any substantial part was clearly contrary to the weight of the evidence; or
- d. A Medical Staff bylaw, rule or regulation relied on by the MRHC in reaching its decision lacked substantive rationality.

D. Notice of Time, Date, Place of Appellate Review Meeting

The Board shall, within forty-five (45) days after receipt by the AVP of Operations of a timely request for appeal, schedule a date for an appellate review meeting. The Board shall, not less than ten (10) days prior to the date of the appellate review meeting, give the parties written notice of the time, place, and date. The date thereof shall be not less than ten (10) days, nor more than sixty (60) days from the date of receipt by the AVP of Operations of the request for appellate review, except that when a request for appellate review is from a Member who is then under suspension, the appellate review meeting shall be held as soon as reasonably practicable but not later than forty (40) days from the date of receipt of the request. The date and time for the appellate review meeting may be extended by the Chairman of the Board for good cause.

E. Appellate Review Proceedings The appellate review proceedings shall be conducted as follows:

1. **Consideration of New Matters:** The Board shall limit its review to the record of the hearing before the MRHC, the MRHC decision and report, and any written briefs submitted by the parties. The Board may, however, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided for MRHC hearings. Such acceptance of additional issues or evidence may be based on the Board's own motion, or upon the request of a party if, not less than seven (7) Days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes written request to the Board to do so, specifying the nature and relevance of the issues or evidence, and gives notice of such request to all other parties. The Board shall give notice of its decision in such matters to all parties as soon as reasonably possible;
2. **Hearing Officer:** The Board may, in its sole discretion, appoint a hearing officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the Board as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision;
3. **Briefs:** Each party shall have the right to submit a written brief in support of his position on appeal, provided that copies of such brief shall be given to all other parties at such time as may be directed by the Board;
4. **Oral Argument:** Neither party shall have the right to make oral argument or presentation, but the Board, in its sole discretion, may allow each party or parties' representative to appear personally and make oral argument at the appellate review hearing, provided that such party shall make written application therefor to the Board not less than seven (7) days prior to the date of the appellate review meeting. The Board shall give notice of its response to such applications to all parties as soon as reasonably possible. If personal appearance is allowed, the Affected Practitioner, if present, and all other parties and representatives present, shall answer any questions posed by any member of the Board.
5. **Recesses:** The Board may, from time to time, adjourn and continue the appellate review meeting to another date or dates if it decides, in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appellate review in the matter. The Board shall give notice to the parties of any such date and time, unless the parties were present when such date and time were announced by the Board;
6. **Deliberations:** At the conclusion of the appellate review meeting, including oral argument, if held, the Board shall, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm, modify, or reverse the decision of the MRHC;

7. General Procedures: The Board shall, in its sole discretion, decide the order of procedures to be followed in the appellate review, as well as answers to questions not otherwise addressed in these Bylaws, to the end that the appellate review, including the appellate review meeting, shall be thorough, orderly, efficient, and fair.
 8. Disruption of Proceedings: No person shall disrupt any appellate review proceeding. Any person in attendance (whether a party or any other person) who disrupts an appellate review meeting after being warned by the Chairman of the Board (or his designee or the hearing officer) to cease such disruption on penalty of indefinite exclusion, shall, at the direction of such Chairman (or his designee or the hearing officer), leave the meeting. Unless directed otherwise for good cause by the Chairman (or his designee or the hearing officer), the appellate review meeting shall proceed in the absence of such excluded person. Any party may enforce the provisions of this Section by court order upon injunctive or other appropriate relief.
- F. Final Decision; Effective Date. The appellate review process shall conclude with the Board's final decision in the matter which shall be made in accordance with the following rules:
1. Within thirty (30) days after either the waiver of appellate rights or the conclusion of the appellate review meeting, the Board shall render its final decision, unless it refers the matter to the MRHC for further review and recommendation. The Board shall give great weight to the decision of the MRHC and shall not act arbitrarily or capriciously. The Board, however, may exercise its independent judgment in determining whether the hearing procedures in these Bylaws were followed;
 2. If the Board refers the matter to the MRHC for further review and recommendation, such referral may include instructions such as that the MRHC arrange for further hearings on specific issues. The Board shall give notice of such referral to the parties. The MRHC shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the Board within forty-five (45) days after the receipt of the referral from the Board. Within forty-five (45) days after receipt of such recommendation, the Board shall render its final decision; and
 3. The Board's final decision shall be in writing and shall include a statement of the Board's basis for its decision. The decision shall be effective immediately and not subject to further hearing or appeal. As soon as the final decision is effective, a copy of it shall be delivered to the Affected Practitioner, the President/Chief Operating Officer, and each party, in person or by mail.



4. The AVP of Operations shall report to government boards, agencies, or other authorities, including without limitation, the National Practitioner Data Bank, any final Adverse Action as required by state or federal law.

SECTION 8 - RIGHT TO ONLY ONE MRHC HEARING AND APPELLATE REVIEW

No party shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter that may be the subject of a MRHC hearing or appeal.

SECTION 9 - INFORMAL INTERVIEWS

Nothing in these Bylaws shall be deemed to prevent any committee, or person contemplating any action or recommendation set forth in this Article, from, at its sole discretion, inviting the Affected Practitioner to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article.

SECTION 10 - RESIGNATION OR WITHDRAWAL OF APPLICATION

Notwithstanding any other provision of these Bylaws, whenever the Affected Practitioner unconditionally: (a) resigns from the Medical Staff; (b) resigns and relinquishes the Privileges that are the subject matter of a hearing; (c) withdraws the application that is the subject matter of hearing; (d) amends an Application or request, with regard to the items that are the subject matter of the hearing; or (e) consents in writing to the action or recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appellate review proceedings with respect to the Practitioner, his Privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the Board, after receiving a written request from, or giving notice to, the Affected Practitioner, and determining that good cause exists for such reopening.

