

# UPMC Pinnacle Lititz Medical Staff Bylaws

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## Definitions:

For the purpose of these Bylaws, the following terms shall have the meaning and definition assigned to them in this Section except as otherwise expressly provided in these Bylaws:

1. **“Allied Health Providers”** or **“AHP”** means Dependent and Independent Allied Health Providers.
2. **“Administration”** or **“Administrative Staff”** means the personnel employed by the Hospital, including the Chief Executive Officer, who are responsible for carrying out the day-to-day management of the Hospital’s operations, under the authority of the Board. The executive members of the Hospital staff, include the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Nursing Officer, Controller and the Director of Risk, Quality and Case Management.
3. **“Adverse Action”** means an action that adversely affects an individual’s Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing process, except as provided in these Bylaws. An adverse action shall include denial, reduction, or termination of clinical privileges all as set forth in these Bylaws.
4. **“Applicant”** means an individual who has submitted a fully complete application for membership, clinical privileges or reappointment.
5. **“Board”** or **“Board of Trustees”** means the governing body of Heart of Lancaster Regional Medical Center.
6. **“Bylaws”** means the Bylaws of the Medical Staff of Heart of Lancaster Regional Medical Center.
7. **“CEO”** or **“Chief Executive Officer”** or **“Executive Director”** or **“Administrator”** of the Hospital means the individual or his designee appointed by HMA Corporate Management to act on its behalf in the overall administrative management of the Hospital.
8. **“Clinical Functions”** means the authority recommended by the Medical Staff and granted by the Board to allow an Independent and a Dependent Allied Health Provider to provide specific medical and/or other patient care services in the Hospital, such Clinical Functions to be within defined limits and to be based on an individual’s professional license or certificate, education, training, experience, and demonstrated competence.
9. **“Clinical Privileges”** or **“Privileges”** means the authority recommended by the Medical Staff and granted by the Board to a Practitioner to provide specific medical and/or other patient care services in the Hospital, such Clinical Privileges to be within defined limits and to be based on an individual’s professional license or certificate, education, training, experience, and demonstrated competence.
10. **“Day”** or **“Days”** means calendar days unless otherwise specified in these Bylaws.
11. **“Dentist”** means an individual with an unrestricted license to practice dentistry as authorized by the Commonwealth of Pennsylvania.
12. **“Dependent Allied Health Provider ”** means an individual, other than a Practitioner, who meets the categorical requirements established by the Board and who is either duly licensed or otherwise qualified by training, experience and certification to provide specific medical and/or other patient care services under the direct supervision of a Physician Member of the Medical Staff. Dependent Allied Health Professionals may include, but not necessarily be limited to, physician assistants, certified registered nurse anesthetists, nurse practitioners, and nurse midwives.
13. **“Ex Officio”** means service as a member of a body by virtue of an office or position held.

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14. **“HCQIA”** means the Health Care Quality Improvement Act of 1986, Section 401 of Public Law 99-660, codified at 42 U.S.C. §11101 et seq. and the rules and regulations promulgated there under, as amended from time to time, or any successor legislation conferring comparable privileges and immunities.
15. **“Hospital”** means Heart of Lancaster Regional Medical Center, Lititz, Pennsylvania.
16. **“Hospital Rules”** means such rules, regulations, policies and procedures adopted by the Hospital that uniformly apply to all persons who conduct all or a portion of their work in the Hospital. The Hospital’s Rules apply to Members of the Medical Staff unless they conflict with language or provisions found in these Bylaws which have already been approved by the Board.
17. **“Independent Allied Health Provider”** means an individual who meets the categorical requirements established by the Board and is duly licensed by the appropriate professional licensing board in the Commonwealth of Pennsylvania and who is authorized by Pennsylvania law to provide specific medical and/or other patient care services, such services to be provided in consultation with a Physician Member of the Medical Staff. Independent Allied Health Providers may include, but not be necessarily limited to, clinical psychologists, chiropractors, podiatrists and audiologists.
18. **“MEC”, “Medical Executive Committee” or “Executive Committee”** means the committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws.
19. **“Medical Staff” or “Staff”** means the body of Practitioners at Heart of Lancaster Regional Medical Center, known as the Medical Staff of Heart of Lancaster Regional Medical Center.
20. **“Medical Staff Coordinator”** means an individual, hired and salaried by the Hospital, who, among other things, is assigned the responsibility to provide administrative and clerical support to the department chairpersons and section chiefs.
21. **“Member”** means a Practitioner who currently holds membership on the Medical Staff.
22. **“Patient Encounter”** means a service rendered to a patient by a Practitioner in the Hospital whether by admission, consultation or outpatient procedure.
23. **“Peer”** means an individual from the same professional discipline and with essentially equivalent qualifications who has personal knowledge of an Applicant.
24. **“Physician”** means an individual with an unrestricted license to practice allopathic medicine or osteopathic medicine as authorized by the Commonwealth of Pennsylvania.
25. **“Podiatrist”** means an individual with an unrestricted license to practice podiatry as authorized by the Commonwealth of Pennsylvania.
26. **“Practitioner”** means a Physician, Dentist, or Oral Surgeon.
27. **“President” or “President of the Medical Staff”** means that Member elected to that position by the Medical Staff according to election procedures set forth in these Bylaws.
28. **“Rules and Regulations”** means the Rules and Regulations of the Medical Staff of the Hospital.
29. **“Special Notice”** means written notification sent by certified or registered mail, return receipt requested.

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## 1. ARTICLE I: Classification of Members of the Medical Staff

### 1.1 Nature of Medical Staff Membership

Membership on the Medical Staff ("Staff") or the exercise of temporary Privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Staff shall confer on the appointee or Member, only such Clinical Privileges as have been granted by the Board in accordance with these Bylaws. No Practitioner shall engage in any patient encounters unless he/she is a Member or has received a written document stating that he/she have been granted temporary privileges in accordance with the procedures set forth in these Bylaws.

### 1.2 Basic Qualification for Membership

#### 1.2.1 Basic Qualifications

Only Practitioners who are licensed in the Commonwealth of Pennsylvania, who meet all the following criteria, are eligible for medical staff membership:

- 1.2.1.1 are graduates of approved colleges or schools in their respective profession;
- 1.2.1.2 have completed an AMA or AOA or ADA residency program and are board certified or in the process of obtaining board certification. Board certification must be obtained within the time frame set forth by the respective certifying board. Exemptions to the board certification timeframe requirement, due to special circumstances (illness, etc..) may be approved by the Medical Executive Committee and the Board of Trustees. Furthermore, board certification must be maintained. Failure to maintain board certification shall require the practitioner to submit a written request for exemption to the Medical Executive Committee who will forward a recommendation to the Board of Trustees. For Practitioners applying for initial Staff Membership after October 1, 2002, such board certification must be by a board recognized by the AMA, the AOA or the ADA. However, should a Medical Staff Department establish additional department-specific criteria, those additional criteria shall apply as well. These additional department-specific criteria shall be approved by the Medical Executive Committee and The Board of Trustees. All requests for exception to the residency program requirement will be reviewed by the MEC which will determine whether the individual is eligible for exception. All exemptions requests will be forwarded to the Board of Trustees for approval. Further documentation, additional peer references or personal interview may be required for this process.
- 1.2.1.3 have been subject to the peer review process in a licensed hospital (or equivalent) accredited by the JCAHO or the AOA at least two of the past 5 years (residency training shall be acceptable in meeting this condition). Practitioners may request, in writing, an exemption from this requirement during the pre-application process. All requests for exemption will be reviewed by the Credentials Committee, which will determine whether the individual is eligible for exemption. Further documentation, additional peer references or personal interviews may be required for this process. Proctorship, specified training, and/or additional requirements may be mandated for provisional membership if the application reaches final approval. If the exemption is denied, the Practitioner is not eligible for any appeal process..
- 1.2.1.4 shall be physically available in a reasonable period of time to allow for continuous care of hospitalized patients or have arranged for coverage by a like-privileged Practitioner, and shall maintain a local office.

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- 1.2.1.5 maintain a federal DEA number (military, certain pathologists, Honorary Staff, and other Practitioners not required by law to maintain a federal DEA number may be exempted from the DEA number requirement);
- 1.2.1.6 shall maintain and submit proof of current malpractice professional liability insurance coverage in the amount specified by law;
- 1.2.1.7 all Medical Staff members shall be encouraged to maintain membership in their national, divisional and local associations;
- 1.2.1.8 shall abide by the rules and regulations and policies of the hospital as approved by the MEC and Board of Trustees;
- 1.2.1.9 Medical Staff dues shall be assessed at an appropriate rate to Active, Courtesy, and Associate staff members. No assessment to Honorary members;
- 1.2.1.10 demonstrate and provide documented evidence of appropriate experience, background, training, and ability to perform the essential functions of the profession for which the Practitioner is seeking privileges, with or without reasonable accommodation;
- 1.2.1.11 are determined on the basis of documented references, to adhere strictly to the ethics of their respective profession, to work cooperatively with others, and to be willing to participate in the discharge of Medical Staff responsibilities; and
- 1.2.1.12 are not currently excluded from any federal health care or state health care program.
- 1.2.1.13 Dental or Oral Surgeons shall be under the general supervision of the Chairperson of the Department of Surgery.
- 1.2.1.14 Comply and have complied with federal, state and local requirements, if any, for their medical practice.
- 1.2.1.15 Are not and have not been subject to liability claims which will adversely affect their services to the hospital.
- 1.2.1.16 Are not and have not been subject to challenges to licensure which will adversely affect their services to the hospital.
- 1.2.1.17 Are not and have not been subject to loss of Medical Staff membership which will adversely affect their services to the hospital.
- 1.2.1.18 Are not and have not been subject to loss of privileges which will adversely affect their services to the hospital.

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## 1.3 Classification of Members of the Medical Staff

### 1.3.1 The Medical Staff shall consist of four classifications:

- 1.3.1.1 Active (include active referring for Family Practice)
- 1.3.1.2 Associate
- 1.3.1.3 Courtesy (include courtesy referring for Family Practice)
- 1.3.1.4 Honorary

### 1.3.2 Membership in the Active Staff

shall consist of physicians, oral surgeons and podiatrists who are actively engaged in their respective practices and are able to practice medicine and;

- 1.3.2.1 meet the basic qualifications for membership;
- 1.3.2.2 meet the basic minimum requirements to maintain active staff status as set forth in each respective department's rules and regulations;
  - 1.3.2.2.1 Regularly admits and/or cares for patients or otherwise actively contributes to the care of patients of Heart of Lancaster Regional Medical Center; (not applicable to active referring Family Practice); Active admitting Family Practice physicians will be automatically moved to active referring if there is no in-patient activity in the physician's two-year re-appointment cycle;
  - 1.3.2.2.2 Assignment in at least one medical staff committee for each year is required.

### 1.3.3 Membership in the Associate Staff shall consist of:

- 1.3.3.1 any physician, oral surgeon and podiatrists who meets the basic qualifications for membership;
- 1.3.3.2 a physician who does not wish to be actively involved in the care of Hospital patients.

### 1.3.4 Membership in the Courtesy Staff shall consist of:

- 1.3.4.1 any physicians, oral surgeons and podiatrists who meets the basic qualifications for membership;
- 1.3.4.2 Physicians who do not meet those requirements for active membership, but wish to remain affiliated with the Hospital.
- 1.3.4.3 Dentists

### 1.3.5 Membership in the Honorary Staff shall consist of:

- 1.3.5.1 those physicians, oral surgeons and podiatrists who are no longer active in the hospital but who are honored by emeritus positions or for physicians of outstanding reputation in the community;
- 1.3.5.2 retired Medical Staff members who have served at least 20 consecutive years on the Medical Staff and are at least age 65.



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## 1.4 Rights and Privileges of the Medical Staff

### 1.4.1 Active Staff

Members may, subject to the granting of privileges, participate in regular inpatient or outpatient Hospital activities, commensurate with their skills and training such as admission of patients, operative and other procedures, consultation, diagnostic study, and administration of accepted therapy in accordance with criteria for standard of medical care established by the medical staff within those areas of competence indicated by the scope of their delineated clinical privileges.

- 1.4.1.1 **Voting Rights** –After their first year of membership, Active staff members are entitled to vote and hold office in the staff organization unless otherwise limited in these Bylaws.
- 1.4.1.2 **Meeting Attendance Requirement** - Active Staff members are required to attend at least 50% of any combination of all required meetings (committee, department and/or medical staff meetings.)

### 1.4.2 Associate Staff:

- 1.4.2.1 Members may refer patients to this Hospital but they may not admit or treat patients at this Hospital.
- 1.4.2.2 Associate members may (but are not required to) attend meetings but may not vote and may not serve as an officer of the Medical Staff.

### 1.4.3 Courtesy Staff

- 1.4.3.1 Members may, subject to the granting of privileges, participate in regular in-patient or out-patient hospital activities commensurate with their skills and training such as admission of patients, operative and other procedures, consultation, diagnostic study, and administration of accepted therapy in accordance with criteria for standard of medical care established by the medical staff within those areas of competence indicated by the scope of their delineated clinical privileges; Courtesy admitting Family Practice physicians will be automatically moved to courtesy referring if there is no in-patient activity in the physician's two year re-appointment cycle.
- 1.4.3.2 Dentists, D.D.S. and D.M.D. may participate in patient care within the scope of their specialty. A Medical Staff member with admitting privileges shall be responsible for the admission, general medical care and discharge of such patients.
- 1.4.3.3 are not entitled to vote.
- 1.4.3.4 may not serve as an officer of the Medical Staff;
- 1.4.3.5 may, but are not required to attend meetings;

### 1.4.4 Honorary Staff

- 1.4.4.1 Honorary Staff members shall have no clinical privileges or medical staff obligations. Honorary staff members do not need to maintain malpractice insurance.

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## 1.5 Granting of Privileges

- 1.5.1 The Credentials Committee shall receive and review all applications, reapplications, requests for transfer of classification and clinical privilege change requests.
- 1.5.2 Each application shall be reviewed by the respective department Chairperson responsible for the medical standards in the areas for which the application for privileges is requested and the chairperson shall forward a recommendation to the Credentials Committee.
- 1.5.3 The Credentials Committee shall then forward a recommendation to the Medical Executive Committee.
- 1.5.4 Such recommendations by the Credentials Committee shall also be transmitted to each involved department Chairperson.
- 1.5.5 The Medical Executive Committee shall recommend to the Board those matters pertaining to staff appointments, reappointments, clinical privileges and any corrective actions.

## 1.6 Specification of Privileges

- 1.6.1 Each department must specify and maintain a list of specific privileges that may be recommended and the same shall be part of the rules and regulations of that department.

## 1.7 Maintenance of Privileges

- 1.7.1 It is the policy of the Hospital to review biennially those privileges granted to any member of the Medical Staff who continues to demonstrate professional qualifications and abilities related to those privileges and abides by the rules and regulations of the Heart of Lancaster Regional Medical Center as approved by the MEC and Board of Trustees.
- 1.7.2 Failure of any staff appointee to fulfill the responsibility of appointment may, upon determination by the Board of Trustees, place the practitioner in another staff classification. No hearing rights will be attached to these circumstances.
- 1.7.3 Failure to maintain the qualifications as set forth elsewhere, including but not limited to licensure, DEA certificate, or required professional liability insurance constitutes a voluntary withdrawal of clinical privileges and medical staff appointment, and such failure to meet eligibility requirements for appointment shall not entitle the Practitioner to a hearing or appeal rights or other due process rights.
- 1.7.4 It is the responsibility of the Credentials Committee to recommend any change in the practitioners' Medical Staff classification to the Medical Executive Committee.
- 1.7.5 Failure of any active staff member to fulfill department, staff and/or committee meeting attendance requirements shall be considered voluntary relinquishment of active staff privileges and result in automatic change in staff category to Courtesy Staff level at reappointment.
  - 1.7.5.1 The member whose status is changed due to lack of meeting attendance requirement may reapply for active classification after two (2) years at time of reappointment. The member may appeal to the Credentials Committee for an earlier change in classification.

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## 1.8 Medical Standards/Physician Health

- 1.8.1 Staff physicians or any Hospital administrator may request that the Medical Executive Committee convene a Medical Standards Committee to consider any complaints regarding ethical, professional, interpersonal, professional competence, disruptive behavior or impairment problem and/or grievance in regard to a member of the Medical Staff. Such complaints shall be made in writing to the President of the Medical Staff or the Chief Executive Officer, or designee of either. Convening a Medical Standards Committee shall be done at the sole discretion of the Medical Executive Committee.

## 1.9 Responsibilities and Conduct of Members of the Medical Staff

- 1.9.1 The Medical Staff members' responsibilities are to attend patients and seek to develop, exemplify and endorse the highest traditions of the profession. The member pledges to practice the profession with thorough self-restraint; to place the welfare of patients above all else; to advance constantly in knowledge by the study of the medical literature, postgraduate work, interchange of opinion among associates, attendance at District, State and National meetings; to regard scrupulously the interest of one's professional colleagues and to seek their counsel when in doubt of one's own judgment; to render help willingly to colleagues; and to give freely of services to the needy.
- 1.9.2 The proper conduct of the Medical Staff, as to ethics and professional care of patients in the Hospital, shall be governed by the requirements and by the rules and regulations of the various divisions and departments within the Hospital or other applicable standards or regulations.
- 1.9.3 All Staff members shall abide by the Code of Ethics of their respective associations and regulatory bodies.
- 1.9.4 Staff members shall not engage in the division of fees under any guise whatsoever, and all Staff members are to comply with the principle that all physicians and surgeons participating in the care of the patient shall render separate statements and issue separate receipts.
- 1.9.5 Osteopathic physicians are to utilize the distinctive osteopathic approach in the provision of patient care.
- 1.9.6 It is the responsibility of the Medical Staff member to report immediately (as soon as the member has knowledge) to the Medical Staff Office or CEO/Administrator or President of the Medical Staff the effective date any of the following:
  - 1.9.6.1 DEA registration denied, suspended, revoked, limited, or otherwise acted upon, either voluntarily or involuntarily.
  - 1.9.6.2 Any medical license denied, suspended, revoked, limited, or otherwise acted against, either voluntarily or involuntarily.
  - 1.9.6.3 Membership voluntarily or involuntarily terminated and/or privileges involuntarily limited, reduced, rescinded, or terminated, at another healthcare facility.
  - 1.9.6.4 Any criminal charges, other than minor traffic violations, brought / initiated against him/her, and any guilty pleas or convictions entered.
  - 1.9.6.5 Liability insurance coverage canceled or refused, resulting in a lapse in coverage.
  - 1.9.6.6 Begun treatment for chemical or alcohol dependency.

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- 1.9.6.7 Any medical, physical, or mental condition that would interfere with ability to treat patients.
- 1.9.6.8 Loss of Board Certification or Eligibility status.
- 1.9.6.9 He/she has been excluded, suspended, or otherwise declared ineligible for cause from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, suspension or ineligibility from such programs, or is knowingly under investigation by any such program.
- 1.9.7 Each Active Staff member shall be responsible to take call in accordance with Medical Staff rules and regulations, and Medical Staff, Hospital and departmental policies state and federal regulations.
- 1.9.8 The Medical Staff shall collaborate and cooperate with the administration in its compliance with all applicable statutes and regulations, or accreditation standards.
- 1.9.9 Oral orders from an authorized practitioner can be accepted by a physician; a PA-C; a CRNP; a registered nurse; a pharmacist who may transcribe oral orders pertaining to drugs; a physical therapist who may transcribe oral orders pertaining to physical therapy regimens; a respiratory therapist who may transcribe orders pertaining to respiratory therapy treatments; a paramedic practicing under state regulations relating to emergency paramedic services.
- 1.9.10 Each Medical Staff Member is responsible to complete the re-appointment process within the stated time frame.
- 1.9.11 Histories and Physicals- Only privileged and/or approved practitioners may complete H&P's.
  - 1.9.11.1 The history will contain, at a minimum, the reason for admission, a description of the present illness and those elements of the past history, social history, family history and allergies which affect positively or negatively the reason(s) for admission.
  - 1.9.11.2 The physical examination should contain, at a minimum, vital signs, and a complete assessment of those organ systems related to the present illness. Significant negative findings should be recorded as well.
  - 1.9.11.3 H&P should be recorded within 24 hours after admission, or in the case of a surgical patient, prior to the performance of the surgery. Emergency admissions should have a pertinent admission note written and placed on the chart at the time of admission.
  - 1.9.11.4 In the case of a surgical patient receiving general anesthesia, anesthesia assessment shall be performed and recorded prior to the procedure. There shall be a recorded reassessment before the patient is discharged from the recovery area.
  - 1.9.11.5 For procedures not requiring sedating, such as but not limited to myelograms, thoracentesis, paracentesis and lumbar puncture, the H&P shall include an appropriate explanation of the nature of the underlying condition, recorded vital signs and physical exam appropriate to the procedure. The note shall also include the clinical indication for the intended procedure.
  - 1.9.11.6 A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating that the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be

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documented. An H&P beyond 24 hours and up to 30 days is acceptable but must be updated prior to the admission / surgery / procedure.