SECTION 11 - WAIVER



If at any time after receipt of a notice of an Adverse Action, a Practitioner fails to comply with this

Article XII, he shall be deemed to have consented to such recommendation or action, and to have voluntarily waived all rights to which he might otherwise have been entitled hereunder.

SECTION 12 - CONFIDENTIALITY OF PROCEEDINGS

Except as otherwise authorized in these Bylaws or by law, all parties, participants, and attendees shall keep the hearing and appellate review proceedings and the contents thereof confidential, and no one shall disclose or release any information from or about the proceedings to any person or the public.

SECTION 13 - EXCEPTIONS TO HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these Bylaws, the hearing and appeal rights under these Bylaws are not applicable under the following circumstances:

A. Closed Staff or Exclusive Contracts

The hearing and appeal rights under these Bylaws do not apply to a Practitioner whose application for Medical Staff membership and Privileges was denied on the basis that the Privileges he seeks are granted only pursuant to a closed staff or exclusive use policy.

B. Termination of System Practitioners

The Privileges and Staff membership of any Practitioner employed by the System shall be subject to termination in accordance with the terms of the Practitioners employment contract. Such Practitioner shall not be entitled to the hearing and appeal rights under these Bylaws, except to the extent that the Practitioners Staff membership or privileges which would otherwise exist independent of the employment contract are to be limited or terminated, or unless otherwise provided in the Practitioners employment contract.

C. Medico-Administrative Practitioner

The hearing and appeal rights under these Bylaws do not apply to those persons serving the System in a medico-administrative capacity. Termination of such person's rights to practice in

the System shall instead be governed by the terms of their individual contracts with the System. However, the hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or Clinical Privileges, which are independent of the Practitioners contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

D. Automatic Suspension or Limitation of Privileges

No hearing is required when a Members Medical Staff membership or Clinical Privileges are automatically suspended in accordance with these Bylaws.

E. Allied Health Professionals. Unless required by state law, AHPs are not entitled to the hearing and appeal rights under these Bylaws, although AHPs are entitled to the grievance process as set forth in Article V, Section 7.

**ARTICLE XIII:
CONFIDENTIALITY, IMMUNITY, AND RELEASES**

A. General

Medical Staff, department, section or committee minutes, files, and records including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent possible, be confidential. Such confidentiality shall also extend to information of any like kind that may be provided by third parties. This information shall become a part of Medical Staff committee files and shall not become part of any particular patient's file or of the System's general records. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff, including these Bylaws, or, where no officially adopted policy exists, only with the express approval of the MEC or its designee and the President/Chief Operating Officer.

B. Breach of Confidentiality

Inasmuch as effective Credentialing, quality improvement, peer review, and consideration of the qualification of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as Practitioners and others participate in Credentialing, quality improvement, peer review activities with the reasonable expectation that this confidentiality will be preserved and maintained, any breach of confidentiality if the discussions or deliberations of Medical Staff departments, sections, or committees, except in conjunction with each other or with another System or the Adventist HealthCare, Inc. System, health facility, professional society, or licensing authority peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive of the operations of the System. If it determines that such a breach has occurred, then the MEC may undertake such corrective action as it deems appropriate.

C. Immunity and Releases

Immunity from Liability for Providing Information or Taking Action -. Each representative of the Medical Staff, Hospital, System, and all third parties shall be exempt from liability to an applicant, Member, or Practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, Hospital, the System, other Systems, the Adventist System, or any other health related organization concerning such person who is, or has been, an applicant to or a member of the Medical Staff or who did, or does, exercise Privileges or provide patient care services at this System or by reason of or otherwise participating in a Medical Staff of System Credentialing, quality improvement, or peer review activities.

Activities and Information Covered - The immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to, the following:

1. Applications for appointment, Privileges, or specified services;
2. Periodic reappraisals for reappointment, Privileges, or specified services;
3. Corrective action;
4. Hearings and appellate reviews;
5. Quality improvement reviews;
6. Peer review;
7. Utilization review;
8. Morbidity and mortality conferences;
9. Other Hospital, System, department, section, or committee functions and activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

D. Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical competence, judgment, character, physical and mental health, emotional stability, professional ethics, or other matter that might directly or indirectly affect patient care.

E. Releases

Each Practitioner shall, upon request of the System, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

F. Cumulative Effect



Provisions in these Bylaws and in any Medical Staff or other Application form relating to confidentiality of information, authorizations, and immunities from liability shall be in addition to the other protection provided by law and not in limitation thereof.

ARTICLE XIV: AMENDMENT AND ADOPTION OF BYLAWS

SECTION 1 - MEDICAL STAFF RESPONSIBILITY

The Medical Staff (through its Bylaws committee and the MEC) shall have the initial responsibility to formulate, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The rules and regulations of the medical staff must conform to the bylaws of the medical staff, and must be approved by both the Medical Executive Committee (MEC) and the medical staff at a general meeting. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

SECTION 2 - METHODOLOGY

The changes to Medical Staff bylaws, rules and regulations, policies and amendment thereto, may be made by the following combined action:

1. Suggested changes in medical staff bylaws, rules and regulations, policies and amendments, thereto, may be initiated by individual medical staff members;
2. The proposed changes are submitted to the MEC which shall discuss and have an vote of the Committees eligible voting members by written ballot or by action at a meeting at which a quorum is present, requiring a majority vote;
3. The approval of the Board, which shall not be unreasonably withheld.
4. The organized Medical Staff, may utilize a twenty-five (25) percent proxy vote to adopt, amend, or repeal medical staff bylaws, rules and regulations, policies, and amendments thereto, and propose them directly to the Governing Body,

SECTION 3 - AMENDMENT

The MEC may propose an amendment or other modification to the Medical Staff Bylaws and shall submit the proposal to the Medical Staff. In the event the Medical Staff does not object to such proposed amendment or modification within ten (10) days after receipt of such proposed amendment or modification (which proposal shall be in writing), the MEC may amend the Medical Staff Bylaws. In such an event, staff recommendations and views shall be carefully considered by the MEC during its deliberations and in its actions; an affirmative vote of a majority of the MEC shall be necessary to adopt or amend the Medical Staff Bylaws. The Medical Director shall submit the MEC approved amendments to the Board. Upon hearing recommended amendments the board shall or shall not adopt the medical staff bylaws. Medical staff members may always communicate with the Governing Body on a rule, regulation, or policy adopted by the organized medical staff or the MEC. The governing body determines the method of communication.