- 1.9.11.7 Any patient admitted for dental / podiatric care must have a history and physical examination recorded by a physician member of the Medical Staff. The dentist or podiatrist is responsible for that part of the history and physical and any other documentation related to their specialty. Oral surgeons with documented adequate background and training in performing history and physical examinations should be authorized to perform them, fulfilling the hospital requirement in this matter.
- 1.9.11.8 Short Form History and Physical forms may be utilized for hospital stays less than 23 hours or for ambulatory/outpatient procedures or observation.

## 1.10 Transfer of Classification

- 1.10.1 Any Medical Staff member may request transfer from one Staff classification to another or from one department to another upon written request to the Medical Staff President or Credentials Committee. The Medical Staff President shall notify the Credentials Committee in writing.

## 1.11 Leave of Absence (LOA)

- 1.11.1 All requests for Leave of Absence must be presented to the Medical Executive Committee in writing stating the purpose. A Leave of Absence allows an individual to retain prior affiliations and agreements with the Hospital while excusing him/her from daily responsibilities such as Committee attendance, Department meetings, etc.
- 1.11.2 In general, a Leave of Absence will be granted for a period not to exceed two years.
- 1.11.3 An Educational Leave of Absence (residency, fellowship, etc.), however, may be granted for the duration of the physician's involvement in the program.
- 1.11.4 A Medical Leave of Absence may be requested by the practitioner who cannot perform to a standard level of proficiency due to health reasons.
- 1.11.5 All Leaves of Absence must be approved by the Medical Executive Committee and the Board of Trustees.
- 1.11.6 If the leave of absence is 6 months or greater, or if the regular reappointment cycle has occurred during the leave of absence, three months prior to the expiration of the Leave of Absence, a reappointment form shall be provided to the individual. At that time, the individual may request in writing an extension of the Leave of Absence, stating its purpose. Any physician, whose reappointment cycles during their leave, must reappoint.
- 1.11.7 Before privileges may be reinstated following a Leave of Absence that has exceeded its pre-approved length, a new application must be approved by the Medical Executive Committee and the Board of Trustees.
- 1.11.8 It is the responsibility of the physician to notify the medical staff office in writing of his/her return from a Leave of Absence.

## 1.12 Peer Review, Records and Discipline

- 1.12.1 In furtherance of quality of care, patient safety, reducing morbidity and mortality, and efficient delivery of high quality medical care, all persons (including members of the Medical Staff) who are requested to discuss the quality of medical care and all such

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persons who provide such care should be able to discuss such issues with confidence with immunity from liability (as far as the law will permit) for providing information to committees, officers and other entities of the Hospital within the context of the Hospital's peer review process.

- 1.12.2 Any such opinions or analysis of occurrences or persons shall be in good faith and without malice.
- 1.12.3 Within that context it is the intent of these Bylaws to permit certain initial discussions of matters relating to medical services and the providers of medical service to be with total candor. Under appropriate circumstances as determined by the Chief Executive Officer, President of the Medical Staff, or designee, certain peer review discussions are intended to be an informal process and designed to evaluate quality and safety of patient care. These informal discussions are not to be a formal process and will not constitute a hearing as defined in these Bylaws.
- 1.12.4 Adequate protection for the person(s) affected by this process appears elsewhere in these Bylaws whereby hearings are provided and an opportunity to respond and present evidence is available. However, the harmony of the Staff and the Hospital (an objective desirable for the provision of the best care possible) is best protected by permitting informal presentation of ideas and concerns under appropriate circumstances.
- 1.12.5 All such informal peer review processes shall be confidential and privileged. Such a process is not mandatory, but is an option that could be requested by the Chief Executive Officer, President of the Medical Staff, or designee, or by the individual in question.
- 1.12.6 The confidentiality of a patient's record will be preserved and the confidentiality of personnel records, whether of those who are members of this Medical Staff or otherwise, will be preserved to the extent appropriate and as legally required.
- 1.12.7 Completed Hospital charts shall be available for study, discussion or research by any authorized member or group of members of the Medical Staff, but only upon registration of the chart and declaration of intent of use with the Medical Record Librarian. Charts are not to be removed from Hospital premises.

### 1.13 Disciplinary Action

#### 1.13.1 Precautionary or Immediate Suspension of Clinical Privileges

##### 1.13.1.1 Grounds for Precautionary or Immediate Suspension

The Medical Staff President or any following officers, the Chairperson of a Clinical Department, the Chairperson of the Credentials Committee, the Chief Executive Officer, or their designees, shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff member or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operations of the hospital. A precautionary suspension shall become effective immediately upon imposition, and shall immediately be reported in writing to the Chief Executive Officer, the President of the Medical Staff, and the Board Chairperson, and the applicable Medical Staff member or affected individual.

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## 1.13.1.2 Report and Review of Precautionary or Immediate Suspension

Any individual who exercises authority to suspend clinical privileges shall immediately take further action in the matter pursuant to these Medical Staff Bylaws.

1.13.1.3 A review of the matter resulting in precautionary or immediate suspension shall be completed by the Medical Executive Committee. The Medical Executive Committee review is to determine whether the precautionary or immediate suspension should be continued or modified pending further investigation, or whether it should be lifted. The Medical Executive Committee review shall be completed within fourteen (14) days of the suspension. If the Medical Executive Committee review is not completed within 14 days, the reason for the delay shall be communicated in writing by the President of the Medical Executive Committee to the Board.

## 1.13.2 Care of Suspended Individual's Patients

1.13.2.1 Immediately upon the imposition of a precautionary or immediate suspension, the appropriate department Chairperson or, if unavailable, the Medical Staff President, Vice President, or Secretary/Treasurer, acting on behalf of the Medical Staff President, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients who are affected by the suspension. The assignment shall be effective until such time as the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.

1.13.2.2 It shall be the duty of all Medical Staff appointees to cooperate with those concerned in enforcing all suspensions.

1.13.2.3 In cases of complete suspension of privileges the Practitioner shall be prohibited from admitting, treating and or consulting. Practitioners under such suspension will not be permitted to admit patients under the service of their partners or treat in-house patients who are under the service of their partners. Partners who participate in violations of this policy shall also be placed on suspension. Notice in writing shall also be given to all members of the group.

1.13.2.4 The Medical Staff President, Vice President or Secretary/Treasurer acting on behalf of the Medical Staff President may temporarily waive the above suspension process for the duration of any emergency.

1.13.2.5 Any physician whose privileges have been immediately suspended shall be entitled to further investigation into the matter as stated procedurally in these Bylaws.

## 1.14 Automatic Relinquishment

The following shall be reasons for automatic voluntary relinquishment of all clinical privileges and medical staff membership by the medical staff member. No hearing or appeal rights attach to this section:

1.14.1 Failure to meet medical records obligations as specified in the Medical Records Delinquency Policy and shall be considered automatic voluntary relinquishment by the Practitioner.

1.14.2 Any action limiting, revoking or suspending a practitioner's license, shall constitute automatic voluntary relinquishment of all privileges and medical staff membership by the Practitioner.

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- 1.14.3 Revocation or suspension of Drug Enforcement Administration (DEA) number shall constitute automatic voluntary relinquishment of all clinical privileges and medical staff membership by the Practitioner.
- 1.14.4 Failure to maintain adequate professional liability insurance coverage shall constitute automatic voluntary relinquishment of all clinical privileges and medical staff membership.
- 1.14.5 Loss of eligibility or failure to maintain board certification shall constitute automatic and voluntary relinquishment of all clinical privileges and medical staff membership. Medical Staff members who were approved by the Board of Trustees prior to January 1, 2007 **and** were not board eligible or board certified at the time of approval are exempted from this requirement.
- 1.14.6 The Medical Staff President in conjunction with the Chief Executive Officer shall cooperate in enforcing all such automatic relinquishment of clinical privileges and medical staff membership.
- 1.14.7 When automatic relinquishment under the Medical Records Delinquency Policy is imposed, privileges shall be automatically reinstated if the cause of termination is removed within 89 days of the automatic relinquishment.
- 1.14.8 When automatic relinquishment is due to failure to provide documentation of current DEA, licensure and/or malpractice insurance, privileges shall be automatically reinstated if the cause of the termination is removed within 10 days of the automatic relinquishment.
- 1.14.9 Failure to maintain a local office setting for clinical follow-up.
- 1.14.10 Failure to complete the re-appointment process within the stated time frame will result in voluntary resignation of membership and privileges.
- 1.14.11 Any practitioner or Allied Health Provider who is excluded, suspended, or otherwise declared ineligible for cause from any state or federal government health care program or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, suspended or otherwise declared ineligible) shall be subject to automatic voluntary relinquishment of all criminal privileges and medical staff membership.

### 1.15 National Practitioner Data Bank

In compliance with the provisions of the Health Care Quality Improvement Act, 42 U.S.C.A. § 11101 et seq., to the extent required, any reduction, restriction, suspension, revocation or denial of clinical privileges against a physician, dentist, or other health care practitioner, lasting more than 30 days, based on his or her professional competence or conduct must be reported to the appropriate licensing board and National Practitioners Data Bank. Revisions to adverse actions will also be reported as required by law.

### 1.16 Non Discrimination Statement

The Medical Staff of HLRMC accepts applications and reviews credentials without regard to race, color, religion, sex, nation origin, or age.



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## 1.17 Bylaws and /or Rules and Regulations

- 1.17.1 Each department of the Medical Staff shall establish Bylaws and/or Rules and Regulations setting forth its organization and government and clinical functions. Such Bylaws and/or Rules and Regulations shall be approved by the Medical Executive Committee. The Hospital Board shall receive a copy of the Bylaws and/or Rules and Regulations for approval.
- 1.17.2 All provisions made in the Staff Constitution and Bylaws and the Bylaws and/or Rules and Regulations of the departments shall conform to the minimum requirements and standards for graduate medical education as set forth in the document "Institutional Requirements for Osteopathic Graduate Medical Education."
- 1.17.3 Bylaws, Rules and Regulations of the Medical Staff and Departments may be amended with the approval of the Medical Executive Committee at any regular meeting of the Committee by an affirmative vote of 2/3 of the total committee membership, subject to final approval by the Board of Trustees. Bylaws shall be subject to final approval by the Board of Trustees. Proposed amendments to the medical Staff Bylaws and Medical Staff Rules and Regulations will be sent to the active Medical Staff members for review prior to approval.

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## 2. ARTICLE II - The Organization of the Medical Staff

### 2.1 Clinical Structure

- 2.1.1 The Medical Staff shall be divided into various clinical departments and their respective subspecialty services. A clinical department shall contain three or more active staff physicians. If a department drops below three active staff physicians, it will be placed on provisional status and will be reviewed annually by the MEC.
- 2.1.2 Departmental status shall be approved by the MEC.
- 2.1.3 A sub-specialty service of a clinical department shall not progress to departmental status regardless of the number of physicians so assigned unless approved by the MEC. Each clinical department shall have its own designated sub-specialty services, as determined by the respective department. Reference in these Bylaws to a department will include a service (but not a subspecialty service), which is such solely because there are less than three active staff physicians.

### DEPARTMENTS

- 1. Anesthesiology
- 2. Emergency Department
- 3. Family Practice
- 4. Internal Medicine
- 5. OB-GYN
- 6. Pathology
- 7. Pediatrics
- 8. Radiology and Diagnostic Imaging
- 9. Surgery

- 2.1.4 Members of the Medical Staff are restricted to membership in one clinical department. However, Medical Staff members may receive privileges in other departments by presenting appropriate credentials to the Credentials Committee. The Credentials Committee shall then consult with the department involved and make recommendations to the Medical Executive Committee. The recommendations of the Medical Executive Committee shall then be sent to the Board of Trustees for action.
- 2.1.5 Physicians to be placed under contract by the Hospital must be members of the Medical Staff.
- 2.1.6 Departments shall meet at least quarterly, maintain accurate minutes of all meetings, and record the attendance at meetings. Quality Assurance, clinical or mortality review, and educational programs, should be included. Failure to meet the above departmental requirements shall result in relinquishment of Medical Executive Committee representation until such time as these requirements are fulfilled.
- 2.1.7 Each department shall elect a Chairperson bi-annually to be held in accordance with that Department's Bylaws and/or Rules and Regulations. These elections are subject to approval by the Medical Executive Committee. The results shall be sent to the Board of Trustees for information purposes. The Chairperson shall be Board certified and a member of the active staff. In the absence of a qualified member a department shall

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select and recommend to the Medical Executive Committee the most suitable qualified member of that department for chairmanship position until such qualified members become available.

- 2.1.8 Department Chairpersons shall exercise responsibility for the following:
- 2.1.8.1 All clinically related activities of the department.
  - 2.1.8.2 All administratively related activities of the department; unless otherwise provided by the hospital.
  - 2.1.8.3 Continuing surveillance of the professional performance of all individuals in the department with delineated clinical privileges.
  - 2.1.8.4 Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
  - 2.1.8.5 Recommending clinical privileges for each member of the department to the Credentials Committee.
  - 2.1.8.6 Assessing and recommending to the Medical Executive Committee off-site resources needed for patient care services not provided by the department or the organization.
  - 2.1.8.7 The integration of the department of service into the primary functions of the organization.
  - 2.1.8.8 The coordination and integration of interdepartmental and intradepartmental services.
  - 2.1.8.9 The development and implementation of policies and procedures that guide and support the provision of services.
  - 2.1.8.10 The recommendations for a sufficient number of qualified as well as competent persons to provide care or service, including those who are not licensed independent practitioners and who provide patient care services.
  - 2.1.8.11 The continuous assessment and improvement of the quality of care and services provided.
  - 2.1.8.12 The maintenance of quality control programs as appropriate.
  - 2.1.8.13 The orientation and continuing education of all persons in the department or service.
  - 2.1.8.14 Recommendations for space and other resources needed by the department or service.
- 2.1.9 Each department shall draw up its own bylaws in conformity with the Medical Staff regulations. Before adoption by the Medical Executive Committee, these Bylaws and/or Rules and Regulations must be approved by a majority of the Members of the department.

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Departmental Bylaws and/or Rules and Regulations shall be reviewed bi-annually. All department Bylaws and/or Rules and Regulations shall be submitted to the Medical Executive Committee for approval and then to the Board of Trustees for final approval.

## 2.1.10

Newly organized departments applying for department status shall have proposed Bylaws and/or Rules and Regulations available for the Medical Executive Committee to review before department status approval.

## 2.1 Assignment

- 2.2.1 Medical Staff members shall signify their choice of department upon the appropriate application form and present it to the Credentials Committee. Assignment shall be made by the Medical Executive Committee on recommendation of the Credentials Committee, after consultation with the department concerned. A Medical Staff member, where qualified, may have privileges in a department other than the one to which assigned. These qualifications shall be subject to the Bylaws and/or Rules and Regulations of the respective department(s).

## 2.2 Transfers

- 2.3.1 A Medical Staff member may request of the Medical Staff President or Credentials Committee, in writing, a transfer from one department to another or from one Medical Staff classification to another, stating the reason. After the request has been reviewed by the Credentials Committee with consultation with the department chair concerned, the request shall be forwarded to the Medical Executive Committee for recommendation. The results will then be sent to the Board of Trustees for approval.

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## 3. ARTICLE III - Operation of the Medical Staff

### 3.1 Officers

- 3.1.1 The officers of the Medical Staff shall be the President, Vice President, and Secretary/Treasurer, who shall be elected, in even-numbered years, at the annual meeting of the Medical Staff and who shall hold office for a two (2) year term. Officers shall be members in good standing on the active medical staff and members in good standing in their respective departments. In order to hold the election, a quorum must be present. In the event that more than one qualified candidate is nominated for an office, a closed ballot will be held.
- 3.1.2 A Parliamentarian shall be appointed from the Medical Executive Committee by the Medical Staff President.

### 3.2 Responsibilities of the Officers

- 3.2.1 The Medical Staff President
  - 3.2.1.1 Shall be a member of the Medical Executive Committee.
  - 3.2.1.2 Responsibilities shall include, but not be limited to:
    - 3.2.1.2.1 Shall call and preside at all Medical Staff meetings. Shall set the agenda and assure that accurate minutes are taken.
    - 3.2.1.2.2 Shall appoint all standing and special committees.
    - 3.2.1.2.3 Shall coordinate Medical Staff and Hospital related issues with the Hospital Administrator.
    - 3.2.1.2.4 Shall be an ex-officio member of all other staff committees, except the Nominating Committee.
    - 3.2.1.2.5 Shall be required to attend meetings of the Board of Trustees.
    - 3.2.1.2.6 Shall be responsible for the Medical Staff's clinical activities and for implementing its administrative functions
    - 3.2.1.2.7 Shall represent the views, policies and needs of the Medical Staff to the Board of Trustees and transmit and/or interpret the views and policies of the Board of Trustees to the Medical Staff.
    - 3.2.1.2.8 Shall be responsible for enforcing the Medical Staff Constitution and Bylaws. Shall be given the authority to initiate disciplinary actions independently, or on the recommendation of the Medical Executive Committee.
    - 3.2.1.2.9 Shall serve as the Medical Staff Spokesperson in its external public and professional relations.

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- 3.2.1.2.10 Shall have the power to make decisions in cases of emergency pertaining to staff business, which shall be effective until approval or disapproval by the Medical Executive Committee at its next regular or special meeting.
  - 3.2.1.2.11 Shall apprise the Medical Staff and its various components of the regulations of accrediting agencies in coordination with the Hospital Administrator.
  - 3.2.1.2.12 Shall, after consultation with the Chairperson or acting Chairperson of the involved department (and the Credentials Committee where applicable), make recommendations to the CEO regarding the granting of temporary privileges to any physician who is not a member of the Medical Staff or to a member of the Medical Staff who does not possess these privileges.
  - 3.2.1.2.13 Shall have the authority to order consultation and/or management for a patient when indicated if an attending physician fails to do so after consulting, when possible, with physician's department Chairperson and the Chairperson of any other involved department.
  - 3.2.1.2.14 The Medical Staff agrees to pay an annual stipend to the Medical Staff President. The amount will be determined by the Medical Executive Committee.
- 3.2.2 The Vice President:
- Shall assume all responsibilities in the absence or resignation of the President. Shall be a member of the Medical Executive Committee.
- 3.2.3 The Secretary/Treasurer
- Shall be a member of the Medical Executive Committee and shall assure that accurate and complete minutes of all meetings of the Medical Staff and Medical Executive Committee are kept, shall call meetings on order of the Medical Staff President, shall attend to all correspondence, and shall perform such other responsibilities as ordinarily pertains to that office. He/she shall also assume the responsibilities of the Vice President of the Medical Staff in his/her absence. He/she shall keep accurate and complete accounts of all monies received and disbursed and make periodic reports to the Medical Executive Committee. He/she shall maintain attendance by roster.

### **3.3 Provisions for Resignation and Removal of Medical Executive Committee members**

- 3.3.1 Any Medical Executive Committee member may resign his position upon 30 days prior written notice to the Medical Executive Committee.
- 3.3.2 Any Medical Executive Committee member may be removed from his position by 51% of the total vote Active Staff at any regular or special meeting of the Medical Staff for reasons including but not limited to inability to fulfill the responsibilities of the office.

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- 3.3.3 In the event of a vacancy in the position of the Vice President or Secretary/Treasurer, the Medical Executive Committee shall appoint a suitable replacement to serve the remainder of the term.

## 3.4 Staff Members on the Board of Trustees

A panel of three recommended nominees shall be recommended by the Medical Executive Committee to the Nominating Committee of the Board of Trustees as defined by the Board of Trustees Bylaws. The recommended nominees shall be active members of the Medical Staff in good standing.

## 3.5 Director of Medical Education

- 3.5.1 Shall be appointed by the Chief Executive Officer with approval of the Board of Trustees after consultation with the Medical Executive Committee.

### 3.5.1.1 Responsibilities:

- 3.5.1.1.1 Coordinate all medical education for Medical Staff, house staff, and externs, ensuring that these activities are related, at least in part, to the type and nature of care offered by the hospital (i.e. patient population served, types of services, the hospital's mission), and the findings of Performance Improvement activities.
- 3.5.1.1.2 Ensure that the minimum requirements for accreditation of training programs for the Interns, Residents, and Externs are met by compliance with AOA training policies.
- 3.5.1.1.3 Direct the education of the Residents, Interns, and Externs and ensure that the training is properly carried out by the trainers in conjunction with the Medical Education Training Committee.
- 3.5.1.1.4 Implement all policy for Intern, Resident and Extern training as outlined by the Medical Education Training Committee.