URGENT AMENDMENTS

The MEC is empowered to act on behalf of the medical staff in situations when a need for an urgent amendment to the rules and regulations is necessary to comply with the law or regulation.

- When urgent nature of amendment prevents prior notification of the medical staff, the amendment and the Governing Body approval shall be provisional.
- The medical staff shall be immediately notified of any urgent amendment of the rule and regulations.
- The medical staff shall be given an opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the MEC shall be implemented.

ARTICLE XV:

RULES AND REGULATIONS

**ADVENTIST HEALTHCARE, BEHAVIORAL HEALTH & WELLNESS
SERVICES
ROCKVILLE, MARYLAND**

The rules and regulation of the medical staff must conform to the bylaws of the medical staff, and must be approved by both the MEC and the medical staff at a general meeting. The purpose of the Rules and Regulations is to promote high standards of medical care to patient of Adventist Behavioral Health Hospital. Furthermore these Rules and Regulations shall serve as a guide for accomplishing this purpose, as well as, to provide certain protection for the patient, the hospital and its personnel and physicians. Each staff member shall be required to abide by the bylaws of the medical staff of Adventist Behavioral Health Hospital, and to assist in achieving the standards set forth by the Joint Commission and other state and federal regulatory bodies.

In accordance with **Article XIV Section 1, of the Medical Staff bylaws**, the following rules and regulations are adopted. Rules and regulations adopted by the medical staff in accordance with the Medical Staff bylaws are binding to all members of the medical staff. These Rules and Regulations have the full force and effect of Medical Staff Bylaws. The collective functions of the medical staff and the independent functions of its individual members shall be accomplished in accordance with applicable state law.

1. MEETINGS

- 1.1 The regular meetings of the Medical Staff are held at least 2 times a year. The annual staff meeting and election of officers will be held in the last quarter of the year. This meeting schedule will be adhered to unless changed by the Medical Staff.

Active Medical Staff members must attend the annual meeting and one other meeting in order to maintain their active Medical Staff status. Absences or exceptions to the attendance requirements can be made only by the Medical Executive Committee.

2. CRITERIA FOR ADMISSION

- 2.1 Each practitioner must accept the criteria for admission to the hospital and to each

program as approved by the medical staff and the Board of Trustees. These criteria are identified in the hospital's Utilization Review Plan and in each program narrative. Waiver of any of these criteria must be approved by the Medical Director.

- 2.2 Physicians are responsible for giving such information prior to admission as may be necessary to establish that the patient meets all admission criteria and to promote the safety of the patient and that of other patients in the hospital.
- 2.3 The hospital, through the Medical Director, AVP of Operations or designated Administrator on Call, reserves the right to refuse admission or to recommend to the Medical Staff member that a patient be referred to another facility because his/her needs cannot be met and/or because treatment cannot be adequately provided by this facility.

3. ADMISSION

- 3.1 Patients may be admitted to the hospital only by physicians with Medical Staff privileges to do so. All admissions to the hospital must meet the hospital's admission criteria as defined in the hospital's Utilization Review Plan.
- 3.2 No patient shall be admitted to the hospital until a provisional diagnosis has been made by the admitting Medical Staff member. The diagnosis may be established by the source of the referral or by the clinician performing the pre-admission assessment. Primary diagnoses are to be consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM - current edition) and should refer to an Axis I Psychiatric Condition
- 3.3 Each patient admitted to the hospital or to the adolescent Partial Hospitalization Program (PHP) shall have a psychiatric and physical examination current within 30 days of admission. Admitting physician will review H&P for any changes; amend if necessary, then sign/date/time. Laboratory work shall be ordered according to the patient and medication protocol needs.
- 3.4 The psychiatric evaluation shall be performed by the admitting or by the attending psychiatrist.
- 3.5 The physical examination may be performed either by the hospital's designated staff internist/pediatrician, nurse practitioner or by another physician only if the latter can assume continuous medical responsibility for the patient and is a member of the Medical Staff.

- 3.6 The complete history and psychiatric evaluation shall, in all cases, be completed within 24 hours after admission of the patient. Complete medical history and physical examination in all cases will be completed and recorded in the medical record within 24 hours. The attending psychiatrist shall review and sign the admission history and physical examination within 24 hours of its completion.
- 3.7 Patients admitted must be seen by the admitting psychiatrist at the time of admission or within 24 hours of admission.

4. CARE AND TREATMENT OF PATIENTS

- 4.1 The attending physician has the ultimate responsibility for providing each patient's diagnosis and treatment and for supervising the care of the patient in the hospital. The physician has the responsibility for prescribing medication. Nurse Practitioners (NP) employed by Adventist Behavioral Health and other clinically privileged Medical Staff appointees may write orders for medication and treatment within their scope of practice, as specified in **section 12** of these rules and regulations. However, such action by the Nurse Practitioner or other clinically privileged Medical Staff appointee should not be construed as a transfer of clinical responsibility of any aspect of a patient's care. Similarly, after the initial admission history and physical exam has been completed, the attending physician remains directly and ultimately responsible for ongoing somatic (physical symptoms, lab results) assessment and treatment.
- 4.2 Each attending physician agrees to adhere to the design of the hospital's treatment programs and agrees to practice in accordance with the program model. Each physician will adhere to all written hospital policies, procedures, protocols, and guidelines.
- 4.3 All patients must be seen within 24 hours of admission by the attending psychiatrist. The admission history and physical, including the psychiatric evaluation and mental status examination, as well as the initial plan of treatment and anticipated length of stay, are to be completed within 24 hours of admission.
- 4.4 The attending physician is responsible for all treatment activities related to patient treatment. The physician is legally responsible for the patient throughout the course of hospitalization and is responsible for all final decisions.
- 4.5 Discharge criteria and discharge planning is to begin at time of admission. Updates and changes in discharge criteria and planning are recorded as appropriate.