## 3.6 Committees

The committees of the Medical Staff shall either be standing or special. All committee members shall be appointed by the Medical Staff President or as otherwise provided in these Bylaws. The committee chairpersons shall be members of the Active Staff. All committees shall consist of Active Staff members unless otherwise specified in the Staff Bylaws. Special committees may be appointed by the MEC for a temporary period of time to perform a specifically designated task.

Any committee member may resign his/her position upon 30 days prior written notice to the Medical Executive Committee. In the event of a vacancy in a committee position (with the exception of the Medical Executive Committee) the Medical Staff President shall appoint a new member to serve the remainder of the term.

### 3.6.1 Medical Executive Committee (MEC)

#### 3.6.1.1 Composition:

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- 3.6.1.1.1 The Medical Executive Committee (MEC) shall be active physicians of the Medical Staff, and may include other licensed independent practitioners, comprised of:
- 3.6.1.1.1.1 President of the Medical Staff
  - 3.6.1.1.1.2 Vice President
  - 3.6.1.1.1.3 Immediate Past President
  - 3.6.1.1.1.4 Secretary/Treasurer of the Medical Staff
  - 3.6.1.1.1.5 Director of Medical Education or designee (if this position is filled by an active member of the medical staff)
  - 3.6.1.1.1.6 Chair of the Peer Review Committee or designee
  - 3.6.1.1.1.7 Chairperson (or designee) of the Credentials Committee
  - 3.6.1.1.1.8 Chairpersons (or their designees) of each department or service as listed under clinical structure.
  - 3.6.1.1.1.9 Two at-large members who shall be elected, at the annual Medical Staff meeting held in September, by the general medical staff. The at-large representatives must be an active member of the medical staff and shall serve a two-year term
  - 3.6.1.1.1.10 Other licensed independent practitioners may participate as deemed appropriate by the MEC.
- 3.6.1.1.2 All of the above shall have voting privileges on the Medical Executive Committee, except the President of the Medical Staff shall only have voting rights when there is a tie. In the event that an individual holds more than one of the foregoing offices, they shall be eligible for only one vote on the Committee. The Hospital CEO or designee and any physician member of the Hospital Board of Trustees shall attend on an ex-officio basis, without voting privileges.
- 3.6.1.1.3 **Executive Session Provision**<sup>1</sup>– The Medical Staff President / designee may call for an executive session with at least one member of administration present, determined by the Hospital CEO or designee, in order to act with a degree of freedom in order to address extremely sensitive issues of self governance
- 3.6.1.2 Quorum
- The quorum for the Medical Executive Committee shall consist of no fewer than 5 voting members in attendance.
- 3.6.1.3 **Conflict of Interest** - In any instance where a member of the Medical Executive Committee has a conflict of interest in any matter involving another medical staff appointee which comes before the Medical Executive Committee, or in any instance where a member of the Medical Executive Committee brought the complaint against that appointee, that member shall not participate in the discussion or voting matter and shall absent himself from the meeting during that time, although he/she may be asked to answer any questions concerning the matter before leaving. The presence of a conflict of interest shall be determined by the Medical Executive Committee, or by the individual medical staff member who believes that he or she has a conflict of interest.



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- 3.6.1.4 Responsibilities:  
The MEC shall:
- 3.6.1.4.1 Transact monthly all business of the Medical Executive Committee.
  - 3.6.1.4.2 Review and act upon reports and/or recommendations of the departments, committees and officers of the medical staff. Submit to the Board specific recommendations based on these assessments.
  - 3.6.1.4.3 Coordinate the actions and policies adopted by the Medical Staff, its departments or committees and implement the Performance Improvement Plan.
  - 3.6.1.4.4 Recommend to the Board those matters pertaining to staff appointments, reappointments, clinical privileges, delineation of individual clinical privileges, any corrective actions, change in status of clinical privileges, or medical staff appointments.
  - 3.6.1.4.5 Ensure the continual professional ethical conduct and clinical competence of Medical Staff Members, including initial investigation and pursuance of corrective action where warranted.
  - 3.6.1.4.6 Make recommendations to the Board concerning medical, administrative and Hospital management matters.
  - 3.6.1.4.7 Periodically evaluate the Medical Staff's position with respect to the community's health care needs and establish and implement Hospital goals and programs.
  - 3.6.1.4.8 Assume responsibility for all aspects of medical care within the institution.
  - 3.6.1.4.9 Make recommendations as to the composure of the Medical Staff to the Board of Trustees.
  - 3.6.1.4.10 Recommend to the Credentials Committee the mechanism used to review credentials and to delineate individual clinical privileges.
  - 3.6.1.4.11 Recommend methods to the Board of Trustees by which medical staff membership may be terminated and the mechanism for peer review and fair-hearing procedures.
- 3.6.1.5 All business transacted by the Medical Executive Committee shall become effective immediately except where full staff action or Board approval is required.
- 3.6.1.6 Any action of the Medical Executive Committee may be subject to review and discussion at any subsequent meeting of the Medical Staff. If the majority of the quorum at any staff meeting disagrees with a Medical Executive Committee decision, it may change such action unless this would violate the Medical Staff Bylaws/Rules and Regulations or Bylaws of the Hospital. Any changes will be sent to the Board of Trustees for approval.
- 3.6.1.7 The Medical Executive Committee shall coordinate the actions and general policies of the various departments and committees of the Medical Staff.
- 3.6.1.8 In the event of a vacancy in an elected seat of the Medical Executive Committee, the previous electing body shall elect a new representative within 30 days. In the event of failure of the previous electing body to select this representative, the Medical Staff President shall appoint a replacement.

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3.6.1.9 The Medical Executive Committee is empowered to act for the medical staff in the intervals between medical staff meetings.

## 3.6.2 Special Committees:

### 3.6.2.1 Nominating Committee

#### 3.6.2.1.1 Membership:

The Nominating Committee shall consist of three members of the Active Medical Staff.

#### 3.6.2.1.2 Purpose:

- 3.6.2.1.2.1 Shall carefully interview and select from possible candidates nominees for the offices of President, Vice President, and Secretary/Treasurer and shall present this slate to the Medical Executive Committee and Medical Staff at the Medical Staff meeting prior to the annual September meeting.
- 3.6.2.1.2.2 Shall interview and select three active staff candidates for consideration by the Board for Medical Staff representation.
- 3.6.2.1.2.3 Shall carefully interview and select from possible candidates a slate of nominees for the position of “at-large” member of the Medical Executive Committee.
- 3.6.2.1.2.4 Any active staff member may name other nominations for any office at the annual meeting.

### 3.6.2.2 Medical Standards/Physicians Health Ad Hoc Committee

#### 3.6.2.2.1 Membership:

The membership shall be a multidisciplinary group composed and appointed by the Medical Staff President or designee on an as needed basis as indicated below. Shall consist of at least three (3) and no more than five (5) members of the active staff appointed by the Medical Staff President/designee on an as needed basis in accordance with the need for expertise and a representative of Hospital Administration, preferably the Director of Risk Management/Quality Assurance. The representative of Hospital Administration shall not be a voting member. The use of outside expert advice is to be encouraged on a case-selected basis.

#### 3.6.2.2.2 Functions:

To investigate upon the request of the Medical Executive Committee, breaches of professional ethics, interpersonal grievances, questions of professional competency, impairment (such as medical, psychiatric or substance abuse problems), and patterns of disruptive behavior, as well as conflict management among the medical staff. (Refer to separate conflict management policy). The services of this committee shall also be available to all employees and staff physicians of the Hospital where questions of professional standards are involved, and such requests must be approved by the Medical Executive Committee. The Medical Standards Committee is authorized to investigate, reach conclusions on the merits of a particular matter, and make recommendations to the Medical Executive Committee. The MEC shall then promptly advise the physician involved in writing.

- 3.6.2.2.2.1 **Medical Standards Committee Process** - The investigatory process of The Medical Standards Committee shall make all reasonable efforts to

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obtain the facts of the matter, and should include as it determines to be appropriate the following:

- 3.6.2.2.2.1.1 Conduct witness interviews, including applicable administrators, physicians, nurses or other staff or peers. This should include interviews with subsequent treating physicians with respect to the physician being investigated, and interviews with anyone who may have information that directly impacts the merits of the matter in question. Additionally, anesthesiologists and operating room nurses and nurse supervisors should also be interviewed as applicable under the circumstances.
- 3.6.2.2.2.1.2 Create summaries of all interviews.
- 3.6.2.2.2.1.3 Review statistics.
- 3.6.2.2.2.1.4 Review relevant medical records through an internal review or external review.
- 3.6.2.2.2.1.5 Meet with the physician in question for his/her input.
- 3.6.2.2.2.1.6 The Medical Standards Committee will submit a written report of all findings and recommendation(s) to the Medical Executive Committee with a detailed and comprehensive summary of all information gathered, considered and relied upon in support of the recommendation(s). This will include the attachment of documents or other information reviewed, such as summaries of witness interviews and expert reports.
- 3.6.2.2.2.1.7 Upon receipt of the written report from the Medical Standards Committee, the Medical Executive Committee shall act promptly and advise the physician involved in writing of its decision.

### 3.6.2.2.3 Meeting Frequency:

Shall meet on an as-needed basis.

- 3.6.2.3** Other special or Ad Hoc committees may be appointed for a temporary period of time to perform a specifically designated task by the Medical Staff President.

### 3.6.3 Standing Committees

The following constitute permanent committees of the Medical Staff. Only physicians shall have voting privileges except where required by Governmental or third-party regulations. All standing committees shall meet at least quarterly unless specified otherwise and shall report to the MEC following each meeting.

Bioethics/Investigational Review Committee  
Cancer Committee  
Constitution and Bylaws Committee  
Credentials Committee  
Infection Control Committee  
Intensive Care Unit/Progressive Care Unit Committee  
Medical Record/Utilization Review Committee  
Operating Room Committee  
Pharmacy & Therapeutics Committee  
Graduate Medical Education Committee

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Medical Staff Peer Review Committee  
Tissue Committee

## 3.6.4 Bioethics/Investigational Review Committee

### 3.6.4.1 Membership:

This committee is a multidisciplinary committee and shall have representatives from:

- 3.6.4.1.1 Active Medical Staff
- 3.6.4.1.2 Nursing Staff
- 3.6.4.1.3 Hospital Administration
- 3.6.4.1.4 Department of Social Services
- 3.6.4.1.5 Community representative (may be a member of the Board of Trustees)

Hospital counsel shall serve as a consultant to this committee.

The Chairperson shall be a member of the Active Medical Staff.

### 3.6.4.2 Functions:

- To serve as an educational forum for medical staff and Hospital employees.
- To serve as a resource, when requested, on bioethical problems and issues. The committee can help formulate guidelines for addressing these issues in the future, when appropriate.
- To monitor changes in legislation which affect these issues.
- To recommend policy and policy changes on these issues to the Medical Executive Committee.
- To supervise and review the use of Investigational Drugs and experimental protocol within the institution in accordance with current government regulations.

### 3.6.4.3 Meeting Frequency:

Shall meet at least annually for review for appropriate issues, and report to the Medical Executive Committee. Other meetings may be called as needed.

## 3.6.5 Cancer Committee

### 3.6.5.1 Membership:

Shall consist of multidisciplinary members of the Active Medical Staff.

### 1.17.3.1 Function:

Is responsible for goal setting, as well as planning, initiating, implementing, evaluating, and improving all cancer-related activities. The Cancer Committee implements the clinical mission in advancing research, in cancer prevention, cancer biology, and cancer treatment by assuring program excellence. The Cancer Committee maintains the hospitals accreditation by the American College of Surgeon's Commission on Cancer.

### 1.17.3.2 Meeting Frequency:

Shall meet at least quarterly to carry out the above functions.

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## 1.17.4 Constitution & Bylaws Committee

### 1.17.4.1 Membership:

Shall be composed of at least three (3) members of the Active Medical Staff.

### 1.17.4.2 Function:

Shall review annually the Staff Constitution, Bylaws, Rules and Regulations; draft appropriate changes and make recommendations for these changes to the Medical Executive Committee and provide for their presentation to the staff.

### 1.17.4.3 Meeting Frequency:

Shall meet at least quarterly to carry out the above functions.

## 1.17.5 Credentials Committee

### 3.6.7.1 Membership:

Membership shall consist of at least six physicians selected from various departments or services of the Medical Staff.

### 3.6.7.2 Functions:

3.6.7.2.1 To prepare a written form for pre-application, application or reapplication for membership to the Medical Staff or Allied Health Providers membership to various departments, transfer from one department to another and privileges in other departments.

3.6.7.2.2 The application shall be considered "complete" only when all information requested by the respective department(s), Credentials Committee, Medical Executive Committee and Board is given by the applicant. Once the application is complete, it shall be acted upon promptly.

3.6.7.2.3 To investigate the professional and ethical qualifications of all applicants for staff membership, department membership, transfers and special privileges in other departments.

3.6.7.2.4 The department Chairperson shall review the application and formulate a recommendation about the application. There shall NOT be a review or formal vote by department members on the application.

3.6.7.2.5 The Credentials Committee shall vote on the application and recommend their decision to the Medical Executive Committee.

3.6.7.2.6 To require a signed statement from all applicants releasing from civil liability those receiving or providing information related to credentialing staff membership and privileges.

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3.6.7.3 Meeting Frequency:  
Shall meet quarterly and on an as-needed basis.

## **3.6.8 Infection Control Committee**

3.6.8.1 Membership:  
Representative of Administration  
Chief Nursing Officer  
Three active staff physicians  
Director of Environmental Services and/or Housekeeping  
Pharmacist  
Others as indicated by nature of business

The Chairperson shall be a physician member of the committee.

3.6.8.2 Functions:

3.6.8.2.1 Determine the mechanisms for effective nosocomial infection surveillance.

3.6.8.2.2 The Chairperson shall review potentially contagious infections and Culture reports and bring significant problems to the committee's attention.

3.6.8.2.3 Any physician or department head may bring to the committee's attention problem areas or significant information.

3.6.8.2.4 Determine which isolation procedure to utilize.

3.6.8.2.5 Review and act on aseptic techniques and procedures to be employed in Operating and Delivery Rooms, Nurseries, Inhalation Therapy and other high risk areas.

3.6.8.2.6 Review monthly surveillance culture reports and make appropriate recommendations.

3.6.8.2.7 Review the culture tests derived from the autoclaves and gas sterilizing and make appropriate recommendations.

3.6.8.2.8 Determine and monitor the employee health policy.

3.6.8.2.9 Recommend appropriate immunization policies for all employees.

3.6.8.2.10 Recommend guidelines for antibiotics usage to discourage Over-utilization and mis-utilization of antibiotics.

3.6.8.2.11 Monitor housekeeping and laundry procedures to insure effectiveness.

3.6.8.2.12 Recommend to President/CEO of the Hospital appropriate restrictions (visiting, admitting) during epidemics and other unusual occurrences.

3.6.8.2.13 Assist in providing appropriate inservices to all Hospital personnel (Medical Staff included) to insure knowledge and understanding of infection control procedures.

3.6.8.2.14 Review the Infection Control -Section-in the Medical Staff Rules and Regulations on a yearly basis.

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## 3.6.8.3 Meeting Frequency:

Shall meet a least quarterly.

## 3.6.8.4 Isolation Procedure

The isolation procedure technique used by Heart of Lancaster Regional Medical Center is guided by that technique set forth by the United States Public Health Service.

## 3.6.9 Intensive Care Unit/Progressive Care Unit Committee

### 3.6.9.1 Membership:

Shall be composed of a minimum of 3 medical staff physicians, at least one of whom is active staff, the supervisor of the ICU and PCU and the Chief Nursing Officer.

### 3.6.9.1 Functions:

Formulate, oversee and enforce standards of medical care for the Intensive and Progressive Care Units.

Recommend proper staffing of the unit and training of the staff.

Obtain necessary information concerning equipment, maintenance, and procurement of equipment and make recommendations in this regard.

The Chairperson of this committee shall be charged with the responsibility to enforce the standards of medical care as set forth by this committee.

### 3.6.9.2 Meeting Frequency:

Shall meet at least quarterly.

## 3.6.10 Medical Records / Utilization Review Committee<sup>2</sup>

### 3.6.10.1 Membership:

Should consist of a minimum of 3 medical staff physicians, at least one of whom is active staff, and the Director of Medical Records or designee, and a representative from Nursing.

### 3.6.10.1 Functions:

The purpose of the committee shall be to conduct a review of the quality and timeliness of documentation in the medical record of all medical staff members and hospital clinical staff. Review and constructively criticize current records as necessary.

The medical staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events.

It shall review the status of the medical staff's delinquent records and individual delinquent physicians and shall work in conjunction with the President of the Medical Staff and the Chief Executive Officer to

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<sup>2</sup> 2003 28 PA. Code §107.26(b)(3)

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enforce bylaws requirements for suspension of medical staff members related to delinquent medical records.

The Committee shall recommend for discipline any member of the medical staff whose records practices fail to conform with necessary record keeping requirements.<sup>3</sup>

Ensure the maintenance of medical records at an acceptable standard of completeness.<sup>4</sup>

Report its findings and recommendations in a written report to the Medical Executive Committee.

It shall approve all proposed changes in medical record format and forms and styles of documentation to be included in the medical record. Recommend to the Medical Executive Committee any new use or any changes in the format of medical records.

Recommend policies for medical records maintenance and review medical records to ensure proper recording of sufficient data to evaluate patient care.

Develop, with the aid of legal counsel, policies to guide the Medical Records Administrator, Medical Staff, and Administration so far as matters of privileged communication or legal release of information are concerned.

Review and recommend policies and procedures to assure that medical records are kept current.

It shall maintain open lines of communication with all medical staff departments, the medical staff Executive Committee and hospital and support services departments.

## 3.6.10.2 Meeting Frequency:

Shall meet at least quarterly.

## 3.6.11 Tissue

### 3.6.11.1 Membership:

3.6.11.1.1 Membership shall consist of at least five (5) members of the medical staff, at least two (2) of whom shall be active, a Hospital Administrator/designee, and the Director of Nursing/designee.

### 3.6.11.2 Tissue Audit Functions<sup>5</sup>

3.6.11.2.1 The responsibilities of the committee are to:

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<sup>3</sup> 2003 28 PA. Code §107.26(b)(3)

<sup>4</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.09.02 / 2003 28 PA. Code §107.26(b)(3)

<sup>5</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.13.01 / 2003 28 PA. Code §107.26(b)(2)



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3.6.11.2.1.1 Evaluate the surgical practice of the institution<sup>6</sup>

3.6.11.2.1.2 Review tissues with minimum or no pathology to determine justification for all surgical procedures performed<sup>7</sup>

3.6.11.2.1.3.Scrutinize the relationship between preoperative and postoperative final diagnosis, <sup>8</sup>

3.6.11.1.1.4 Review and evaluate where there is a disagreement among the preoperative, post-operative and pathological diagnosis or where a question of the acceptability of the procedure undertaken has been raised<sup>9</sup>

3.6.11.1.1.5 Determine the types of cases it will review, such as; <sup>10</sup>

3.6.11.1.1.5.1 Preoperative diagnosis and postoperative surgical and pathology diagnosis agree.

3.6.11.1.1.5.2 Discrepancy between preoperative surgical, postoperative surgical and pathology diagnosis.

3.6.11.2.5.3 Tissue insufficient for diagnosis; multiple biopsies from different sites submitted in one container, incidental findings (not planned removal).

3.6.11.2.1.5.4 Improper completion of surgical pathology examination request form.

3.6.11.2.1.5.5.Specimen inadequately or improperly labeled; no fixative or wrong fixative.

3.6.11.2.1.5.6 Specimen not received in Pathology.

3.6.11.2.1.5.7 Surgical margins involved.

3.6.11.1.1.6 The committee shall formulate and record its conclusions after review of each case and reports its findings to the surgical department, the medical staff and the hospital administration

3.6.11.1.1.7 Members shall not review their own charts or those of their associates  
Reports shall be made using Hospital case numbers and Physician Numbers

3.6.11.3 Shall meet monthly<sup>11</sup>

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<sup>6</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.13.01

<sup>7</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.13.02

<sup>8</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.13.03

<sup>9</sup> 2003 28 PA. Code §107.26(b)(2)

<sup>10</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.13.04

<sup>11</sup> 2003 28 PA. Code §107.26(b)(3)

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## 3.6.12 Operating Room Committee

### 3.6.12.1 Membership

3.6.12.1.1 Membership shall consist of representatives from the medical staff of the Surgery department, medical or allied health staff of the Anesthesia department, an OR staff representative/designee and a day hospital representative/designee.

### 3.6.12.2 Operating Room Component Functions:

3.6.12.2.1 Evaluation and make recommendations to assure the appropriate utilization, safety and cost effectiveness of the operating facility.

3.6.12.2.2 Facilitate communication between surgeons, anesthesiologists, nursing, and administration.

3.6.12.2.3 Address problems raised pertaining to quality or cost issues.

3.6.12.2.4 Make recommendations pertaining to purchasing of materials and equipment.

3.6.12.2.5 Make recommendations on major Hospital Operating Room Policies and Procedures to the Department of Anesthesia and/or the Department of Surgery as applicable.

3.6.12.2.6 The committee shall meet at least quarterly.

## 3.6.13 Pharmacy and Therapeutics/Nutrition Support Committee

### 3.6.13.1 Membership:

Shall consist of at least two (2) members of the Active Medical Staff and representatives from Dietary, Pharmacy and Nursing to act as consultants.

### 3.6.13.2 Functions:

3.6.13.2.1 Formulate, in cooperation with the Hospital pharmacist, drug policies and establish pharmacy procedures subject to approval of the Medical Executive Committee.

3.6.13.2.2 Develop a Hospital Formulary.

3.6.13.2.3 Shall recommend the trial, acceptance or discontinuance of drugs in the Hospital Formulary.

3.6.13.2.4 Will collaborate with the Nutrition Support Team, provide in-service education, develop protocols periodically, review products and equipment associated with nutritional support and make recommendations on their use and review individual cases as necessary.

### 3.6.13.3 Meeting Frequency:

Shall meet at least quarterly, or more often if necessary, and submit reports to the Medical Executive Committee on all activities and issues.

## 3.6.14 Graduate Medical Education Committee

3.6.14.1 Membership: Should consist of the following voting members:

3.6.14.1.1 The Director of Medical Education (DME) and/or Designated Institutional Officer (DIO)

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- 3.6.14.1.2 The Program Directors for each accredited residency program
- 3.6.14.1.3 A minimum of two peer-selected residents from among the accredited residency programs
- 3.6.14.1.4 A quality improvement or patient safety officer or designee
  - 3.16.14.1.5 A minimum of two active staff members other than program directors
  - 3.6.14.1.6 At least one member of the Medical Executive Committee
- 3.6.14.2 Meetings:
  - 3.6.14.2.1 Must meet a minimum of once every quarter during each academic year.
  - 3.6.14.2.2 Each meeting of the GMEC must include attendance by at least one resident
  - 3.6.14.2.3 GMEC must maintain meeting minutes that document execution of all required GMEC functions and responsibilities
- 3.6.14.3 Responsibilities:
  - 3.6.14.3.1 Oversight of the AOA/ACGME accreditation status of the Sponsoring Institution and each of its AOA/ACGME-accredited program
  - 3.6.14.3.2 Oversight of the quality of the GME learning and working environment within the Sponsoring Institution and each of its AOA/ACGME accredited programs, and its participating sites
  - 3.6.14.3.3 Oversight of the quality of educational experiences in each AOA/ACGME accredited program that lead to measurable achievement of educational outcomes as identified in the AOA/ACGME Institutional Requirements and in the Common and specialty-specific Program Requirements
  - 3.6.14.3.4 Oversight of the AOA/ACGME-accredited programs' annual evaluation and improvement activities
  - 3.6.14.3.5 Oversight of all processes related to reductions and closures of individual AOA/ACGME-accredited programs, major participating sites, and the Sponsoring Institution
  - 3.6.14.3.6. Oversight of institutional GME policies and procedures
  - 3.6.14.3.7 Review of annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits
  - 3.6.14.3.8 Oversight of applications for AOA/ACGME accreditation of new programs and/or requests for permanent changes in resident/fellow complement
  - 3.6.14.3.9 Oversight of major changes in each of its AOA/ACGME-accredited programs' structure or duration of education
  - 3.6.14.3.10 Oversight additions and deletions of each of its AOA/ACGME-accredited programs' participating sites

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3.6.14.3.11 Recommend appointment of new program directors to Administration and the Medical Executive Committee

3.6.14.3.12 Provide oversight of the subcommittees of the GMEC.

3.6.14.3.13 Develop responses to Clinical Learning Environment Review (CLER) reports

3.6.14.3.14 Review exceptions to duty hour requirements

3.6.14.3.15 Oversight of any appeal processes related to an adverse action by a Review Committee

3.6.14.3.16 Oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR)

3.6.14.3.17 Identify institutional performance indicators for the AIR

3.6.14.3.18 Demonstrate effective oversight of underperforming program(s) through a Special Review process including the criteria for identifying underperformance and the quality improvement goals, corrective actions and monitoring of outcomes by GMEC

3.6.14.3.19 Recommend interns and residents from among the applicants to Administration, the Medical Executive Committee, and the Board of Trustees.

3.6.14.3.20 A GMEC representative shall provide a minimum of quarterly reports to the Medical Executive Committee.

3.6.14.3.21 Oversight of the institution's medical library including:

3.6.14.3.21.1 Review on an annual basis of the functions of the Medical library, the collection of textbooks, periodicals and computer services

3.6.14.3.21.2 Review the acquisition, purchase or discarding of educational materials

3.6.14.3.21.3 Assist the medical librarian or designee in charge of the medical library to establish rules and regulations for use of the medical library

3.6.14.3.22 Submit a written annual executive summary of the AIR to Administration provided by the DME/DIO.

3.6.14.5 Institutional Requirements:

3.6.14.5.1 Develop an annual self-study including (AIR):

3.6.14.5.1.1 Results of surveys of residents and core faculty members

3.6.14.5.2 Notifications for each of the AOA/ACGME accredited programs' accreditation status and program self-study visits

3.6.14.5.2 Monitoring procedures for action plans resulting from the review

3.6.14.6 DME/DIO Responsibilities:

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3.6.14.6.1 Shall be appointed by the Chief Executive Officer with approval of the Medical Executive Committee and the Board of Trustees after consultation with the GMEC

3.6.14.6.2 Coordinate all medical education for Medical Staff, house staff, and externs, ensuring that these activities are related, at least in part, to the type and nature of care offered by the hospital (i.e. patient population served, types of services, the hospital's mission), and the findings of Performance Improvement activities.

3.6.14.6.3 Ensure that the minimum requirements for accreditation of training programs for the Residents and Medical Students are met by compliance with AOA/ACGME training policies

3.6.14.6.4 Implement all policy for Residents and Medical Student training as outlined by the GMEC

## **3.6.15 Medical Staff Peer Review / Medical Care Evaluation**

### **3.6.15.1 Membership**

The membership shall be a multidisciplinary group composed and appointed as indicated below.

Shall consist of:

- 3.6.15.1.1 At least three active medical staff members
- 3.6.15.1.2 CEO
- 3.6.15.1.3 Director of Medical Records or designee (as needed)
- 3.6.15.1.4 Director of Risk Management
- 3.6.15.1.5 Nurse Reviewer
- 3.6.15.1.6 Director of Medical Quality

3.6.15.2 The functions and responsibilities shall be as outlined in the Performance Improvement Plan and the Peer Review Policy.

3.6.15.3 The Medical Staff Peer Review Committee shall function in a manner that is:

- 3.6.15.3.1 Consistent. Peer review is conducted according to defined policies and procedures for all cases meeting the organization's definition of reviewable circumstances.
- 3.6.15.3.2 Timely. The time frames specified in the peer review procedures are adhered to reasonably.
- 3.6.15.3.3 Defensible. The conclusions reached through the process are supported by a rationale that specifically addresses the issues for which the peer review was conducted, including, as appropriate, reference to the literature and relevant clinical practice guidelines.
- 3.6.15.3.4 Balanced. Opinions and views of the physician being reviewed are considered and recorded, in addition to those offered by the reviewer.
- 3.6.15.3.5 Useful. The results of peer review activities are considered in practitioner-specific credentialing and privileging decisions and, as appropriate, in the organization's performance improvement activities.
- 3.6.15.3.6 Ongoing. Peer review conclusions are tracked over time, and actions based on peer review conclusions are monitored for effectiveness.

3.6.15.4 When the findings of quality assurance or performance improvement activities are relevant to the performance of an individual who is a Medical Staff member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual's

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competence pursuant to the Bylaws as well as policy and procedure. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately.<sup>12</sup>

## 3.6.15.5 Mortality Review Function<sup>13</sup>

3.6.15.5.1 Review all mortalities<sup>14</sup>

3.6.15.5.2 Determine whether all cases had appropriate evaluation and care<sup>15</sup>

3.6.15.5.3 Evaluate to see if attending physician was aware of the critical nature of the case as noted in the physician's orders, laboratory procedures ordered, and timeliness of consultation orders<sup>16</sup>

3.6.15.5.4 Review and analyze the supervision of mortalities beginning with the early recognition of complications, reevaluation based on clinical and laboratory studies, and modification of the therapeutic regime in accordance with the changing condition of the patient to determine if the diagnosis can be supported<sup>17</sup>

3.6.15.5.5 Report educationally interesting cases to CME Committee for potential instructional use of the attending and house staffs<sup>18</sup>

## 3.6.15.6 Transfusion Review Function<sup>19</sup>

3.6.15.6.1 Establish policies governing all transfusions of blood and blood by-products, systems for reporting transfusion reactions and evaluate such policies and procedures at regular intervals<sup>20</sup>

3.6.15.6.2 Investigate all transfusion reactions occurring in the hospital<sup>21</sup>

3.6.15.6.3 Recommend improvement in transfusion procedures<sup>22</sup>

3.6.15.6.4 Develops policies and procedures related to infectious blood and blood products.<sup>23</sup>

## 3.6.15.7 Meeting Frequency:

The Medical Staff Peer Review Committee shall meet at least bi-monthly and shall maintain a permanent record of its proceedings and activities, and submit reports to the MEC on all activities and issues.

## ARTICLE IV – Organization of Meetings

### 4.1 General Medical Staff Meetings

4.1.1 One meeting shall be designated as the annual meeting. Officers shall be elected and installed at that meeting in even numbered years, for a two (2) year period.

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<sup>12</sup> MS.8.3; 42 C.F.R. §482.22(a)(1)

<sup>13</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.10.01

<sup>14</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.10.01

<sup>15</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.10.02

<sup>16</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.10.03

<sup>17</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.10.04

<sup>18</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.10.05

<sup>19</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.14.01

<sup>20</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.14.01

<sup>21</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.14.02

<sup>22</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.14.03

<sup>23</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.14.04

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- 4.1.2 Meetings will be held four (4) times per year.
- 4.1.3 Special meetings may be called at any time by the Medical Staff President on written notice or by verbal communication to the Medical Staff in emergency situations, giving the reasons for calling the meeting. Special meetings may also be called on written request to the Medical Staff President by any ten (10) members of the Active Staff.
- 4.1.4 The rules contained in Robert's Rules of Order (as most recently revised) shall govern the Medical Staff in all cases to which they are applicable, and in which they are not inconsistent with the Bylaws or special rules of the Staff Organization.
- 4.1.5 **Executive Session Provision**<sup>24</sup> – The Medical Staff President / designee may call for an executive session with at least one member of administration present, determined by the Hospital Administrator, in order to act with a degree of freedom in order to address extremely sensitive issues of self governance

## 4.2 Quorum

- 4.2.1 At least one-third of the active staff members, not including provisional active members, shall constitute a quorum for the transaction of business at any Staff meeting. The votes of a majority of those present at the meeting shall be sufficient to decide any matter except as otherwise specified.

## 4.3 Agenda of Regular Medical Staff Meeting

Regular Staff meetings shall include the following format:

- 4.3.1 Education Programs (as appropriate)
- 4.3.2 Staff Business
  - 4.3.2.1 Action on previous Staff meeting minutes
  - 4.3.2.2 Reading of the Medical Executive Committee minutes as needed.
  - 4.3.2.3 Hospital President's Report
  - 4.3.2.4 Staff Board Representative's Report as needed.
  - 4.3.2.5 Medical Staff President's Report
  - 4.3.2.6 Special Announcements or Reports
  - 4.3.2.7 Old Business
  - 4.3.2.8 New Business
  - 4.3.2.9 Adjournment

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<sup>24</sup> 2001 AOA Accreditation Requirements for Healthcare Facilities Standard/Element 03.03.01

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## ARTICLE V – Financial Obligation of Staff Members

### 5.1 All Medical Staff Members

- 5.1.1 The annual dues of each member of the Medical Staff shall be payable upon receipt of invoice.
- 5.1.2 Notice of dues for the ensuing year shall be mailed to the members before the end of the Staff year by the Secretary/Treasurer.
- 5.1.3 Monies collected as dues shall be retained by the Secretary/Treasurer of the Medical Staff for use in the administration of Medical Staff business.
- 5.1.4 Honorary Staff members shall not be required to pay dues.
- 5.1.5 The MEC may waive the dues of an individual practitioner or a group of practitioners as deemed appropriate to benefit the Medical Staff and the Hospital.

### 5.2 Delinquency

Delinquency of payment of all required dues automatically results in voluntary relinquishment of medical staff membership and privileges, without any due process rights including those set forth in these Bylaws.



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## ARTICLE VI – Allied Health Providers

### 6.1 Introduction

When it is recommended by the Medical Staff and approved by the Hospital's Board that the services of any recognized Allied Health Provider are proper and necessary to the Hospital's function and patient treatment, the Medical Staff may establish and the Board may approve a category for the particular discipline of the allied health profession in question. Individuals who qualify as Allied Health Providers, in any category approved by the Board, may be considered for specific Clinical Functions only as recommended by the Medical Staff and approved by the Board, such approval to be consistent with applicable state licensing statutes and regulations and with recognized education, training, experience and certification.

### 6.2 Credentialing

The Medical Staff recommends to the Board the granting of Clinical Functions to Allied Health Providers. Such recommendations shall be based upon investigation and evaluation of the education, training, experience and demonstrated ability of the requesting individual, as well as on an assessment of the Hospital's available facilities and resources and of the patient care needs of the community. The applicable credentialing procedures set forth in these Bylaws, the Rules and Regulations and hospital policies will be followed in the granting of Clinical Functions to Allied Health Providers. Allied Health Providers are not required to participate in the pre-application process.

### 6.3 General Principles

The following items apply to all Allied Health Providers:

- 6.3.1 Periodic Review - The credentials of all the Allied Health Providers shall be reviewed every two (2) years. All Allied Health Providers are required to submit a reapplication form every two (2) years.
- 6.3.2 Identification - All Allied Health Providers shall wear identifying badges indicating their titles as designated and required by the Pennsylvania Department of Health.
- 6.3.3 Medical Staff Bylaws, Rules and Regulations - Allied Health Providers shall agree in writing to comply with those aspects of these Bylaws, the Rules and Regulations, and the Heart of Lancaster Regional Medical Center bylaws and policies that pertain to them.
- 6.3.4 Liability Insurance - The Allied Health Provider must show evidence of adequate professional liability coverage as determined annually by the Medical Executive Committee in compliance with Pennsylvania law.
- 6.3.5 Education - Allied Health Providers shall be graduates of approved schools or programs in their respective professions.
- 6.3.6 Progress Sheets – Dependent Allied Health Providers may record their observations and findings on the progress sheet. All such observations and findings must be countersigned by the Supervising Physician. The Allied Health Provider documentation in no way relieves the Physician from responsibilities for timely patient visits and completion of Physician progress notes.
- 6.3.7 The Allied Health Provider shall collaborate and cooperate with the administration in its compliance with Act 13.

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## 6.4 Dues

- 6.4.1 The annual dues of each Allied Health Provider shall be payable upon receipt of invoice.
- 6.4.2 Notice of dues for the ensuing year shall be mailed to the Allied Health Providers before the end of the Staff year by the Medical Staff Secretary/Treasurer.
- 6.4.3 Monies collected as dues shall be retained by the Secretary/Treasurer of the Medical Staff for use in the administration of Staff business.
- 6.4.4 Honorary Staff members shall not be required to pay dues.
- 6.4.5 The MEC may waive the dues of an individual practitioner or a group of practitioners as deemed appropriate to benefit the Medical Staff and the Hospital.

### Delinquency

Delinquency of payment of all required dues automatically results in voluntary relinquishment of Allied Health Provider functions without any due process rights including those set forth in these Bylaws

## 6.5 Due Process

- 6.5.1 Independent and Dependent Allied Health Providers employed by a Medical Staff Member:
  - 6.5.1.1 Allied Health Providers are entitled to only those due process procedures set forth in this section and are not entitled to the additional due process procedures set forth in Article X for medical staff members.
  - 6.5.1.2 An Allied Health Provider covered by this section shall have the right to request in writing an appeal of the Board's adverse decision regarding his/her clinical functions within thirty (30) days of such adverse decision. "Adverse decision" means the Board's determination to deny, decrease, or suspend for a period of more than thirty (30) days, clinical functions to an individual to whom this section applies. An adverse decision by the Board shall be in writing and shall state both the reason(s) for the adverse decision and the individual's right to appeal under this section, as well as the applicable timeframe. The individual's failure to request an appeal within such time limit shall constitute a final waiver of the individual's right to appeal the adverse decision.
  - 6.5.1.3 Upon the Board's receipt of a written request for appeal, the Board shall appoint a hearing examiner to hear the appeal, who shall be any person who does not have a direct economic interest in the outcome of the appeal, and who has not participated previously in the appealed matter. The hearing examiner shall schedule the hearing and notify the Board and the individual of the time, date and place of the hearing at least (30) days prior to the scheduled date.
  - 6.5.1.4 The hearing examiner shall preside over the hearing. At the hearing, the individual and the Board shall have the following rights: to be present; to present relevant evidence regardless of its admissibility in a court of law; to present, examine and cross examine witnesses; to submit a written statement within five (5) days following the close of the hearing; and to receive a written transcript of the hearing, of which the cost shall be borne equally by the Board and the individual. The individual's

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failure to appear for the hearing shall constitute a final waiver of the individual's right to appeal the adverse decision.

- 6.5.1.5 The burden of proof applicable to the hearing shall be as follows: The Board shall have the initial burden of presenting evidence supporting its adverse decision, but following such presentation the Allied Health Provider shall be responsible for proving by a preponderance of the evidence that the adverse decision lacks any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.
- 6.5.1.6 Within thirty (30) days of the later to occur of the close of the hearing or the hearing examiner's receipt of the hearing transcript, the hearing examiner shall render a final written decision of the appeal, which shall contain a concise statement of the reason(s) justifying the decision and shall deliver copies of such decision to the Board and the individual.
- 6.5.1.7 Upon the Board's receipt of the hearing examiner's written decision, it shall either (1) affirm the hearing examiner's decision, in which case the decision will be deemed final or (2) remand the matter back to the hearing examiner for further review or clarification. This remand process, which shall include the issuance of a supplementary written decision by the hearing examiner, shall not exceed thirty (30) days in duration.

### **6.6 Allied Health Providers employed by the Hospital:**

All Allied Health Providers employed by the Hospital/Central Penn Management Group are entitled to utilize only the due process procedures set forth in the Hospital's Employee Handbook.

### **6.7 Independent Allied Health Providers**

#### **6.7.1 Definition.**

For the purpose of these Bylaws, an Independent Allied Health Provider is a practitioner who practices clinical psychology (with a Ph D. or Psy. D), audiology, nurse midwifery (Certified Nurse Midwife) or chiropractic care and who is duly licensed by the appropriate professional licensing board of the Pennsylvania Department of State and who is authorized by Pennsylvania law to exercise independent judgment within the scope of their licensure, certification or registration and provide specific, direct patient care services, such services to be provided in conjunction with a physician member of the Active or Courtesy Medical Staff.

#### **6.7.2 Qualifications, Procedures and Responsibilities.**

- 6.7.2.1 Independent Allied Health Providers must hold a current license to practice from the Commonwealth of Pennsylvania or appropriate certification or registration in the Commonwealth of Pennsylvania to be considered for specific Clinical Functions. Applicants must fall under a category of Allied Health Providers established by the Medical Staff and approved by the Board and must meet postgraduate education requirements where applicable.
- 6.7.2.2 An applicant for Functions to provide specific patient care services shall submit an application provided by the Hospital, containing information set forth in these Bylaws.