- 4.6 The attending physician or designee will see each of his/her patients no less than six (6) days per week if the patients are admitted to acute hospital services. Residential patients will be seen weekly.
- 4.7 The attending physician is expected to be present at treatment planning meetings on all of his/her patients. The physician shall document relevant interventions, review, and approve by signature all treatment plans.
- 4.8 Within 24 hours of the patient's admission, the attending physician is expected to have a verbal or face to face meeting with the adolescent patient's legal guardian(s) and, with consent, the adult patient's family members.
- 4.9 Special provisions with respect to treatment/coverage of child psychiatry patients:
 - 4.9-1 A member of the Medical Staff holding adult psychiatry privileges may provide night, weekend, and holiday coverage for child psychiatry patients for no more than 72 consecutive hours. However, in such cases a member of the medical staff who holds child psychiatry privileges must be available for telephonic consultation.
 - 4.9-2 Only members of the medical staff with privileges in child psychiatry may act as attending physician for child psychiatry patients. However, when necessary, member of the medical staff holding adult psychiatry privileges may provide care to such patients under supervision of a credentialed child psychiatrist. In such cases, the child psychiatrist shall review the treatment and countersign progress notes and orders with twenty-four hours of their having been written.

5. **MEDICAL RECORDS**

5.1 **Confidentiality/Release of Information**

Information, written and/or verbal, is released under the direction of the Medical Records Department with written consent by the patient, or court order, or subpoena, or by statute. Release of mental health records and information contained therein are governed by the Maryland State Mental Health Code. The release of alcohol and drug records and information is governed by the Code of Federal Regulations Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2.

- 5.2-1 All medical records are the property of the hospital. Records may be removed from the hospital in accordance with a court order, a subpoena duces tecum (or subpoena for production of evidence), or pursuant to statutory authority. Written consent of the patient is required for the release of records to those not otherwise authorized to receive these records.
- 5.2-2 The release of a medical record that contains any reference to treatment for substance or alcohol abuse shall be in accordance with the stipulations of 42 CFR Part 2.
- 5.2-3 In the case of readmission of the patient, all previous records shall be available for the use of the attending physician or staff under his/her direction.
- 5.2-4 Access to medical record of patients shall be afforded to appointees to the Medical Staff in good standing for study and research under policies and procedures established by the hospital.
- 5.2-5 Patients may request to read their medical records. The specific guidelines for this procedure as defined by state law and hospital policy and procedure should be obtained from the Medical Records Department.

5.3 **Physician Responsibility for Medical Records**

The attending psychiatrist is responsible for providing a complete medical record on each patient and shall be responsible for dating, timing, and documenting legibly and in chronological order admission information, orders for consultations, procedures, progress notes reflecting patient progress according to his/her signed treatment plan, responses to abnormal laboratory results, rationale and outcome of therapeutic passes and diagnosis at the time of discharge summary within 30 days of discharge. All attending psychiatrists are to follow the guidelines for medical records documentation distributed by the hospital's Medical Records Department.

5.4 **Physician Orders**

- 5.4-1 Standing and range orders shall not be utilized. PRN Orders that indicate the route can be either PO or IM must specifically state the criteria/rationale under which either route should be used.
- 5.4-2 The admitting psychiatrist will issue all initial orders; all succeeding orders,

which must be in accordance with established general medical standards and in compliance with hospital regulations, will be issued by the attending psychiatrist. In certain circumstances, nurse practitioners or on-call psychiatrists may write orders for an attending psychiatrist's patient; in such case, the orders shall be reviewed and initialed by the attending psychiatrist.

The attending psychiatrist may write an order authorizing the hospital internist/pediatrician or certified nurse practitioner in consultation with the attending, to write medical orders as necessary according to the recommendations of their History and Physical Examination and/or consultation.

- 5.4-3 All orders shall be in writing. If the physician is absent from the hospital, an order shall be considered to be in writing if dictated over the phone by the individual to a licensed Registered Nurse or Pharmacist for clarification of medication order. The physician issuing the order should require that the Registered Nurse 'Read Back and Verify' that the correct order is noted. Orders dictated over the phone shall be signed by the person whom dictated, dated and timed within 48 hours, with the exception of seclusion and restraint orders which shall be signed within 24 hours.
- 5.4-4 In some instances, the ordering physician may not be able to authenticate the verbal order. In such cases, it is acceptable for a covering physician to co-sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final.
- 5.4-5 A physician's order shall be written clearly and legibly and shall be complete. Orders that are illegibly or improperly written will not be carried out until rewritten by the duly authorized person. The use of "renew", "resume", and "continue" will not be acceptable. It is necessary to fully discontinue a previous medication order and write an updated one.
- 5.4-6 Orders are required for seclusion, restraint, medications, and restrictions of patient rights and shall be time limited pursuant to code and regulation.
- 5.4-7 Orders are required to restrict patient rights to unimpeded, private, and uncensored communication by mail, telephone and visitation. These orders must document that the restriction is for therapeutic purposes, to protect the

recipient or others from harm, harassment or intimidation.

5.5 **Symbols and Abbreviations**

Only symbols and abbreviations approved by the hospital and Medical Staff can be used in the medical record. Information is available in the Medical Records Department and on the units. Symbols and abbreviations may not be used in recording diagnosis.