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- 6.7.2.3 Clinical Functions granted to Independent Allied Health Providers shall be specifically delineated in the written Physician/Allied Health Associate Agreement and need not include all modes of treatment or surgery that may be within the definition of the practice of the Allied Health Associate as set forth in Pennsylvania statutes.
- 6.7.2.4 A patient who is to be treated in the Hospital by an Independent Allied Health Provider may only be admitted by a qualified Physician Member of the Medical Staff who has voluntarily agreed to accept responsibility for the medical needs of the patient that may be present at admission or that arise during hospitalization. Each such patient shall receive the same basic history and physical examination as required for other patients, such history and physical examination to be completed by or counter-signed by a qualified Physician Member of the Medical Staff.
- 6.7.2.5 Independent Allied Health Providers shall be assigned to the Department or service most relevant to the Clinical Functions granted and that department or service shall be responsible for the performance standards.
- 6.7.2.6 As a condition of continued Clinical Functions, Independent Allied Health Providers are required, when invited, to attend meetings involving clinical review of patient care in which they participated.
- 6.7.2.7 Independent Allied Health Providers are not eligible for Membership on the Medical Staff and therefore are not entitled to the rights and privileges of Medical Staff Membership.

### **6.8 Dependent Allied Health Providers**

#### **6.8.1 Definition.**

- 6.8.1.1 For the purpose of these Bylaws, an Dependent Allied Health Provider is an individual who is duly licensed by the appropriate professional licensing board of the Pennsylvania Department of State or certified or registered in the Commonwealth of Pennsylvania and who is authorized by Pennsylvania law to exercise independent judgment within the scope of their licensure, certification or registration and provide specific, direct patient care services, such services to be provided under the direct supervision of a physician member of the Active or Courtesy Medical Staff.

#### **6.8.2 Qualifications, Procedures and Responsibilities.**

- 6.8.2.1 Dependent Allied Health Providers must hold a current license to practice from the Commonwealth of Pennsylvania or appropriate certification or registration in the Commonwealth of Pennsylvania to be considered for specific Clinical Functions. Applicants must fall under a category of Allied Health Providers established by the Medical Staff and approved by the Board and must meet postgraduate education requirements where applicable.
- 6.8.2.2 An applicant for Functions to provide specific patient care services shall submit an application provided by the Hospital, containing information set forth in these Bylaws.
- 6.8.2.3 Clinical Functions granted to Dependent Allied Health Providers shall be specifically delineated in the written Physician/Allied Health Associate Agreement and need not include all modes of treatment or surgery that may be within the definition of the

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practice of the Dependent Allied Health Providers as set forth in Pennsylvania statutes.

- 6.8.2.4 A patient who is to be treated in the Hospital by an Dependent Allied Health Providers may only be admitted by a qualified Physician Member of the Medical Staff who has voluntarily agreed to accept responsibility for the medical needs of the patient that may be present at admission or that arise during hospitalization. Each such patient shall receive the same basic history and physical examination as required for other patients; such history and physical examination to be completed by or counter-signed by a qualified Physician Member of the Medical Staff.
- 6.8.2.5 Dependent Allied Health Providers shall be assigned to the Department or service most relevant to the Clinical Functions granted and that department or service shall be responsible for the performance standards.
- 6.8.2.6 As a condition of continued Clinical Functions, Dependent Allied Health Providers are required, when invited, to attend meetings involving clinical review of patient care in which they participated.
- 6.8.2.7 Dependent Allied Health Providers are not eligible for Membership on the Medical Staff and therefore are not entitled to the rights and privileges of Medical Staff Membership.

### **6.8.3 Activities –**

Except as specifically authorized, an Dependent Allied Health Providers shall:

- 6.8.3.1 Not perform any task or function without the Supervising or employing Physician being either physically present, immediately available as required by standard protocol, or immediately available within the Hospital to provide further guidance except in life threatening emergencies.
- 6.8.3.2 Not make a final or definitive diagnosis of disease or ailment or the absence thereof independent of the Supervising Physician;
- 6.8.3.3 Not independently prescribe any treatment or a regimen thereof;
- 6.8.3.4 Not, except as authorized by the provisions of applicable Pennsylvania law, prescribe, order, or dispense medication, or sign prescriptions on behalf of the Supervising Physician, or have prescription blanks available that have been pre-signed or stamped by a Physician, or order the refilling of a prescription.
- 6.8.3.5 Not replace the Supervising or employing Physician in making visits in the Hospital, emergency room or Hospital outpatient clinic;
- 6.8.3.6 Not initiate therapeutics on any patient before the Physician has seen the patient and ordered the method of treatment, except in life-threatening emergencies, or when care is rendered under standard protocols as authorized under Pennsylvania law and regulations (i.e. as specified in the written physician/CRNP collaborative agreement).
- 6.8.3.7 Not write orders unless specifically directed to do so by the Supervising or employing Physician and permitted to do so under Pennsylvania law. Orders are transcribed as verbal orders by the Dependent Allied Health Providers are to be countersigned by the Supervising or employing Physician within 24 hours.

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Under NO circumstances are Dependent Allied Health Providers permitted to sign-off on complete final discharge summaries.

## **6.9 Dependent Allied Health Providers Employed by the Hospital**

### **6.9.1 Procedures for Medical Staff Involvement in the Selection of Dependent Allied Health Providers Employed by the Hospital**

#### **6.9.1.1 The Hospital Administration shall:**

6.9.1.1.1 establish job descriptions for positions held or to be held by Dependent Allied Health Providers after consultation with the Department Chairperson to which each of the position's responsibilities most pertain, which shall specify the clinical responsibilities and Clinical Functions desired, as well as the name of the Medical Staff Member who, by his own choice, accepts responsibility for the supervision of the Dependent Allied Health Providers, and

6.9.1.1.2 obtain the approval of the MEC as to the content of each job description.

### **6.9.2 Clinical Functions of Dependent Allied Health Providers Employed by the Hospital May be Terminated Immediately for Any of the Following Reasons:**

6.9.2.1 Automatically upon termination of employment by the Hospital according to the Hospital's personnel policies;

6.9.2.2 Automatically upon the loss of license, certification or other regulatory status in Pennsylvania;

6.9.2.3 At such time a recommendation to terminate or suspend Clinical Functions is approved by the Board;

6.9.2.4 Immediately, according to procedures set forth in this Article relative to summary suspensions.

6.9.2.5 Action of any two (2) of the following: the President of the Medical Staff (or designee), the Hospital Administrator, and the appropriate Department Chairperson who may suspend the Clinical Functions of an Dependent Allied Health Provider for a period of up to thirty (30) days when there is potential harm to the health and welfare of patients, employees and/or others associated with the Hospital. Such suspension will be reviewed by the MEC which will recommend disposition of the case for final action by the Board.

## **6.10 Dependent Allied Health Providers Employed by a Medical Staff Member**

### **6.10.1 Procedures for Approving Functions for Dependent Allied Health Providers Employed by Medical Staff Member**

6.10.1.1 The employer of the Dependent Allied Health Provider shall submit a completed application form, provided by the Hospital, indicating the Clinical Functions and responsibilities proposed to be assigned to the individual Dependent Allied Health Provider, together with information concerning the individual's education, experience, professional liability insurance coverage, background and current licensure, certification, or other regulatory status in the Commonwealth of

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Pennsylvania. In the case of a Physician Assistant, information furnished by, or on behalf of, the individual to the appropriate state licensing board shall also be submitted. The application shall be signed by both the employer and the Dependent Allied Health Provider.

- 6.10.1.2 The application shall be given to the appropriate Department Chairperson(s) and the Credentials Committee for review and recommendation. Upon receipt of these recommendations, the MEC will make a recommendation to the Board on the disposition of the request for Clinical Functions, such recommendations to include a proposed list delineating specific Clinical Functions, if appropriate.
  - 6.10.1.3 The recommendation of the MEC shall be presented to the Board for action. However, prior to the submission of the MEC's recommendation to the Board, the employer, if he/she so requests it in writing, is entitled to a meeting with the MEC to discuss the application. The minutes of such a meeting will be included with the information included with the MEC's recommendation to the Board. The Board shall establish hearing and appeal procedures for Dependent Allied Health Providers who are not employed by the hospital. The Board's action on requests for Clinical Functions shall be final.
- 6.10.2 Clinical Functions of Dependent Allied Health Providers Employed by a Member of the Medical Staff May be Terminated Immediately for any of the Following Reasons:
- 6.10.2.1 termination of Medical Staff appointment of the employer or the termination or expiration of the employer's registration with the appropriate Pennsylvania professional licensing board;
  - 6.10.2.2 curtailment of the employer's Clinical Functions to the extent that the services of the individual are no longer necessary or permissible to assist the employer;
  - 6.10.2.3 termination of employment of the Dependent Allied Health Provider;
  - 6.10.2.4 loss by the Dependent Allied Health Provider of professional liability insurance coverage, licensure, certification, or other regulatory status in the Commonwealth of Pennsylvania;
  - 6.10.2.5 recommendation of the MEC and with the approval of the Board; or
  - 6.10.2.6 action of any two (2) of the following: the President of the Medical Staff (or his designee), the Hospital Administrator, and the appropriate Department Chairperson who may suspend the Clinical Functions of a Dependent Allied Health Provider for a period of up to thirty (30) days when there is potential harm to the health and welfare of patients, employees and/or others associated with the Hospital. Such suspension will be reviewed by the MEC which will recommend disposition of the case for final action by the Board.
- 6.10.3 The approval of Clinical Functions for an Dependent Allied Health Provider employed by a Medical Staff Member is conditioned upon the employer meeting the following requirements:
- 6.10.3.1 accepting full responsibility and accountability for the conduct of his employee within the Hospital;

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6.10.3.2 accepting responsibility to acquaint the Dependent Allied Health Provider with the Rules and Regulations and the Medical Staff policies applicable to the Department or service to which the Medical Staff Member is assigned;

6.10.3.3 furnishing continued evidence of adequate professional liability insurance coverage, as determined by the MEC and the Board, for the acts and omissions of the Dependent Allied Health Provider; and

6.10.3.4 maintaining Membership on the Medical Staff as either an Active, Courtesy, or Provisional Member.

### **6.11 Granting of Temporary Functions for Independent and Dependent Allied Health Providers**

6.11.1 If temporary privileges are requested during the initial application process, Medical Staff Office requires the same documents.

6.11.2 Medical Staff Office will perform verification process:

6.11.2.1 Review application and clinical Functions form for completeness and required signatures.

6.11.2.2 Verify applicant's state licensure and if in good standing.

6.11.2.3 Allied Health Provider must meet all hospital orientation requirements once temporary or provisional credentialing is granted.

6.11.3 If all documents, application and verifications are in order, applicant information will be presented to the Department Chairperson, the Chairperson of the Credentials Committee, the Medical Staff President, then the Hospital Administrator. If approved, the applicant will receive temporary Functions until the application process is complete. Confirming letter will be sent to applicant. If not approved, additional information that is required will be followed up and presented again for review and approval.

6.11.4 Interviews may be scheduled with the Credentials Committee as deemed necessary.

### **6.12 Allied Health Assistants**

6.12.1 Definition

Allied Health Assistants are persons who: (1) are duly qualified by training experience and certification and/or licensure to provide specific patient care services under the direct supervision of a Physician; (2) are either employed by a Member of the Medical Staff or by the Hospital; and (3) are governed by this Section. Allied Health Assistants do not exercise any degree of independent practice in the management of patients. These include but are not limited to: dental assistants, OR techs, LPN's and 1<sup>st</sup> and 2<sup>nd</sup> assistants. The above listed will not be required to be credentialed but will be subject to HLRMC's current Human Resource hiring procedures and policies. RN first assistants, and other non MD/DO surgical assistants are subject to the credentialing process defined elsewhere in these Bylaws.

6.12.2 Qualifications, Procedures and Responsibilities



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- 6.12.2.1 The employer will remain responsible, at all times, for all acts of any of his Allied Health Assistants within the Hospital. Correspondingly, the Hospital, through its designated Supervising Physicians, will be responsible for each of its Allied Health Associate employees.
- 6.12.2.2 Not perform any task or function without the Supervising or employing physician being either physically present, immediately available as required by standard protocol, or immediately available within the Hospital to provide further guidance except in life threatening emergencies.
- 6.12.2.3 The employer shall accept the responsibility to acquaint the Allied Health Assistant with the Rules and Regulations and the Medical Staff policies applicable to the Department or service to which the Medical Staff Member is assigned.
- 6.12.2.4 The employer shall furnish continued evidence of adequate professional liability insurance coverage as determined by the Board for the actions and omissions of his Allied Health Assistants.
- 6.12.2.5 The employer shall be registered with the Pennsylvania Board of Osteopathic Examiners, or the Pennsylvania State Board of Medicine as designated in its current rules.
- 6.12.2.6 Any modifications of the Clinical Functions or responsibilities of Allied Health Assistants not become effective until the changes have been approved by the department chairman.
- 6.12.2.7 Allied Health Assistants are not eligible for Medical Staff Membership and, therefore, are not entitled to the rights and privileges of Medical Staff Membership; provided however, that Allied Health Assistants are encouraged, but not required to attend Medical Staff meetings.
- 6.12.2.8 Allied Health Assistants are not entitled to the due process provisions set forth in these bylaws.
- 6.12.2.9 Each Supervising Physician shall designate at least one (1) physician, who is also registered as required in subparagraphs, above, to provide substitute supervision of his Allied Health Assistant in his absence or when he is unable to provide requisite aid to this individual.

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## 6.13 Allied Health Assistants Employed by a Medical Staff Member

### 6.13.1 Procedures for Approving Functions for Allied Health Assistants Employed by Medical Staff Member

6.13.1.1 The employer of the Allied Health Assistant shall submit a completed application form, provided by the Hospital, indicating the Clinical Functions and responsibilities proposed to be assigned to the individual Allied Health Assistant, together with information concerning the individual's education, experience, professional liability insurance coverage, background and current licensure, certification, or other regulatory status in the Commonwealth of Pennsylvania. Information furnished by, or on behalf of, the individual to the appropriate state licensing board shall also be submitted. The application shall be signed by both the employer and the Allied Health Assistant.

6.13.1.2 The application shall be given to the appropriate Department Chairperson(s) for approval.

### 6.13.2 Clinical Functions of Allied Health Assistants Employed by a Member of the Medical Staff May be Terminated Immediately for any of the Following Reasons:

6.13.2.1 termination of Medical Staff appointment of the employer or the termination or expiration of the employer's registration with the appropriate Pennsylvania professional licensing board;

6.13.2.2 curtailment of the employer's Clinical Functions to the extent that the services of the individual are no longer necessary or permissible to assist the employer;

6.13.2.3 termination of employment of the Allied Health Assistant;

6.13.2.4 loss by the Allied Health Assistant of professional liability insurance coverage, licensure, certification, or other regulatory status in the Commonwealth of Pennsylvania;

6.13.2.5 recommendation of the MEC and with the approval of the Board; or

6.13.2.6 action of any two (2) of the following: the President of the Medical Staff (or his designee), the Hospital Administrator, and the appropriate Department Chairperson who may suspend the Clinical Functions of a Allied Health Assistant for a period of up to thirty (30) days when there is potential harm to the health and welfare of patients, employees and/or others associated with the Hospital. Such suspension will be reviewed by the MEC which will recommend disposition of the case for final action by the Board.

### 6.13.3 The approval of Clinical Functions for an Allied Health Assistant employed by a Medical Staff Member is conditioned upon the employer meeting the following requirements:

6.13.3.1 accepting full responsibility and accountability for the conduct of employee within the Hospital;

6.13.3.2 accepting responsibility to acquaint the Allied Health Assistant with the Rules and Regulations and the Medical Staff policies applicable to the Department **or service** to which the Medical Staff Member is assigned;

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6.13.3.3 furnishing continued evidence of adequate professional liability insurance coverage, as determined by the MEC and the Board, for the acts and omissions of the Allied Health Assistant; and

6.13.3.4 maintaining Membership on the Medical Staff as either an Active, Courtesy Member.

### **6.14 Allied Health Assistants Employed by the Hospital**

6.13.1 Allied Health Assistants employed by the hospital are subject to the policies and procedures as outlined in the Employee Handbook and will be hired through HLRMC's Human Resource hiring process.

6.13.2 Clinical Functions of Allied Health Assistants Employed by the Hospital May Be Terminated For Any of the Following Reasons:

6.13.2.1 automatically upon termination of employment by the Hospital according to the Hospital's personnel policies;

6.13.2.2 automatically upon the loss of license, certification or other regulatory status in Pennsylvania;

6.13.2.3 action of any two (2) of the following: President of the Medical Staff (or designee), the Hospital Administrator, and the appropriate Department Chairperson who may suspend the Clinical Functions of an Allied Health Assistant for a period of up to thirty (30) days when there is potential harm to the health and welfare of patient, employees and/or others associated with the Hospital. Such suspension will be reviewed by the MEC which will recommend disposition of the are for final action by the Board.

9/97

Approved by Board of Trustees 1/98

Changes made (podiatry moved from Courtesy to AHP 1/98 By C&B

9/98

2/01

6/03

5/04 Changes Approved by Board of Trustees

10/05 Changes Approved by Board of Trustees

4/06 Changes approved by the Board of Trustees

10/06 Changes approved by the Board of Trustees

08/07 Changes approved by the Board of Trustees

Changes approved (BOT) 10/08 , 04/10

BOT approved: 01/12; BOT approved 05/13 BOT approved 09/15

# UPMC Pinnacle Lititz Medical Staff Bylaws

## 7. ARTICLE – VII Amendments

Proposed amendment to these bylaws or rules and regulations may be originated by the MEC or by written documentation of a 51% Majority of the active staff.

At least 51% of the active staff must propose to adopt a Medical Staff rule, regulation, policy or an amendment. They must first communicate the proposal, in writing, to the Medical Executive Committee at least 30 days prior to the next regularly scheduled meeting of the Board of Trustees. If the MEC proposes to adopt a Medical Staff rule, regulation or amendment, it must first communicate the proposal to the Medical Staff.

### 7.1 Bylaws

These Bylaws may be amended by a majority of those voting at any regular or special meeting provided that at least 51% of the eligible staff members are present at the time of the vote. If a written vote between regular or special meetings is conducted, the Bylaws may be amended by 51% of the total eligible staff members. If acted on at a regular or special business meeting or by written vote, all members are to be notified in writing at least 30 days before the meeting or vote.

These Bylaws may also be amended by the Medical Executive Committee in accordance with these Bylaws. Such amendments shall be reported to the Medical Staff at its next regular meeting.

Amendments shall become effective upon approval by the Board of Trustees.

### 7.2 Rules and Regulations

The Rules and Regulations may be amended by the Medical Executive Committee in accordance with these Bylaws. Such amendments shall be reported to the Medical Staff at its next regular meeting. Changes shall become effective upon approval by the Board of Trustees.

In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC is delegated to provisionally adopt and the Board of Trustees may provisionally approve this amendment without prior notification of the Medical Staff. The Medical Staff will be immediately notified of the provisional approval and will have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict, 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 will be implemented. If necessary, a revised amendment is then submitted to the Board of Trustees for action.

### 7.3 Policies

New or revised policies affecting the Medical Staff shall be presented to the Medical Executive Committee for review or approval. Changes shall become effective upon approval by the Board of Trustees. Proposed changes to policies affecting the medical staff will be sent to the active medical staff members for review prior to approval

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## 7.4. Conflict

Conflict between the Medical Staff and the MEC, including but not limited to proposals to adopt a rule, regulation, or policy or amendment will be referred to the Medical Standards Committee. Referral to the Medical Standards Committee does not prevent the majority of the active staff from communicating with the Board of Trustees on a rule, regulation, amendment or policy. The Board of Trustees will determine the method of communication to be used by the majority of the active staff in this instance.

# UPMC Pinnacle Lititz Medical Staff Bylaws

## 8. ARTICLE VIII - Adoption

### 8.1 Adoption

These Bylaws may be adopted by a majority of those present at any regular meeting of the Medical Staff provided that at least 51% of eligible staff members are present, and shall become effective when approved by the Board. If a written vote between regular or special meetings is conducted, the Bylaws may be adopted by 51% of the total eligible staff members. They shall, when adopted and approved, be equally binding on all members of the medical staff and shall be recognized by the Board of Trustees as the Constitution and Bylaws under which the Medical Staff shall operate.

### 8.2 Authority

Subject to the authority and approval of the Board of Trustees, the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associates rules and regulations and policies and under the Board of Trustees bylaws of the Hospital in compliance with law and regulation.

### 8.3 Approval

These Bylaws were adopted by the Medical Staff of the Heart of Lancaster Regional Medical Center on:  
September 15, 1998; July 1999; February 2001; June 2003; December 2003;  
January 2004; May 2004; February 2006; September 2006; June 2007; October 2008;  
October 2009; March 2010, October 28, 2009, 04/28/2010, 01/12, 05/13, 09/15, 01/16

David J. Simons, D.O., Medical Staff President

Deborah Willwerth CEO, Secretary Board of Trustees

### 8.4 Successor in Interest

These Bylaws, and privileges of individual members of the medical staff accorded under these Bylaws, will be binding upon the Medical Staff, and the Board of Trustees of any successor in interest in this hospital, except where hospital medical staff are being combined. In the event that the staffs are being combined, the Medical Staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospitals' Board of Trustees or its successor in interest. Until such time as the new Bylaws are approved, the existing Bylaws of each institution will remain in effect.