5.6 **Admission Documentation**

5.6-1 An admission psychiatric history should include the following elements:

- a. Chief Complaint
- b. History of Present Illness
 - 1) Precipitating event
 - 2) Circumstances leading to admission
 - 3) Recent symptoms as well as pertinent negatives
- c. Justification for inpatient level of care
- d. Past Psychiatric History
 - 1) Hospitalizations and other episodes of treatment
 - 2) Longitudinal course of symptoms
- e. Past Medical History
- f. Current Medications
- g. History of medications taken and clinical response
- h. Mental Status Exam
- i. Strengths/Weaknesses
- j. Formulation
- k. Summary of positive findings
- l. DSM (current version) Diagnoses
- m. Initial Treatment Plan
- n. Estimated Length of Stay
- o. Criteria for Discharge

5.6-2 The history and physical examination should include history of somatic illness, review of systems, and physical exam of organ systems according to established standards. Both the admission psychiatric evaluation and history and physical

examination are to be completed and in the record within 24 hours after the patient's admission.

5.6-3 It is recognized that given the patient population, often history is difficult to obtain. In this case, any attempt to obtain history and the reason for the failure to do so should be noted.

5.6-5 The Medical Executive Committee will periodically review data on Admission for Documentation quality and adherence to required elements.

5.7 **Progress Notes**

5.7-1 Pertinent progress notes related to diagnosis and to treatment plan goals and objectives, sufficient to permit continuity of care shall be recorded at the time of observation.

Wherever possible, each of the patient's clinical problems/goals should be clearly identified in the progress note and correlated with specific orders, as well as results of tests and treatments.

5.7-2 Physicians shall document:

- a. Abnormal laboratory values and their response to such;
- b. Therapeutic pass goals and patient's response to passes.

5.7-3 Consultants must make dated and timed recorded entries whenever they see a patient.

5.8 **Therapeutic Passes**

5.8-1 Therapeutic passes are defined as times away from the hospital in order to provide an opportunity to work toward therapeutic objectives critically necessary to patient recovery and leading to discharge. They may be used during hospitalization to permit orderly transition from the hospital to a less restrictive level of care. Passes may also be subject to approval from 3rd party payers.

5.8-2 Therapeutic passes shall be integrated into the patient's written treatment plan.

5.8-3 The psychiatrist shall write an order specifying the date and length of the pass, therapeutic goals and the identity of any person to accompany the patient. The order will indicate any medication to be taken by the patient during the pass by a specific order.

5.8-4 The order shall include whether search procedures and/or toxicology screens are clinically indicated upon a patient's return from pass.

The psychiatrist shall document the therapeutic outcome of each pass in the medical record.

5.9 **Discharge Documentation**

5.9-1 Patients shall be discharged only on written order of the attending psychiatrist. AMA discharges must be written by the attending psychiatrist or covering psychiatrist if the AMA occurs on the weekend or when the attending psychiatrist is on extended leave. The attending psychiatrist shall complete the discharge summary according to the approved guidelines, state final DSM5 diagnosis and sign and date the record.

5.9-2 All discharge summaries and signatures not specified in 5.4.3 of this section will be completed within 30 days following the patient's discharge. Incomplete records as defined above will be considered delinquent. The following disciplinary measures may be instituted against the psychiatrist who fails to complete medical records within the specified time frame:

5.9 – 2.1 Fines as outlined in the medical staff delinquent records policy as approved by the MEC.

6.0 **Medication Usage**

6.1 The prescribing of medication is limited to physicians, dentists, and podiatrists with appropriate qualifications, licenses and clinical privileges and to nurse practitioners employed by Adventist Behavioral Health.

6.2 Licensed Nurses/Pharmacist are the only individuals allowed to accept telephone medication orders from a physician or nurse practitioner.

6.3 In conservative medical practice, medications are be used only for standard

indications as published in the United States Pharmacopeia, DI, of the Physician's Desk Reference, current edition. However, it is recognized that in psychiatry medications are often used for other than the approved indication. Use of medications in this manner must be consistent with established psychiatric practice. In doubtful situations, it is recommended that the use of medications in this manner be supported by such measures as (1) consultation of another member of the medical staff or (2) appending to the clinical record peer reviewed articles or letters (or established secondary sources referencing such) describing the successful , outcomes associated with this intervention.

- 6.4 Medications prescribed will specify dosage, frequency, route of administration, and rationale. Medication prescribed for PRN administration will indicate a maximum dosage over a stated period of time and will identify the symptoms for which the medication should be administered. You must have an indication for PRN use.
- 6.5 Stop Orders: For the following classes of medications, the physician will order medications for a specified number of days or for a specified number of dosages: Narcotics, Antibiotics, Hypnotics, Steroids, and Anticoagulants. If this is not done, reorders will be necessary as follows: Narcotics = 3 days, Anticoagulants (Heparin and Coumadin) = 5 days, Antibiotics = 10 days, Sleep medications (Dalmane, Restoril, Chloral Hydrate) = 7 days, Steroids = 10 days.
- 6.6 The maximum duration of any medication order is 30 days. The medication orders will not be continued without being reviewed and rewritten at least every 30.
- 6.7 The attending physician must be notified before any medication is discontinued.
- 6.8 When drugs are prescribed that are known to involve a substantial risk or to be associated with undesirable side effects, the appropriate protocols or guidelines must be observed. These include guidelines for the use of Schedule II drugs for maintenance use, Lithium Carbonate, Antabuse, MAO Inhibitors, Neuroleptics, Droperidol, and Schedule II and Schedule IV drugs used in polypharmacy. This list of drugs is for illustrated purposed only, and is not intended to be all inclusive.
- 6.9 Physicians shall discuss fully with patients and appropriate relatives the indications and side effects of prescribed medications with documentation as

established by hospital policy and procedure.

- 6.10 When prescribing Schedule II drugs for maintenance use, the physician should inform the patient (and guardian if appropriate) of the risks and benefits of the medication. The patient/guardian must be provided with sufficient information to make an informed decision regarding the proposed medication. A progress note detailing the benefits, risks and any alternate treatment(s) will be entered into the medical record by the physician.