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## 9. ARTICLE IX – CREDENTIALING AND RE-CREDENTIALING

### 9.1 Requirements for Appointment

#### 9.1.1 Eligibility, Qualifications, Basic Responsibilities and Conditions and Duration

All persons practicing medicine, dentistry, or oral surgery in the Hospital, unless specifically exempted by these Bylaws, must first have been granted Membership and Privileges on the Medical Staff and meet the Basic Qualification for membership as outlined.

Criteria for appointment may not include sex, race, creed, national origin, handicap or other considerations not impacting the applicant's ability to discharge the privileges for which he/she has applied.

### 9.2 Application for Initial Appointment and Clinical Privileges

#### 9.2.1 Submission of Application

All applicants for initial appointment to the Medical Staff shall submit to the Medical Staff office. A written and signed application on the form developed with all provisions completed (or accompanied by an explanation of why omitted reasons are unavailable), and any application fee. The form shall be obtained from Medical Staff office. When an applicant is sent an application form, he/she shall be given a copy of the Medical Staff Bylaws and the Rules and Regulations. Upon receipt of a fully completed application, the Medical Staff office shall notify the Administrator of the Hospital and the Department Chairperson in which the applicant seeks Clinical Privileges. The application or a copy thereof will be transmitted to the Credentials Committee.

#### 9.2.2 Application Form

The initial application form shall be approved by the MEC. The application shall require detailed information concerning the applicant's professional qualifications and character and shall include, but not be limited to, the following:

- 9.2.2.1 the names of at least three (3) Physicians in the same specialty who have had recent experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's present professional competence and ethical character;
- 9.2.2.2 information as to whether the applicant's Medical Staff appointment or Clinical Privileges have ever been voluntarily or involuntarily denied, revoked, suspended, investigated, reduced or not renewed at any other hospital or health care facility;
- 9.2.2.3 information as to any investigation or previously successful or pending challenges against the applicant's membership in local, state or national medical societies or license to practice any profession in any state, or federal license to prescribe and administer controlled substance or voluntary relinquishment of

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license or DEA certification. The submitted application shall include a copy of all of the applicant's current licenses to practice, as well as current federal narcotics license, if issued;

9.2.2.4 information relative to board certification status with and appropriate national specialty board, if applicable;

9.2.2.5 information as to whether the applicant currently has professional liability insurance coverage in force, the name of the insurance company, and the coverage amounts and classification of coverage;

9.2.2.6 information concerning the applicant's malpractice experience, including any claims, final judgments or settlements;

9.2.2.7 a consent to release necessary information from applicant's present and past malpractice insurance carriers and a consent to obtain necessary information from other third parties and a full waiver and release of liability to the third parties providing the information;

9.2.2.8 a request for the specific Clinical Privileges desired by the applicant; and

9.2.2.9 such other information as the Board or Credentials Committee may require.

9.2.2.10 Documentation as to the identity of the applicant i.e., federally or state issued ID such as a drivers license, military ID or passport.

9.2.2.11 Information relevant as to whether the provider has been excluded, suspended, or otherwise declared ineligible for cause from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets criteria for mandatory exclusion, suspension or ineligibility from such programs, or has knowledge of being under investigation by any such program.

### **9.3. Terms of Application**

Every application for appointment shall be signed by the applicant and shall contain the applicant's:

9.3.1 specific acknowledgment of the obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the applicant has responsibility;

9.3.2 acknowledgment that the current Bylaws and the Rules and Regulations and any relevant staff manuals have been received and read and agreement to be bound by the terms in all matters relating to consideration of the application whether or not appointment to the Medical Staff is granted;

9.3.3 agreement to abide by these and subsequent Bylaws and the Rules and Regulations as shall be in force for the duration of Membership on the Medical Staff;



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- 9.3.4 agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by the Medical Staff;
- 9.3.5 agreement to appear for personal interviews in regard to the applications;
- 9.3.6 agreement to abide by generally recognized principles of professional ethics;
- 9.3.7 agreement to refrain from fee splitting or other inducements relating to patient referral;
- 9.3.8 agreement to not deceive a patient as to the identity of any other Practitioners performing surgery, providing treatment or services;
- 9.3.9 agreement to only delegate the responsibility for the diagnosis and treatment of patients to qualified Practitioners;
- 9.3.10 agreement to exhaust the administrative remedies offered by these Bylaws before taking legal action when an adverse ruling is made concerning appointment to the Medical Staff status or Clinical Privileges;
- 9.3.11 statement that the information provided with the application is true and correct to the applicant's knowledge, information and belief, and an understanding that false, incorrect or misleading information provided by applicant shall be grounds for rejection of the application;
- 9.3.12 a statement acknowledging the applicant's responsibility for timely payment of dues and assessments, if any; and
- 9.3.13 a statement acknowledging the applicant is subject to review when appointment is made, as part of the hospital's performance improvement activities.
- 9.3.14 a current photograph.

### **9.4 Application Fee**

The Hospital may require payment of an initial appointment application fee. The amount of the application fee, if any, shall be set by the MEC.

#### **9.4.1 Release and Immunity from Liability**

The following are applicable to any Member or Practitioner applying to the Medical Staff for appointment and reappointment. These statements or summary shall be included on the application form, and by applying for appointment to the Medical Staff and for Clinical Privileges, the applicant or Member expressly accepts these conditions during the processing and consideration of application, whether or not appointment to the Medical Staff and Clinical Privileges are granted, as well as for the duration of Membership:

9.4.1.1 To the fullest extent permitted by law, the applicant or Member extends absolute immunity and release from liability the Medical Staff, the Hospital, the

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Board, their authorized representatives and any third party providing information from any and all civil liability arising from any acts, communications, reports, recommendations, or disclosures involving the applicant or Member, either performed, made or received in good faith, by the Medical Staff, the Hospital, the Board and their authorized representatives, specifically including, but not limited to, Members of its Medical Staff by or from any third party concerning activities relating to, but not limited to:

- 9.4.1.2 applications for appointment or Clinical Privileges, including temporary Privileges or expansion of privileges;
- 9.4.1.3 periodic reappraisals undertaken for reappointment or for increase or decrease in Clinical Privileges;
- 9.4.1.4 proceedings for suspension of Clinical Privileges or revocation of Staff Membership;
- 9.4.1.5 summary suspension;
- 9.4.1.6 hearings and appellate review;
- 9.4.1.7 medical care evaluation;
- 9.4.1.8 utilization review;
- 9.4.1.9 other Hospital, Department or committee activities conducted under Hospital auspices relating to the quality of patient care or the professional conduct of a Practitioner; and concerning matters relating to an applicant's or Member's professional qualifications, credentials, clinical competence, ethics, character, including, prior to final appointment, mental or emotional stability and physical condition pertinent to applicant's ability to perform the essential functions of his or her practice without threat of harm to himself, herself or to others, or any other matter that might directly or indirectly have an effect on the individual's competence or the quality of patient care, or the orderly operation of this or any other hospital or health care facility, including otherwise privileged or confidential information.
- 9.4.1.10 Any act or communication with respect to any applicant or Member made in good faith and at the request of an authorized representative of the Medical Staff or the Board or any other hospital or health care facility, for the purposes set forth above, shall be privileged to the fullest extent permitted by law and shall extend to Members of the Medical Staff, the Board and their authorized representatives and to any third parties who supply information to any of the foregoing authorized to receive, release or act upon same.
- 9.4.1.11 The Medical Staff, the Board and their designated representatives are specifically authorized to:
  - 9.4.1.11.1 consult with the management and members of the medical staffs of other hospitals, health care facilities or institutions with which the applicant or Member has been associated, and

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with others who may have information bearing on competence, character and ethical qualifications;

9.4.1.11.2 inspect all records and documents that may be material to an evaluation of: (I) the applicant's or Member's professional qualifications or competence to perform the Clinical Privileges requested or currently possessed; and (II) the moral and ethical qualifications or stability as they may directly or indirectly affect the individual's competence, patient care or the operation of this Hospital or any other health care facility;

9.4.1.11.3 inquire with and receive a report from the National Practitioners Data Bank on the applicant or Member; and

9.4.1.11.4 report to the Pennsylvania Bureau of Professional and Occupational Affairs professional review actions required to be reported pursuant to HCQIA or other applicable statute or regulation. .

9.4.1.12 The applicant or Member specifically releases from any liability the Medical Staff, the Hospital, the Board and any and all of their designated representatives or agents, for statements made or acts performed in good faith in evaluating the applicant for any of the purposes or reasons set forth in these bylaws.

### **9.4.2 Burden of Providing Information**

The applicant shall have the burden of producing a completed application and adequate information for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications within four (4) months from the date of original submission of the application. The absence of requested information shall constitute an incomplete application which shall not be processed until such time as the applicant fulfills responsibility to provide the requested information or cause it to be provided. He/she shall have the burden of providing evidence that all the statements made and information given on the application are factual and true.

### **9.4.3 Automatic Withdrawal**

If the applicant fails to complete the application or have the required information submitted within four (4) months from the date of original submission, the application shall automatically be considered withdrawn. A thirty-day extension may be requested in writing prior to the end of the four (4) months; such a request should be addressed to the chairperson of the Credentials Committee and may be granted for good cause at the discretion of the committee chairperson. Thirty-day extensions may be granted no more than two times.

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## 9.5 Description of Initial Clinical Privileges

### 9.5.1 Delineation of Clinical Privileges

Each Practitioner appointed to the Medical Staff shall be entitled to exercise only those Clinical Privileges recommended by the MEC and approved by the Board. When requested, the practitioner is required to submit any reasonable evidence of current ability to perform privileges that may be requested. The Clinical Privileges recommended to the Board shall be based upon the applicant's current licensure, education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal of the applicant's or Member's qualifications by the Department(s) in which such Privileges are sought. All individuals with clinical privileges shall only provide services within the scope of privileges granted, including restricted DEA's. Recommendations of the Department(s) in which Privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for Staff appointment.

## 9.6 Procedure for Initial Appointment

### 9.6.1 Processing of Application

9.6.1.1 The application form for appointment to the Medical Staff shall be submitted by the applicant to the Medical Staff Office. After verifying the information provided, the Medical Staff Office shall make a determination as to whether the application is complete. Any new application not deemed complete within 90 days of initial receipt is considered null and void. The Medical Staff Office verifies the information about the applicant's licensure, specific training, experience, and current competence provided by the applicant with information from the primary source(s) whenever feasible. When the application is deemed to be completed, the Medical Staff Office shall transmit the application and all supporting materials to each Chairperson of the Department(s) in which applicant desires Clinical Privileges for evaluation. A separate record is maintained for each individual requesting membership or clinical privileges. If the application and the collection of required supporting material is not completed within sixty (60) days of the receipt of the initial application form, the applicant shall be notified of the reason for the delay by the Medical Staff Office.

9.6.1.2 The Medical Staff Office shall make certain that an appropriate inquiry has been made with the National Practitioners Data Bank concerning the applicant and that a report regarding the same will be included with the materials submitted to the Department Chairperson(s).

9.6.1.3 Upon receipt of the completed application for appointment to the Medical Staff, the Department Chairperson(s) shall:

9.6.1.3.1 Evaluate the applicant based on the following: Current licensure and/or certification as appropriate, verified with the primary source; the applicants specific relevant training, verified with the primary source; evidence of physical ability to perform the requested privileges; data from professional practice review by an organization(s)

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that currently privileges the applicant (if available); and peer and /or facility recommendations.

9.6.3.1.2 Before recommending privileges the department chairperson will evaluate: changes to any licensure or registration; voluntary or involuntary relinquishment of any license or registration; voluntary or involuntary termination of medical staff membership; voluntary or involuntary limitation, reduction or loss of clinical privileges, any evidence of an unusual pattern of an excessive number of professional liability actions resulting in a final judgment against the applicant, documentation as to the applicant's health status; relevant practitioner-specific data as compared to aggregate (when available); morbidity and mortality data (when available.)

## 9.6.1.4 Time Period Guidelines for Processing New Applications

Medical Staff Office	60 days
Department Chairperson Review	31 days
Credentials Committee Review	31 days
Medical Executive Committee Review	31 days
Board of Trustees	61 days

These time period are deemed to be guidelines and do not create any right to have an application proceed within these time frames and do not account for any deferrals requested by the Department Chairperson, the Credentials Committee, the Medical Executive Committee or the Board of Trustees. These time periods do not apply to the Fair Hearing Process.

9.6.1.5 Forward a written recommendation to the Credentials Committee, via signature and/or any other recommendations on the privilege request form and application form. In the absence of the department chairperson, another physician from the department can be substituted. It is recommended that it be the vice chairperson. This individual must be designated in advance.

## 9.6.2 Credentials Committee Action on the Application

The Credentials Committee, after receiving recommendations from the Department Chairperson(s), shall review the pertinent information available and make a recommendation for Staff appointment to the Medical Executive Committee. The Credentials Committee, in making its recommendation, may interview the applicant personally and/or request a discussion with any Medical Staff Member who possesses information on the applicant's qualifications.

When evaluating new applications for Staff appointment, the Credentials Committee should make a recommendation to the Medical Executive Committee no later than sixty (60) days after the date that the application is deemed complete and all requested documentation has been received. If such a recommendation is not made within sixty (60) days, a monthly status report shall be made to the Administrator of the Hospital and the Medical Executive Committee. A copy of the Credentials Committee recommendation is forwarded to the MEC.

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## 9.6.3 Medical Executive Committee Action on the Application

The Medical Executive Committee may take the following action on the application:

9.6.3.1 Favorable Recommendation - When the recommendation of the Medical Executive Committee is favorable to the applicant, the President of the Medical Staff then signs the application. In the absence of the President of the Medical Staff/designee, a member of the MEC may be utilized. The Medical Executive Committee shall promptly forward its recommendation to the Board—for action. All recommendations to appoint shall include the Clinical Privileges to be granted, which may be qualified by any probationary conditions relating to such Clinical Privileges.

9.6.3.2 Defer Action - When the recommendation of the Medical Executive Committee is to defer the application for further consideration or investigation, it must be followed up within thirty (30) days by a subsequent recommendation to the Board for appointment, for rejection of the application or an explanation for any further delay. The MEC shall have the option of referral for further investigation. The deferred action will be notified to the applicant in writing.

9.6.3.3 Adverse Recommendation - When the recommendation of the Medical Executive Committee is adverse to the applicant with respect to either appointment to the Medical Staff or Clinical Privileges requested, it shall be forwarded to the President of the Medical Staff who shall promptly notify the Administrator of the Hospital who shall promptly notify the applicant by certified mail, return receipt requested. The President of the Medical Staff shall then hold the application until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in these bylaws. The applicant shall not be entitled to a hearing for the following non-adverse denials of appointment, reappointment and requests for all or some Clinical Privileges:

9.6.3.3.1 requests for appointment/Privileges for services outside the scope of services approved by Pennsylvania law and/or by the Board:

9.6.3.3.2 requests for appointment/Privileges where the individual does not meet Medical Staff or Department criteria established in these Bylaws or the Rules and Regulations; and

9.6.3.3.3 requests for appointment/Privileges for contracted services when the applicant is not employed by the contractor.

At the time the applicant has been deemed to have waived the right to a hearing (if applicable), the President of the Medical Staff shall forward the recommendation, together with all supporting documentation, to the Board. If the applicant has waived the right to a hearing and the Board affirms the adverse recommendation, notice will be provided to the Pennsylvania Bureau of Professional and Occupational Affairs and the National Practitioner Data Bank pursuant to HCQIA.

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9.6.3.4 Contrary Board Action - In the event the Board's action is contrary to the Medical Executive Committee's recommendation, the Board shall not finalize its action without referring the matter to an ad hoc Joint Advisory Committee. The Joint Advisory Committee shall consist of 2 officers of the Board of Trustees and 2 members of the MEC. The Joint Advisory Committee shall have access to all records in connection with the application. The Joint Advisory Committee shall submit a recommendation to the Board within Thirty (30) days of the receipt of the matter including all requested documentation unless that time period is extended by the Committee for good cause.

### 9.6.4 Favorable Board Decision

Once the Board has acted on the MEC's recommendation the application is to be signed by the Secretary of the Board of Trustees. The Administrator of the Hospital shall promptly notify the applicant or Member of the Board's decision to grant Clinical Privileges and/or Functions. The written notification shall include, if applicable:

9.6.4.1 the Department to which applicant is assigned;

9.6.4.2 the Clinical Privileges and/or Functions applicant may exercise;

9.6.4.3 any special conditions attached to appointment or Clinical Privileges/ Functions; and

9.6.4.4 the duration of appointment, not to exceed two (2) years.

### 9.6.5 Hospital's Inability to Accommodate

A recommendation by the MEC, or a decision by the Board, to deny particular Clinical Privileges on the basis of Hospital's present inability, as supported by documented evidence, to provide adequate facilities or supportive services for the applicant and his/her patients, shall be referred to the MEC and the Board of Trustees to assist administration to develop such services.

### 9.6.6 Executive Board Session

The Board of Trustees may delegate the authority to render decisions regarding appointment, reappointment and clinical privileges to a committee consisting of at least two Board members, which will meet as often as necessary as determined by its chairperson. The applicant is ineligible for the expedited process if any of the following occurred: The applicant submits an incomplete application; The Medical Executive Committee makes a final recommendation that is adverse or has limitations. The following situations are evaluated on a case-by-case basis and usually results in ineligibility of the expedited process: There is current challenge or a previous successful challenge to licensure or registration; The applicant has received an involuntary termination of medical staff membership at another hospital; the applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; The hospital determines that there has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

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## 9.7 Procedure for Temporary Clinical Privileges

### 9.7.1 Temporary Privileges for Applicants

#### 9.7.1.1 Important Patient Care Need – Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following a review and recommendation by the Department Chair and pending MEC review and Board approval. “New applicant” includes an individual applying for clinical privileges at the hospital for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

In these cases, only the CEO or his/her designee, upon recommendation of the President of the Medical Staff may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privilege at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days of service.

The letter approving temporary privileges shall identify the specific privilege granted. Except as provided above, temporary privileges may not be granted pending processing of application for appointment or reappointment.

#### 9.7.1.2 Important Patient Care Need – No Pending Application

Temporary privileges may be granted by the CEO upon recommendation of the President of the Medical Staff when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of time, when no application for medical staff membership or clinical privileges is pending. An example would be situation in which a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately. Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a practitioner temporarily privileging services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the practitioner establishing his/her qualification to the satisfaction of the MEC and the Board and in no event to exceed on hundred and twenty (120) days of service within a calendar year. All practitioners providing coverage, for other practitioner must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges. Further, prior to award or temporary privileges due to important patient care need, the applicant must submit a written



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request for specific privileges and evidence of current competence to perform them, proof or appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's unrestricted license to practice medicine, DEA certificate, confirmation of good standing with the practitioner's primary hospital, confirmation of board certification or being in the board certification process, and viewing of a driver's license / military ID/passport

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute practitioner shall whenever possible, advise the Hospital at least sixty (60) days in advance of the identity of the practitioner and provide all needed documentation and the dates during which the services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action and will result in the practitioner not being eligible for temporary privileges.

**9.7.2** For existing medical staff members, in an emergency, any medical staff member with clinical privileges is "temporarily privileged" to provide any type of patient care necessary as a life-saving measure or to prevent serious harm – regardless of his or her current clinical privileges – if the care provided is within the scope of the individual's license.

**9.7.2.1** Special requirements of supervision and reporting may be imposed by the MEC on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the CEO/designee upon notice of any failure by the practitioner to comply with such special conditions.

**9.7.2.2.** The CEO, on behalf of the Board of Trustees may at any time, upon the recommendation of the President of the Medical Staff, terminate a practitioner's temporary privileges effective as of the discharge from the hospital of the practitioner's patient(s) then under his/her care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to these Bylaws. Immediately upon the imposition of summary suspension, the Medical Staff President, in consultation with the Department Chair, shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner or independent allied health professional who are still in the Hospital at the time of the suspension. The wishes of the patient shall be determinative, if possible, in the selection of alternative coverage.

### **9.7.3** Consultative Services

Consultative services requested by Practitioners who have current Staff Privileges shall not require temporary privileges for the consulting Physician and such consultation shall be the responsibility of the requesting Practitioner.

### **9.7.4** Special Requirements

Special requirements of supervision and reporting may be imposed by the respective Department Chairperson on any individual granted temporary Clinical Privileges.