7. **Seclusion and/or Restraint**

7.1 **Definitions:**

7.1-1 Restraint is used to limit or restrict the movement of the whole, or a portion of, patient's body for the purpose of preventing intentional harm to self or others. Mechanical restraints shall not be utilized.

7.1-2 Seclusion is the involuntary confinement of a patient alone in a room in which a patient is physically prevented from leaving. This activity may only be initiated by the order of a physician as specified in the seclusion and restraint policy subject to the exception specified in paragraph 7.4 below.

7.2 **Treatment Under the Least Restrictive Conditions**

7.2-1 Each patient shall be treated under the least restrictive conditions consistent with his/her condition and shall not be subjected to unnecessary restraint and seclusion. In no event shall seclusion and/or restraint be utilized to punish or discipline a patient or for the convenience of the staff.

7.2-2 Seclusion and/or restraint may be ordered as a therapeutic measure to prevent a patient from causing physical harm to him/herself.

- 7.3 Documentation in the progress notes for seclusion/restraint shall be in accordance with approved hospital policy and procedures.

7.3-1 **Orders for seclusion and/or restraint will:**

- (a) be time limited and include the date and time of order;
- (b) include the emergency safety intervention ordered, including the length of time for which the physician ordered it;
- (c) not exceed the approved time limits per age-specific populations;
- (d) be STAT orders only;
- (e) specify the reason for utilization;
- (f) be signed by the physician within 24 hours of initiation;
- (g) indicate whether restraint or seclusion is being used;
- (h) identify special precautions, if any, to safeguard the patient; and,
- (i) indicate criteria for release of restraint or discontinuation of seclusion.

7.3-2 Each patient placed in seclusion or restraint shall have his/her physical condition and psychiatric condition monitored by qualified personnel as per hospital policy.

7.3-3 The attending physician performs a face to face assessment of the patient within one hour of the seclusion or restraint order and documents, signs, times and dates said assessment in the medical record. Alternatively, in the absence of the attending physician, a qualified nurse shall perform a face to face assessment of the patient within one hour of seclusion or restraint order and shall document, sign, date and time findings of his/her face to face assessment.

7.3-4 The physician will review and sign seclusion/restraint progress note written by nursing within 24 hours.

7.4 In case of an emergency, a Registered Nurse, specifically trained, upon the assessment of the need for seclusion and restraint may initiate seclusion and/or restraint. Physician's order must be obtained within one hour and the order must be

countersigned by the physician within 24 hours. A face to face assessment of the patient must still be made by a physician within one hour of the initiation of the emergency seclusion or restraint.

- 7.5 The Medical Director or his/her designee will review cases of multiple seclusion and restraint cases daily. On the weekends or in the absence of the Medical Director, an on-call member of the medical staff will review cases of multiple seclusion and restraint. Unusual or unwarranted patterns or utilization will be investigated by the Risk Manager and reported to the Safety, Performance Improvement and Medical Executive Committees.
- 7.6 Repetitious use of restraint and/or seclusion, as defined by hospital policy and procedure, must be justified by the physician in the progress notes and must be integrated into the patient's treatment plan.

8. **Restrictions**

A patient placed on a behavior modification program as part of his/her treatment plan may be restricted but not physically confined to a given area or room for a reasonable period of time and such restriction shall not constitute seclusion. The approved hospital guidelines must be followed in the use of this procedure and/or any other restrictions.

9. **Medical Alternate**

- 9.1 When the attending physician is not at the hospital, he/she will notify the hospital of an alternate member of the medical staff who has agreed to provide care of his patients during his absence. The information should be transmitted to the Medical Director through the Medical Staff executive assistant who will disseminate notice by email.
- 9.2 In an emergency when the attending physician or his /her designee is unavailable, the Medical Director must be contacted and shall have the authority to make provisions for caring for the patients.

10. **Patient Hand-Off**

- 10.1 Hand-off between physicians refers to an event in which clinical responsibility for a patient is transferred from one physician to another. This includes coverage for weekends, vacations, illness or absence from the hospital. Any time nursing staff is instructed, by order, memo, or call schedule, to consider a different doctor responsible for a patient's care, a hand-off has occurred.
- 10.2 When a patient-hand off, as defined above, has occurred. The transferring physician will communicate to the receiving physician clinical information relevant to the immediate management of the patient. Such communication can take place verbal-- in person or by telephone-- or as a written sign-out report. If a written sign-out report is used, the transferring physician will be available until an agreed upon time by phone to allow for questions or a discussion to take place
- 10.2-1 The hand-off communication should consist of the following elements:
- 1) Patient's name
 - 2) Psychiatric and medical diagnoses
 - 3) Current clinical status, including active psychiatric and medical problems
 - 4) Medications
 - 5) Pending lab tests or values of immediate clinical relevance
 - 6) Assessment of state and current needs
 - 7) Recommendation for management during the coverage time.
- 10.2-2 In the case of an on-call physician transferring newly admitted patients according to the redistribution procedure, the required hand-off communication would be expected to be brief and to include such information as the patient's name, diagnoses, medical concerns, and any medications that have been ordered.

11. **On-Call**

- 11.1 The AVP of Operations and the Medical Director shall be administratively responsible for maintaining the hospital's on-call roster.
- 11.2 Each attending physician is responsible for arranging adequate medical /psychiatric coverage in his/her absence.

- 11.3 Physicians routinely attending acute hospital patients are expected to participate in the Doctor of the Day rotation for admissions. Guidelines for this rotation system are to be addressed by the Medical Executive Committee.
- 11.4 Physicians are expected to be fully compliant with COBRA regulations; patients who meet commitment criteria, as defined by COMAR regulations, are expected to be admitted and attended by physicians regardless of the patient's financial resources.