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## 9.7.5 Locum Tenens

- 9.7.5.1 Locum tenens is a special request for privileges, not membership, specifically to cover for a current staff member or to provide needed specialty coverage. All requests for Locum Tenens privileges must be accompanied by an application for Locum Tenens privileges.
- 9.7.5.2 The application will be processed and presented to the department chairperson for review. All Locum Tenens applications will be processed through the Credentials Committee, the Medical Executive Committee and will be presented to the Board of Trustees for approval. The applicant must provide evidence of the following:
  - 9.7.5.2.1 Appropriate licensure within the Commonwealth of Pennsylvania;
  - 9.7.5.2.2 Proof of current malpractice insurance;
  - 9.7.5.2.3 A current Drug Enforcement Administration certificate;
  - 9.7.5.2.4 A list of all prior hospitals and health care facilities where the Practitioner applied for privileges and has been performing any such privileges within the last six months; and
  - 9.7.5.2.5 A query of the National Practitioners Data Bank and the OIG.
- 9.7.5.3 Privileges for Locum Tenens coverage shall not be valid for a period in excess of one year.
- 9.7.5.4 Locum Tenens are not eligible for the due process provisions set forth in these Bylaws.
- 9.7.5.5 Locum Tenens applicants may request temporary privileges. These may be granted by the CEO under the same guidelines as noted in that section of these Bylaws.

## 9.7.6 Termination of Temporary Clinical Privileges

- 9.7.6.1 Termination - The President of the Medical Staff may, at any time, terminate an individual's temporary Clinical Privileges for failure to comply with any special conditions imposed or for a breach of these Bylaws or the Rules and Regulations. Clinical Privileges shall then be terminated when the individual's in-patients are discharged from the Hospital. However, where it is determined that the care and safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary Clinical Privileges may be imposed and such termination shall be immediately effective.
- 9.7.6.2. Reassignment of Patients - The appropriate Department Chairperson shall assign to a Member of the Medical Staff responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

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9.7.6.3 Limitations of Temporary Privileges - The granting of any temporary admitting and Clinical Privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such temporary Privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

9.7.6.4 Immediate Termination of Temporary Privileges - Temporary Privileges shall be terminated immediately if the Credentials Committee recommends unfavorably in respect to the applicant's appointment to the Medical Staff or if the Credentials Committee recommends different Privileges than the temporary Privileges that were previously granted.

9.7.7 Care of Specific Patients: Upon receipt of a written request for specific temporary Privileges, an appropriately licensed Practitioner of documented competence who is not an applicant for membership may be granted temporary Privileges for the care of one or more specified patients. Such Privileges shall be restricted to the treatment of not more than five (5) patients in any one year by any Practitioner, after which such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

### 9.8 Emergency Clinical Privileges

For the purposes of this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

#### 9.8.1 Emergency Privileges for Non-Members

In an Emergency involving a particular patient, a Practitioner who is not currently a Member of the Medical Staff may be permitted to exercise Clinical Privileges to act in such Emergency, within the scope of license, using all necessary facilities of the hospital, including calling for any consultation necessary or desirable. The Medical Staff President/designee or Vice President/designee or Secretary/Treasurer/designee or Chairperson of the Credentials Committee may grant such Emergency Privileges. If all of the above mentioned are unavailable, any member of the MEC may grant such emergency privileges.

#### 9.8.2 Emergency Privileges for Members

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

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## 9.8.3 Termination of Emergency Privileges

When the Emergency situation no longer exists, such Practitioner must request the Temporary Privileges necessary to continue to treat the patient. In the event such Temporary Privileges are denied or not requested, the patient shall be assigned to an appropriate person who is currently a Member of the Medical Staff by the appropriate Department Chairperson, giving consideration wherever possible to the wishes of the patient.

## 9.8.4 Disaster Privileges for Non-Members

The Chief Executive Officer, the President of the Medical Staff or an individual designated by either of the forgoing may grant disaster privileges to licensed independent practitioners who are not members of the Medical Staff during any disaster in which the existing members of the Medical Staff are unable to meet immediate patient needs following activation of the Hospital's emergency plan. Any grant of disaster privileges shall be made accordance with the Medical Staff's policy relating to disaster privileges.

## 9.8.5 Telemedicine

The hospital may choose to use telemedicine to support its diagnostic and medical management capabilities. Telemedicine means a service which renders a diagnosis, or otherwise provides clinical treatment through the use of electronic equipment or other communication technologies to provide or support clinical care at a distance. Practitioners approved for privileges in telemedicine may be credentialed through one of the following mechanisms:

- The originating site fully privileges and credentials the practitioners according to current Joint Commissions standards; the same process as all medical staff applications, meeting all qualifications and requirements as set forth except those relating to geographic location, coverage agreements and emergency call responsibilities;
- The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization and participates in Medicare
- or The originating site uses the credentialing and privileging decision from the distant site to make final privileging decision if all the following requirements are met: (credentialing by proxy) The distant site is a Joint Commissions-accredited hospital or ambulatory care organization, The practitioner is privileging at the distant site from those services to be provided at the originating site, A signed attestation must be received from the distant site that all information provided is complete, accurate and up to date. Any practitioner wishing to provide telemedicine services will be required to comply with all credentialing and privileging guidelines and criteria as listed above. Individuals granted telemedicine privileges shall be subject to the Hospitals peer review activities. The result of peer review activities including adverse events or complaints filed about the practitioner providing telemedicine service from patients, other practitioners or staff will be shared with the hospital or entity providing telemedicine services. Practitioners who provide only telemedicine services are granted privileges and not Medical Staff or Allied Health staff membership. These practitioners are not extended due process. The CEO, on behalf of the Board of Trustees, may at any time, upon recommendation of the President of

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the Medical Staff, or following officer, terminate a practitioner's telemedicine privileges.

- Telemedicine services granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

## 9.9 Procedure for Reappointment

### 9.9.1 Completion of Reappointment Form

9.9.1.1 Any Member of the Medical Staff who, at the designated time of processing the reappointment to the Medical Staff, wishes to be considered for a change in Medical Staff category or in Clinical Privileges, or who does not desire reappointment, shall so indicate on the reappointment form. All Members of the Medical Staff who do not indicate otherwise shall be considered for reappointment to the same category of the Staff with the same Clinical Privileges they then hold unless the MEC recommends otherwise. Reappointment to the Medical Staff shall be for a period of not more than two (2) years.

Any Practitioner who desires a change in Clinical Privileges or Medical Staff status during the term of appointment shall follow the reappointment procedures set forth in these bylaws.

9.9.1.2 Each Member who wishes to be reappointed shall meet and maintain the qualifications for Membership as set forth in these bylaws and be responsible for reviewing the initial application form and stating on the reappointment form any material changes in the information given there. The submission of false or misleading information will be grounds for terminating a Member's Membership and Clinical Privileges according to procedures set forth in these bylaws. The Medical Staff reappointment form shall be approved by the MEC.

9.9.1.3 The Hospital shall make an appropriate inquiry with the National Practitioners Data Bank pursuant to HCQIA for all re-applicants to the Medical Staff.

9.9.1.4 The Hospital may require payment of a reappointment application fee. The amount of the fee, if any, shall be set by the MEC.

### 9.9.2 Factors to be Considered

Each recommendation concerning reappointment of a Member of the Medical Staff or a change in Staff category, where applicable, shall be based upon, but not limited to, any or all of the following factors:

9.9.2.1 professional ethics, demonstrated competence and clinical judgment in the treatment of patients and relevant recent training and such other specific data concerning the Member's ethics, competence and qualifications as may relate to ability to provide good patient care. The applicant is required to submit any reasonable evidence of current ability to perform privileges that may be requested.

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- 9.9.2.2 attendance at Medical Staff, Department and committee meetings and cooperative participation in Medical Staff affairs;
- 9.9.2.3 compliance with the Bylaws and the Rules and Regulations;
- 9.9.2.4 behavior and cooperation with Hospital personnel, fellow Practitioners and others;
- 9.9.2.5 use of the Hospital's facilities for patients, cooperation and relations with other Practitioners, and general attitude toward patients, the Hospital and the public;
- 9.9.2.6 physical and mental health pertinent to his or her ability to perform the essential functions of his or her practice without threat of harm of himself, herself or others;
- 9.9.2.7 satisfactory completion of such continuing education requirements as may be imposed by law, applicable accreditation agencies or the Rules and Regulations;
- 9.9.2.8 professional liability insurance coverage, claims, suits or settlement;
- 9.9.2.9 review of records of patients treated in this or other hospitals; and
- 9.9.2.10 challenges and sanctions of any kind imposed or pending by any other health care institution or organization or licensing or regulatory agency or any request by same to withdraw an application or to voluntarily resign.
- 9.9.2.11 findings on individual performance drawn from quality improvement activities when available including morbidity and mortality.
- 9.9.2.12 peer references
- 9.9.2.13 Relevant information as to whether the provider has been excluded, suspended, or otherwise declared ineligible for cause from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets criteria for mandatory exclusion, suspension or ineligibility from such programs, or has knowledge of being under investigation by any such program.

### **9.9.3 Procedure**

- 9.9.3.1 Each year, the Medical Staff Office, or designee, shall provide each Medical Staff Member undergoing the reappointment process with a reappointment form for Medical Staff Membership and Clinical Privileges. This re-appointment application must be completed and returned to the Medical Staff Office. Failure to return the re-appointment application within the stated time frame will result in voluntary resignation of membership and privileges. In such instances the Member in question is not entitled to the fair hearing proceedings.

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- 9.9.3.2 The completed reappointment forms shall be promptly forwarded to the Department Chairperson, who shall transmit within Thirty (30) days to the Credentials Committee a current list of those Members being evaluated for reappointment in that Department, together with the Clinical Privileges each then holds, accompanied by the applications of those Members who have applied for a change in Clinical Privileges or for a change in Medical Staff category. In addition, the Department Chairperson shall submit individual recommendations and the reasons therefore, for any changes recommended in staff category and in Clinical Privileges.
- 9.9.3.3 Recommendations for changes by the Department Chairperson shall be based upon, but not necessarily limited to: Current licensure and/or certification, as appropriate, verified with the primary source; the applicants specific relevant training, verified with the primary source, evidence of physical ability to perform the requested privileges; data from professional practice review by an organization(s) that currently privileges the applicant (if available); peer and/or facility recommendations; review of the practitioner's performance within the organization.
- 9.9.3.4 Before recommending privileges, the department chairperson will evaluate: changes to any licensure or registration; voluntary or involuntary relinquishment of any licensure or registration; voluntary or involuntary termination of any medical staff membership; voluntary or involuntary limitation, reduction, or loss of clinical privileges; any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant; documentation as to the applicants health status; relevant practitioner-specific data as compared to aggregate data (when available); morbidity and mortality data (when available.)

### **9.9.4 Credentials Committee Procedures**

- 9.9.4.1 The Credentials Committee, after receiving recommendations from each Department Chairperson, shall review all pertinent information available and make recommendations for Staff reappointment, for change in Medical Staff category, and for granting of Clinical Privileges for the ensuing two years.
- 9.9.4.2 The Credentials Committee shall submit its report and recommendations for reappointment to the MEC.

### **9.9.5 MEC Procedures**

- 9.9.5.1 When the MEC's recommendation for reappointment is favorable, those names shall be transmitted by the President of the Medical Staff to the Hospital Board for its consideration.
- 9.9.5.2 Where non-reappointment, non-promotion of an eligible current Practitioner, or a limitation in Clinical Privileges is recommended, the reason or reasons shall be stated, documented and included in a report prepared by the MEC. This report shall not be transmitted to the Board until the Affected Practitioner has exercised or has been deemed to

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have waived the right to a hearing as provided in these bylaws provided however, that the applicant shall not be entitled to a hearing for the following denials of reappointment:

9.9.5.2.1 requests for reappointment/Privileges for services outside the scope of services approved by Pennsylvania law and/or by the Board:

9.9.5.2.2 requests for reappointment/Privileges where the individual does not meet Medical Staff or Department criteria established in these Bylaws or the Rules and Regulations; and

9.9.5.2.3 requests for reappointment/Privileges for contracted services when the applicant is not employed by the contractor.

If the Practitioner waives the right to a hearing (if applicable), any action by the Board with regard to the matter will be deemed final. As such, if the final action by the Board is adverse to the Practitioner, such action will be reported to the Bureau of Professional and Occupational Affairs pursuant or National Practitioner Data Bank to HCQIA.

9.9.5.3 When action is delayed on the application for reappointment, the Practitioner shall be entitled to continue to exercise Clinical Privileges currently in force, unless a suspension has been enacted according to procedures set forth these Bylaws.

### **9.10 Confidentiality of Peer Review Credentialing Documents and Materials**

#### **9.10.1 Peer Review Credentialing Documents and Materials**

For the purpose of this Part and these Bylaws, the phrase "peer review credentialing documents and materials" means all written or otherwise recorded information related to:

9.10.1.1 processing applications for Medical Staff Membership and the granting of Clinical Privileges;

9.10.1.2 reappointment of Medical Staff Members;

9.10.1.3 corrective action taken against a Member of the Medical Staff; and

9.10.1.4 any and all other material and information maintained in the credentials file which may lead to an adverse action against a Member of the Medical Staff.

Information concerning the qualifications, clinical competence, performance, conduct or mental or physical health of either an applicant for Medical Staff Membership, a Medical Staff Member seeking reappointment or a Medical Staff Member who is the object of a corrective action, shall be classified as peer review credentialing documents and materials and as such, shall be considered confidential.



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## **9.10.2 Content, Examination and Removal of the Credentials File**

The content, examination and removal of the credentials file of an individual Member shall be established by policy adopted by the Medical Staff and approved by the Board.

## **9.10.3 Content, Examination and Removal of the Peer Review File**

The content, examination and removal of the peer review file of an individual Member shall be established by policy adopted by the Medical Staff and approved by the Board.

## **9.11 Membership, Clinical Privileges and Contractual Relationship with the Hospital**

All Practitioners employed pursuant to an exclusive contract and any other Physicians who have contractual or employment relationships with the Hospital must be Members of the Medical Staff and are subject to the same procedures as all other applicants for membership and privileges. In the event the contract is terminated, privileges should terminate if noted in the contract.

Privileges of medical staff members, contractual or non-contractual, are granted independent of employment or contractual relationship with the hospital.

Prior to the hospital (i) entering into an exclusive contract for services, (ii) renewing an exclusive contract for services, or (iii) terminating an exclusive contract for services with a contract practitioner or group, the Chief Executive Officer shall first consult with and seek input from the Medical Executive Committee.

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## ARTICLE X - Hearing and Appeal Procedure

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

### **10.0 Definitions**

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

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

### **Initiation of Hearing**

#### **10.1 Recommendation or Actions**

The following recommendations or actions shall entitle the practitioner affected thereby to a hearing:

- 10.1.1 Denial of initial staff appointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;
- 10.1.2 Denial of reappointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;
- 10.1.3 Suspension of staff membership for fourteen (14) days or more, except automatic suspensions as noted in the Medical Staff Bylaws;
- 10.1.4 Revocation of staff membership;
- 10.1.5 Denial of requested advancement of staff category, if such denial materially limits the physician's exercise of privileges;
- 10.1.6 Limitation of the right to admit patients, unless based upon a reduction of staff category not related to an adverse determination as to a practitioner's competence or professional conduct;

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- 10.1.7 Denial of an initial request for particular clinical privileges, unless based upon failure to meet the basic objective criteria for the privileges requested;
- 10.1.8 Reduction of clinical privileges for a period of excess of thirty (30) days;
- 10.1.9 Permanent suspension of clinical privileges, except automatic suspensions pursuant as noted in the Medical Staff Bylaws;
- 10.1.10 Permanent revocation of clinical privileges;
- 10.1.11 Terms of probation or consultation, if such terms of probation or consultation materially restrict the physician's exercise of privileges for more than thirty (30) days; and
- 10.1.12 Summary suspension of privileges or staff membership for a period in excess of fourteen (14) days.

### **10.2 When Deemed Adverse**

A recommendation or action shall be deemed adverse only if it is based upon competence or professional conduct, is practitioner-specific and has been:

- 10.2.1 Recommended by the MEC; or
- 10.2.2 Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or
- 10.2.3 Taken by the Board on its own initiative without prior recommendation by the MEC.

### **10.3 Notice of Adverse Recommendation or Action**

A practitioner against whom an adverse recommendation or action has been taken shall promptly be given special notice of such action. Such notice shall:

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

### **10.4 Request for Hearing**

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

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## **10.5 Waiver by Failure to Request a Hearing**

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

10.5.1 An adverse recommendation or action by the Board, CEO or their designees, shall constitute acceptance of that recommendation or action. (Hereinafter, references to decisions by these entities or individuals shall be designated as decisions or actions of the Board); and

10.5.2 An adverse recommendation by the MEC or its designee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the MEC's recommendation at its next regular meeting following the waiver. In its deliberations, the Board shall review all relevant information and material considered by the MEC and may consider all other relevant information received from any source. The Board's action on the matter shall constitute a final decision of the Board. The CEO shall promptly send the practitioner special notice informing him/her of each action taken and shall notify the President of the Medical Staff and the MEC of each such action.

## **Hearing Prerequisites**

### **10.6 Notice of Time & Place for Hearing**

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

### **10.7 Statement of Issues and Events**

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

### **10.8 Practitioner's Response**

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

### **10.9 Examination of Documents**

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

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for the adverse action shall be made available to the practitioner, at his/her expense, within a reasonable time after a request is made for same.

## **10.10 Appointment of Haring Committee**

### **10.10.1 By Medical Staff**

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

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

### **10.10.2 By Board**

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

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

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## **10.10.3 Service on Hearing Committee**

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

## **Hearing Procedure**

### **10.11 Personal Presence**

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights.

### **10.12 Presiding Officer**

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

### **10.13 Representation**

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of the Medical Staff in good standing, a member of his/her local professional society, or other individual of the physician's choice. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine the witnesses. If the affected practitioner desires to be represented by an attorney at any hearing or any Appellate Review, his/her request for the hearing should state his/her wish to be so represented at either of both such proceedings in the event they are held. The MEC or the Board may also be represented by an attorney.

### **10.14 Rights of the Parties**

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

10.14.1 Call and examine witnesses;

10.14.2 Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

10.14.3 Cross-examine any witness on any matter relevant to the issues;

10.14.4 Impeach any witness;

10.14.5 Rebut any evidence;

10.14.6 Have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and

10.14.7 Submit a written statement at the close of the hearing.

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

## **10.15 Procedure & Evidence**

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

## **10.16 Official Notice**

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

## **10.17 Burden of Proof**

10.17.1 When a hearing relates to initial appointment, advancement of staff category, or denial of an initial request for particular clinical privileges, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory.

10.17.2 For the other matters the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

## **10.18 Record of Hearing**

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

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## **10.19 Postponement**

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

## **10.20 Presence of Hearing Committee Members & Voting**

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

## **10.21 Recesses & Adjournment**

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

## **Hearing Committee Report & Further Action**

### **10.22 Hearing Committee Report**

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

### **10.23 Action on Hearing Committee Report**

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



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## 10.24 Notice & Effect of Result

### 10.24.1 Notice

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

### 10.24.2 Effect of Favorable Result

10.24.2.1 Adopted by the Board: If the Board's result is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered finally closed.

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

### 10.24.3 Effect of Adverse Result

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

## Initial & Prerequisites of Appellate Review

### 10.25 Request for Appellate Review

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

### 10.26 Waiver Failure to Request Appellate Review.

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

Such waiver shall have the same force and effect as that provided elsewhere in this Plan.

### 10.27 Notice of Time & Place for Appellate Review

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

## **10.28 Appellate Review Body**

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

## **Appellate Review Procedure**

### **10.29 Nature of Proceedings**

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

### **10.30 Written Statements**

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

### **10.31 Presiding Officer**

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

### **10.32 Oral Statement**

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

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## **10.33 Consideration of New or Additional Matters**

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

## **10.34 Presence of Members & Voting**

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

## **10.35 Recesses & Adjournment**

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

## **10.36 Actions Taken**

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

## **10.37 Conclusion**

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

## **Final Decision of the Board**

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

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## General Provisions

### **10.39**      **Hearing Officer Appointed Duties**

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

### **10.40**      **Attorneys**

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

### **10.41**      **Number of Hearings & Reviews**

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

### **10.42**      **Release**

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

### **10.43**      **Waiver**

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

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**100.0 PRE ADMISSION TESTING**

100.1 The Hospital shall provide a Pre Admission Testing Program.

**101.0 Medical Record – Electronic Health Record (EHR)**

**101.1 Admissions**

- 101.1-1 Physicians shall admit or observe patients suffering from all types of diseases for primary therapy within the Hospital’s scope of care.
- 101.1-2 No patient shall be admitted to or observed in the Hospital until after a provisional diagnosis has been stated. A specific admitting diagnosis must be given. “Possible”, "Probable", and "rule out" will not be sufficient enough for an Admitting diagnosis.
- 101.1-3 Physicians admitting patients shall be held responsible for giving information as shall be necessary to insure protection of hospital personnel and other patients from those who are a source of danger from any cause whatsoever.
- 101.1-4 All admissions must have an attending physician, who must agree to accept the admission. The attending physician or designee shall be defined as that physician who has accepted the patient and will provide the majority of care of the patient at admission up to, and including discharge of the patient.
- 101.1-5 An emergency shall be defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
  - 101.1-5.1 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - 101.1-5.2 serious impairment to any bodily functions; or
  - 101.1-5.3 serious dysfunction of any bodily organ or part
- 101.1-6 Urgent is a medical condition that is not an emergency; however, it must be attended to within a specific time delineated by the attending physician to prevent further deterioration in the patient’s medical condition or for the alleviation of significant pain.
- 101.1-7 A doctor of medicine or osteopathy will manage and coordinate the care of any Medicare patient’s psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine or optometry, a chiropractor, or a clinical psychologist.

**101.2 Discharges**

- 101.2-1 Follow-up orders shall be entered into EHR at the time of discharge.
- 101.2-2 Patients shall be discharged only on order of the attending physician. At the time of discharge, the attending physician will state his final diagnosis, give discharge instructions as appropriate, and document the instructions to patient and family (if any) in the medical record.

**101.3 Summaries**

- 101.3-1 The summary sheet shall contain;
  - 101.3-1.1 the reason for hospitalization,
  - 101.3-1.2 significant findings,
  - 101.3-1.3 resolution of admission diagnosis and chief complaint,
  - 101.3-1.4 the course of the facility stay,
  - 101.3-1.5 interventions, procedures, operations, consults, etc.,
  - 101.3-1.6 any complications arising and how they were managed,
  - 101.3-1.7 progress made in regard to specific interventions (i.e. physical therapy, respiratory care, etc.),
  - 101.3-1.8 difficulties in establishing the diagnosis and an effective treatment plan,
  - 101.3-1.9 condition on discharge,
  - 101.3-1.10 instructions for follow-up care including pain management post-discharge,
  - 101.3-1.11 nutrition,
  - 101.3-1.12 medication,
  - 101.3-1.13 activity,
  - 101.3-1.14 any referrals, and
  - 101.3-1.15 the next appointment with the attending physician if appropriate.

**101.4 Completions**

- 101.4-1 The attending physician shall be held responsible for the preparation of a complete medical record for each patient. No medical record shall be filed until it is complete, except by order of the Medical Record Committee. Physician partners may complete medical records on the patient.
  
- 101.4-2 All medical records shall be completed within 30 days following discharge. Failure to do so will constitute an automatic suspension of admission privileges until the delinquent charts are completed as confirmed by Medical Records, as further described in the Medical Staff Medical Record Delinquency Policy.

**101.5 Orders**

- 101.5-1 All practitioner's (physician/CRNP/PA-C/CNM) orders shall be entered into the EHR.
  
- 101.5-2 Verbal: Orders dictated over the telephone must be done by a practitioner, intern or resident and shall be signed, dated and timed by the person to whom dictated with the name of the physician per his or her name. Any practitioner responsible for the care of a patient who is authorized by the Hospital and permitted by state law to independently write a specific order is permitted to authenticate an order. The order must be signed, dated and timed within 24 hours. Verbal orders may not be given when the ordering practitioner, intern or resident is on the patient's nursing unit; it must be entered into the EHR. Verbal orders shall be accepted only in emergent situations where the EHR is not accessible or practical due to the nature of the emergency and need to be read back and verified by:
  - 101.5-2.1 a physician
  - 101.5-2.2 a CRNP / PA-C / CNM
  - 101.5-2.3 a registered nurse
  - 101.5-2.4 a pharmacist may transcribe verbal orders pertaining to drugs



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- 101.5-2.5 a physical therapist may transcribe verbal orders pertaining to physical therapy regimens.
- 101.5-2.6 a respiratory therapist may transcribe verbal orders pertaining to respiratory therapy treatments.
- 101.5-2.7 a paramedic practicing under state regulations relating to emergency paramedic services.
- 101.5-3 Automatic Stop Orders: There shall be an automatic stop order for drugs as follows as per current P&T Policy:
- 101.5-3.1 Schedule II Drugs- 72 hours;
- 101.5-3.2 antimicrobials- 5 7 days;
- 101.5-3.3 anticoagulants -5 7 days;
- 101.5-3.4 oxytoxics:
- 101.5-3.5 chemotherapy: administered according to a specific protocol;
- 101.5-3.6 All other drugs 20 days.
- 101.5-4 Daily lab study orders must be renewed every three days.
- 101.5-5 Timing of Orders: The following categories shall be used:
- 1) STAT
  - 2) URGENT {6 hours within time of writing}
  - 3) REGULAR
- 101.5-6 Standing and Electronic Orders and Order Sets
- 101.5-6.1 Standing Orders: In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed annually by the physician and the respective department. Standing orders shall be dated and signed by the practitioner. Standing orders shall not replace or void those orders entered for a specific patient.
- 101.5-6.2 Evidence Based Order Sets: Use of electronic orders sets that are consistent with nationally recognized and evidence-based guidelines will be permitted in this facility subject to approval by the Medical Staff as outlined below. The Medical Staff will be responsible for approval of Evidence Based Order Set templates, in consultation with the nursing and pharmacy leadership. Evidence based order set templates shall be periodically reviewed to determine the continuing usefulness and safety of the orders, and may be updated from time to time in order to track regulatory agency requirements, patient safety requirements, and other appropriate changes. The Medical Staff delegates to the Medical Executive Committee in consultation with nursing and pharmacy leadership to responsibility for approving all updates. All such orders shall be dated, timed and authenticated in the patient's medical records pursuant to the requirements of these Rules and Regulations by the ordering practitioner or another practitioner responsible for the care of the patient and authorized to enter orders by Hospital policy and state law.

### **101.6 Ordering Physician Responsibilities:**

The Ordering physician is responsible for include sufficient detail to facilitate the consultant's review. He should present the problem upon which the consultant's opinion is desired.

If he/she does not do so, the Attending Physician may do so.

Practitioners with appropriate state licensure may order services, including respiratory and rehabilitation services, in accordance with hospital policies and procedures. Practitioners are responsible to order services within the scope of their practice.

### **107.7 Progress Notes**

101.7-1 Progress notes should be entered daily into the EHR to justify the patient's stay in the hospital and the change of diagnosis shall be updated and documented as necessary.

### **101.8 Operations**

101.8-1 The medical staff shall define the scope of assessment for operative and other procedures as in: History and Physical, risk and benefits of the procedure, use of diagnostic data, the need to administer blood and blood components, define the requirement for emergent and non-emergent operative and other procedures.

101.8-2 An operative report or other high-risk procedure report is entered or dictated using EHR approved process, upon completion of the operative or other high-risk procedure and before patient is transferred to another level of care. An exception to this may occur when an operative or other high-risk procedure progress note is entered immediately after the procedure, in which case the full report can be dictated within 24 hours of the procedure. It is appropriate for the practitioner that performed the procedure to accompany the patient to the new unit or area of care to complete the progress op note or dictate the full report.

The progress note immediately completed after the operation or high-risk procedure must include the name of the primary surgeon(s) and assistant(s), procedure(s) performed and a description of each procedure finding, estimated blood loss, specimens removed and post-operative diagnosis.

101.8-3 All patients undergoing surgery by a dentist, or podiatrist shall be seen by medical staff member prior to the procedure on the day of surgery who shall act as the attending physician during the patient's hospitalization and shall be discharged by the attending physician.

101.8-4 During a surgical procedure when the surgeon is a non-physician practitioner i.e. dentist or podiatrist and the anesthesia provider is also a non-physician, a physician will be immediately available to manage the care of the patient during medical crisis.

101.8-5 A preoperative diagnosis shall be recorded before surgery by the licensed independent practitioner responsible for the patient.

101.8-6 The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note shall be entered immediately.

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- 101.8-7 Postoperative documentation records the patient's discharge from the post anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria. Compliance with discharge criteria shall be fully documented in the medical record. Postoperative documentation shall record the name of the licensed independent practitioner responsible for discharge.
- 101.8-8 The primary surgeon or other practitioner shall not leave the operating room or procedure room until the procedure is complete, including, as appropriate, completion of suture placement, wound closure, and/or removal of all surgical devices, or (ii) care is transferred to another qualified practitioner who is authorized to assume responsibility for the patient. If the primary surgeon or other practitioner leaves the operating room or procedure room prior to the completion of the procedure as described above, then he or she must include in his or her operative report (i) the time that he or she left the room, (ii) the condition of the patient and steps remaining in the surgery or procedure at that time, and, if applicable, (iii) the identity and position of the person to whom the care was transferred. If the primary surgeon or other practitioner leaves the operating room or procedure room prior to the completion as described above, without transferring care to another qualified practitioner who is authorized to assume responsibility for the patient, then an incident report shall be prepared and provided to the Peer Review Committee for peer review and follow up as appropriate.

### **101.9 Patient Consent**

- 101.9-1 An Informed Consent for operations shall be signed by all patients undergoing surgery or their legal representatives if those patients are unable to or are ineligible to sign.

A physician must directly explain the procedure to the patient and there must be a written witness of the informed consent.

- 101.9-2 Medical Assistance patients for sterilization must have consent forms signed at least 30 days prior to surgery or surgery is canceled. All other patients must have consent forms signed within 30 days of the date of procedure.
- 101.9-3 An Informed Consent for anesthesia shall be signed by all patients receiving anesthesia or by their legal representatives if those patients are unable to or are ineligible to sign. The anesthesiologist shall explain the anesthesia procedure to the patient and be a written witness to the informed consent. Consent forms obtained during investigational studies should be made part of the chart.

### **101.10 Radiology**

- 101.10-1 A radiologist who is a doctor of medicine or osteopathy qualified by education and experience in radiology supervises ionizing radiology services.

101.10-2 An abbreviated normal report shall be accepted from the Radiology Department.

101.10-3 Critical findings will be communicated directly to the ordering physician.

101.10-4 When the interpreting radiologist finds a clinically significant discrepancy in the Emergency physician's report, the interpreting radiologist will directly notify

the Emergency physician on duty. The attending physician or physician of record (family physician) will be notified by the ER physician of any radiologic discrepancy.

**101.11 Laboratory Reports**

101.11-1 Laboratory reports shall interfaced directly into the medical record in a prompt and reasonable time period. Results for the study listed as STAT and TIMED shall also be communicated by verbal means to the physician, or their designed licensed caregiver, who ordered the study as indicated.

101.11-2 Laboratory results meeting the criteria for critical values shall be communicated verbally to the ordering physician, or their designated caregiver, who will report the results to the ordering physician.

101.11-3 Laboratory examinations which cannot be made in the Hospital shall be referred to an outside laboratory approved by the Medical Director of Laboratories.

101.11-4 Newborn Testing. All newborns shall be tested as per Rules and Regulations of the Department of Pediatrics.

**101.12 Utilization**

101.12-1 All utilization review issues will be evaluated by the case management physician advisor. A physician who is identified by the physician advisor, in coordination with the chairperson of the Utilization Review Committee/Medical Records committee, to have a documented history of or who is currently engaging in practice outside of those outlined in the hospital utilization management plan will be referred to the Medical Executive Committee for possible disciplinary action.

**101.13 Medical Records**

101.13-1 Medication Records shall be contained in the patient's medical record.

101.13-2 Any review of hospital records by an individual must have the written approval of the patient or his legal designate. The attending physician and the Hospital Administration must be notified on any potential risk management situations.

101.13-3 Patients who request complete copies of their records will be given them after the records have been completed, subject to the notification of the attending physician when any potential risk management situation is present.

101.13-4 Patients under chemotherapy on a continual basis shall have their medical record updated every 30 days.

101.13-5 All practitioners will complete the following entries into the EHR: Day Hospital medical record (EHR) on Outpatients having procedures requiring anesthesia:

- Physician order / Progress note
- Pre Anesthesia evaluation
- Consent forms appropriate to procedure and treatment

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- H&P
- P.A.T. Instruction as indicated
- Medical Reconciliation

### Pain Management medical record (EHR):

- Informed Consent for Pain Management Procedures
- Pre Anesthesia evaluation (if applicable)
- Anesthesia Consent (if applicable)
- H&P
- Physician Treatment and Progress Entry
- Medical Reconciliation

### Day Hospital medical record on Outpatients having invasive medical procedures in the Day Hospital:

- Physician order / Progress Note
- Consent for appropriate to procedure and treatment
- H&P
- Medical Reconciliation

101.13-6 For medical patients receiving continuing ambulatory services (3 or more outpatient visits), the medical record contains a summary list of known significant diagnosis, conditions, procedures, drug allergies and medications.

101.13-7 The closing or retirement of incomplete medical records will be managed as per the current approved policy.

### **101.14 Diabetes Management**

101.14-1 A physician's order is required to prescribe a certified diabetes self-management education program.

### **101.15 Histories & Physicals**

Language moved to Medical Staff Bylaws

## **102.0 Clinical Care**

### **102.1 Coverage**

102.1-1 Physicians who are not accessible for more than 24 hours shall notify the staff as to who is covering them. An order shall be entered on the patient's medical record allowing the covering physician to manage the patient's case.

102.1-2 Physicians under suspension will not be permitted to admit patients under the service of their partners or treat in-house patients who are under the service of their partners.

102.1-3 The attending physician must see the patient in a reasonable period of time appropriate per the patient condition after admission, or else transfer the patient to someone who can see the patient in the Hospital.

102.1-4 The attending physician must coordinate care of the patient with other practitioners and hospital personnel as relevant to the care of an individual patient. A physician will coordinate the care of a patient's psychiatric problems. A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy.

102.1-5 Physicians generally should not treat themselves or members of their immediate families. Except in emergencies it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members (I, II, IV)

## 102.2 Consultations

102.2-1 Disagreement of a consult:

If the attending physician and a consultant disagree on the management of a patient, the attending physician may call a second consultant.

102.2-2 Except in an emergency, consultations are required:

102.2-2.1 When the medical care requirements of the patient exceed the privileges of the physician.

102.2-2.2 Patients who are not good surgical risks.

102.2-2.3 Patients whose diagnoses are difficult or obscure.

102.2-3 Definition of a Consult

A Consultant is a second physician called by an attending physician to examine a patient and discuss the case and the consultant must be qualified to give an opinion in his/her area of medical expertise.

The patient is to be seen by the consultant within twenty-four (24) hours of notification unless otherwise stated in the consultation order.

102.2-4 A Consultation:

102.5-4.1 may be declared to be mandatory in certain clinical situations or diseases. Such requirements shall be delineated in these rules and regulations or in those of the respective departments.

102.5-4.2 Is a documented opinion, signed, dated and timed by the Consultant and included in the medical record. Consultation should include:  
Reference to medical record review  
Patient examined  
Impression/Recommendations

102.5-4.3 The consultant shall respond and make findings available within 24 hours of the request, unless otherwise stated in the consultation order, an opinion signed by the consultant shall be recorded in emergency or urgent situations. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

102.5-4.4 Shall include examination of the patient and the patient's record. Procedures such as xray reports, tissue reports, EKG's, cystoscopies, etc. are not considered to be consultations.

102.5-4.5 Medical consultations are required for all critically ill patients before surgical intervention, except in surgical emergencies.

102.2-6 Attending Physician Responsibilities:

The attending physician is responsible for requesting consultation when indicated. When ordering a consultation, the attending physician shall include sufficient detail to facilitate the consultant's review. He should present the problem upon which the consultant's opinion is desired.

If he/she does not do so, the Department Chairperson and/or the President of the Medical Staff may do so.

It is the duty of the Staff through its Department Chair and Executive Committee to make certain that members of the Staff request consultations when needed.

102.2-7 **Specification for the Consult:**

When a consultation is requested, the consultation automatically is considered to be for Consultation and Management of a Specific Entity or Procedure Only, in which the consultant may write orders to manage the special entity or procedure for which the consulting physician has been consulted but overall responsibility remains with the attending physician.

The consulting physician is prohibited from writing orders on the chart outside that for which they have been consulted.

102.2-8 The consulting physician shall not consult other specialists without the specific consent of the attending physician. Failure of the consulting physician to follow this requirement shall subject the consulting physician to appropriate action through the Medical Staff Peer Review.

102.2-9 The attending physician may also consult, but is not limited to, the following specifically written consults

102.2-9.1 **Consultation Only**, which leaves management to the attending physician and prohibits consultants from writing orders on the chart.

102.2-9.2 **Consultation and Management** which permits the attending physician and the named physician to write orders, however, overall chart responsibility remains with the attending physician.

102.2-9.3 **Transfer of Care** to another named physician, in which case patient care responsibilities in the hospital are transferred to the named physician and the admitting physician may no longer write orders.

102.2-10 **Consulting Physician Responsibilities:**

The consulting physician is responsible to evaluate the specific entity or perform the procedure for which the consulting physician has been consulted and write

orders to manage the specific entity or procedure but overall responsibility remains with the attending physician.

When a consultation does not have sufficient detail to facilitate the consultant's review, the consulting physician shall immediately contact the attending /ordering physician to clarify the consult. The consultant is obligated to at a minimum discuss the clarification with the ordering physician.

The consulting physician shall not consult other specialists without the specific consent of the attending physician.

It is the duty of the consulting physician to make certain that the interest of the patient is first and foremost. If the consulting physician identifies patient needs beyond those for which the consulting physician has been consulted, the consulting physician shall bring those issues to the attention of the attending physician or the ordering physician as appropriate but overall responsibility remains with the attending physician.

### **102.3 Infection Control**

- 102.3-1 Patients admitted with a known infection scheduled for incision and drainage, will have a specimen obtained at the time of surgery.
- 102.3-2 When a patient is admitted with meningitis or suspected meningitis, they are to be placed in droplet precautions until meningitis is confirmed or excluded as per Infection Control Committee policy.
- 102.3-3 PPD may be read by members of the licensed nursing staff, and noted as negative or positive with measurements-

### **102.4 Intensive Care Unit**

- 102.4-1 The Intensive Care Unit shall be governed by the rules of the ICU Committee.
- 102.4-2 When a problem arises with a patient in ICU, who is under the care of an attending physician who is unavailable, the Charge Nurse shall notify the-respective Department Chair or designee and if unavailable, shall notify the Medical Staff President. Together they will decide an appropriate action. The Charge Nurse shall also document the incident. It shall be mandatory that interns be allowed to care for ICU patients, provided that the intern be in contact with the attending Physician.

### **102.5 Isolation – see Hospital Infection Control Policies / Procedures**

### **102.6 Tissues**

- 102.6-1 All tissue, not otherwise exempted by the Pathologist, removed in the hospital shall be sent to the hospital laboratory where the pathologist will make any examination he considers necessary to arrive at a pathological diagnosis.
- 102.6-2 Occult blood testing may only be performed by physicians who have documentation of competency and color blindness testing on file.



**102.7 Obstetrical Patients**

- 102.7-1 Copies of Pre-natal records, if available, are required to be on the floor.

**102.8 Operating Room**

- 102.8-1 All scrub nurses, circulation nurses, anesthetists, anesthesiologists surgeons, etc. shall change masks after each case.
- 102.8-2 No person may go past the nurses' station in the O.R. suite without first having changed from street clothes to operating room suit, cap, and mask.
- 102.8-3 Where indicated, an emergency local or regional cases can be done in the O.R. without lab or admission paper work at the discretion of the physician provided the case is first seen in the Emergency Room.
- 102.8-4 No inflammable anesthetics are permitted in the hospital.

**102.9 Osteopathic Manipulative Therapy (OMT)**

- 102.9-1 Each physician shall order OMT wherever applicable and document it on the chart.
- 102.9-2 All orders for OMT treatments should be specific.  
Documentation of treatments given must be specific.
- 102.9-3 Any physician giving OMT should record the treatment on the revised OMT record. Physicians should also document their treatment and findings on the progress notes each time OMT is given in addition to completing the form.

**102.10 Myocardial Infarction**

- 102.10-1 Any patient admitted with a diagnosis of myocardial infarction or suspected myocardial infarction should be admitted to the ICU. Any exception shall be approved by the Department Chairperson of Internal Medicine.

**102.11 Para-professional Services**

- 102.11-1 The Department of Surgery shall be responsible for:  
102.11.1.1 Podiatric Surgery  
102.11.1.2 To supervise the administration of the sub-service of podiatry.

Patients admitted to the hospital for podiatric care must be admitted under the service of an active staff member of the Hospital.

- 102.11-2 