12. **Consultations**

- 12.1 Consultations must be requested by the attending psychiatrist or nurse practitioner.
- 12.2 Progress notes must indicate the reason for the consultation and requests are by written order, specifying reasons for consultation request.
- 12.3 Emergency consultation requests must be requested by the attending psychiatrist directly to the consulting clinician. A verbal order may be dictated in the case of an emergency.
- 12.4 Initiation of a request for consultation by the patient or, if the patient is incompetent, by next of kin, must be accompanied by an order. The Medical Director may initiate a requested consultation in the absence of the attending psychiatrist or designee.
- 12.5 Psychiatric consultations are required in cases in which:
 - (a) The patient's diagnosis is obscure;
 - (b) There is a doubt as to the best therapeutic measures to be utilized;
 - (c) There are unusual treatment risks for the patient;
 - (d) The case has been determined by Utilization Review to require consultation. Requests for consultation may be made by the attending psychiatrist, or the Medical Director.

13. **Utilization Review**

The attending physician is required to document the need for admission and for continued hospitalization. Utilization reviews are scheduled on a systematic basis

according to the Utilization Review Plan of the Hospital as approved by the Medical Staff and the Board of Trustees. Willful or continued failure to furnish such required documentation is cause for a request to the Medical Executive Committee for corrective action and can be initiated by the Utilization Review Department.

14. **Patient Request to Change Physician**

A patient may request to change attending physician. In the event of controversy, the Medical Director should be contacted to investigate and, if appropriate, to facilitate the change.

15. **Hospital Disaster and Exposure Control Plan**

15.1 All members of the medical staff of the hospital agree to follow the outlined hospital's Infection Control policies and procedures as approved by the medical staff.

15.2 Medical Staff Participation during Disaster Plan Implementation

Physicians are expected to understand their role in the hospital's disaster plan and will perform their duties as assigned. The Medical Director and the AVP of Operations will work as a team to coordinate activities and directions. In cases of evacuation of patients from the hospital to another, or evacuation from the hospital premises, the Medical Director will authorize the movement of patients. All policies concerning patient care will be a joint responsibility of the Medical Director and the President/Chief Operating Officer.

16. **Medical Services Payment**

Each attending physician shall communicate to his/her patient (and family where appropriate) the financial terms of the treatment relationship including the applicable compensatory services provided by all professionals under the attending physician's supervision.

17. **Patient Death and Autopsy**

In the event of a patient's death, 911 shall be called. The attending physician or his

designee shall notify the family. Completion of death pronunciations and certificates shall be governed by the applicable state regulations and reporting requirements. It

shall be the duty of the attending physician to secure an autopsy, whenever appropriate. A provisional anatomic diagnosis shall be requested from the coroner and recorded in the medical record within 72 hours. All autopsies shall be performed by a licensed Pathologist or his designee, and with written consent signed in accordance with State law. In all cases, the guidelines established in the hospital's autopsy policy and procedures shall be followed.

18. **Staff Dues**

Subject to the approval of the Board, the MEC shall have the power to set amounts for annual dues and initial application fees as well as determine the manner of expenditure of said dues. The amount of annual dues may vary among staff statuses.

19. **Annual Documentation Review**

These By-laws, rules and regulations shall be reviewed at least every three years for changes in regulatory compliance and approved by the Medical Staff and Hospital Board.

APPENDIX A

ADVENTIST BEHAVIOR HEALTH MEDICAL STAFF POLICY

Credentialing Physicians and Allied Health Professionals in the Event of Disaster

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

Purpose

During a disaster, when the Hospital Emergency Operations Plan (Code Yellow - Disaster Plan) has been activated and Adventist Behavior Health (ABH) 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 ABH approved category who is not on the allied health staff of ABH who presents themselves as volunteers to render their services during a disaster shall be processed accordingly.
- B. Physicians shall be directed to the Credentialing Verification Office (CVO) at Shady Grove Adventist H 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:
 - C. Proof of current licensure\certification to practice medicine;
 1. 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.

- 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, Emergency Management

APPENDIX B

ADVENTIST BEHAVIOR HEALTH MEDICAL STAFF POLICY

Professional Practice Evaluations

Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)

Effective Date:	December 2009	Policy No:	#
Cross Reference:	n/a	Origin:	Med. Exec. Comm.
Reviewed:		Authority:	Med. Exec. Comm.
Revised:	April 15, 2014	Page:	5 pages
Approved:			

PURPOSE

To assure that the system, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care. This policy refers to the records and proceedings of the Medical Staff, which has the responsibility of evaluation and improvement of the quality of care rendered in the System. The records and proceedings of the Medical Staff that relate to this Policy in any way are protected from legal discovery.

Goals:

- a. Identify opportunities for practice and performance improvement of individual practitioners. Practitioners are Medical Staff members and Allied Health Professionals who practice in the System.
- b. Monitor for significant trends in performance by analyzing and aggregating data and case findings.
- c. Ensure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful.
- d. Monitor clinical performance of Medical Staff practitioners.
- e. Improve the quality of care provided by individual practitioners.
- f. Provide suggested areas for system-wide improvement, addressable by focused project teams and other quality improvement activities.

It is the policy of Adventist Behavioral Health to comply with statutory and regulatory requirements regarding ongoing professional practice evaluation and focused professional practice evaluation. Ongoing data review and findings about practitioner practice and performance are evaluated by Medical Executive Committee with the focus on improvement. The findings of the committee are used to assess the quality of care of each practitioner at the time of reappointment to the medical staff.

DEFINITIONS and RESPONSIBILITIES

Professional practice evaluations

1. Ongoing professional practice evaluation (OPPE) is a program that allows the medical staff to identify professional practice trends that impact the quality of care and patient safety on an ongoing basis. The program includes:

a. The evaluation of an individual practitioner's professional performance and includes opportunities to improve care based on recognized standards.

b. Uses multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, results of peer review, compliance with system policies, the Rules and Regulations of the Bylaws of the medical staff, and clinical standards, input from system clinical and administrative staff, and the use of rates compared against established benchmarks or norms.

c. Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care. To this end, practitioner performance is evaluated according to six general areas of competencies:

- Patient Care**

Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

- Medical and Clinical Knowledge**

Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others

- Practice-based Learning and Improvement**

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices

- Interpersonal and Communication Skills**

Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members

of health care teams.

- **Professionalism**

Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

- **Systems-based Practice**

Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

d. The procedure for ongoing professional practice review is specified in section 3 below.

2. Focused professional practice evaluation (FPPE) is a process in which the medical staff evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege. FPPE may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. FPPE process will be implemented consistently.

- a. All initially appointed practitioners undergo FPPE as an element of the initial credentialing process.
- b. FPPE is a time-limited period during which the organization evaluates and determined the practitioners' professional performance.
- c. FPPE is used when questions arise regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.
- d. All existing practitioners who have been granted new privileges.

e. Methodology/FPPE may include:

- Direct Observation of the required number of procedures/cases as determined by MEC.
- And/or Chart Review of no fewer than 3 Medical Record Reviews. Medical Record Review Indicators with Satisfactory performance = 100% compliance.

f. Timeframe for initial (newly credentialed practitioners) FPPE will be for the three (3) months and/or until all required methodology has been evaluated. The time period of the evaluation can be extended up to 3 months maximum with a total review period not to exceed 6 months.

g. Organized medical staff will do the following:

- Develop criteria for extending the evaluation period
- Communicate to the appropriate parties the evaluation results and recommendations based on results
- Implements changes to improve performance.

h. Trigger events for FPPE are:

Occurrence Reports

Patient/family complaints

Sentinel events and events required by regulatory agencies to be reported

Referral from other practitioners

Referral from Professional Practice Evaluation Reviews

Cases identified by patterns or trends noted in rule or rate based indicators.

i. End of review period:

- Confirmation that the practitioner has been reviewed and that there are no potential problems with the performance or trends that would impact quality of care and patient safety
- FPPE successfully completed; continue existing privileges; enter OPPE phase of credentialing
- FPPE unsuccessfully completed; privileges to be limited or revoked.

3. Ongoing Professional Practice Evaluation (OPPE) is a process that allows the Medical Staff to identify professional practice trends that impact on quality of care and patient safety on an ongoing basis. The process include: (a) the evaluation of an individual practitioner's professional performance and identification of opportunities to improve care based on recognized standards. It differs from other quality improvement practices in that it evaluates the strengths and opportunities of an individual's performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system. (b) The use of multiple sources of information, including but not limited to direct observation, review of individual cases, aggregate data, compliance with Hospital policies, protocols, and the Bylaws and the Rules and Regulations of the Medical Staff, clinical standards, and the use of rates compared against established benchmarks or norms. (c) Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing medical care. (d) Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. Findings from ongoing professional practice evaluation are factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal.

- a. All existing practitioners not currently undergoing FPPE will follow OPPE process
- b. OPPE is an ongoing monitoring process conducted at least every six (6) months
- c. External review may be required when there are a limited number or no medical staff members within the required specialty on the medical staff
- d. Trigger events are as noted above
- e. Organized medical staff will do the following:
 - Develops criteria for extending the evaluation period

- Communicated to the appropriate parties the evaluation results and recommendation based on results

- Implements changes to improve performance.

f. End of the review period:

- Confirmation that the practitioner has been reviewed and that there are no potential problems with the performance or trends that would impact quality of care and patient safety.

- If any problems do arise, FPPE might be implemented (See FPPE section).

4. Medical Staff is responsible for findings, conclusion, recommendations and actions to improve individual and organization performance.

5. Quality Improvement will:

a. Screen charts against pre-established criteria

b. Aggregate rate based measures data

c. Provide correspondence and/or copies to Credentialing Verification Organization (CVO) for placement in physicians' Medical Staff credentials files

d. Enter data into Physicians' MSO database.

6. Conflict of Interest. A member of the Medical Staff asked to perform professional practice evaluation may have a conflict of interest if he or she cannot render an unbiased opinion. This may be due to either involvement in the patient's care or a relationship with the practitioner involved as a direct competitor or partner. Individuals determine to have a conflict may be present during discussion of professional practice evaluation, but they will be required to recuse themselves from the actual evaluation process.

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 Adventist Behavior Health (ABH) during this disaster and agree to practice, as directed and under the supervision of a member of the Medical Staff of ABH.

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 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 ABH 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 Adventist Behavior Health for Medical Staff Disaster Emergency Clinical Privileges:

1. I authorize the agents and employees of Adventist Behavior Health 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 federal 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 Adventist Behavior Health, 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, Adventist Behavior Health, all Adventist Behavior Health 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:

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

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? Yes 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 Title _____ Date
Or Designee

Exhibit F

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

The following patients were seen/treated 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 #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
Pt: _____	Med Rec #: _____
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: _____

NPDB Query Date: _____ Report Recd Date: _____

OIG Report Verified on: _____ by: _____

Verified by: _____ Date: _____ Time: _____ AM/PM
 Medical Staff Services

VERIFICATION NOT COMPLETE Date: _____ Time: _____ AM/PM

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

VERIFICATION DENIED BY: _____
 Medical Staff Services

Date: _____ Time: _____ AM/PM

Exhibit H

<i>Medical Staff Volunteer Disaster Privileges</i>	<i>Medical Staff Volunteer Disaster Privileges</i>
NAME/CREDENTIALS	NAME/CREDENTIALS
SPECIALITY	SPECIALITY
DATE/TIME REGISTERED	DATE/TIME REGISTERED
DATE/TIME VERIFIED	DATE/TIME VERIFIED
DATE/TIME EXPIRES	DATE/TIME EXPIRES

Medical Staff Volunteer Disaster Privileges	Medical Staff Volunteer Disaster Privileges
NAME/CREDENTIALS	NAME/CREDENTIALS
SPECIALITY	SPECIALITY
DATE/TIME REGISTERED	DATE/TIME REGISTERED
DATE/TIME VERIFIED	DATE/TIME VERIFIED
DATE/TIME EXPIRES	DATE/TIME EXPIRES
	

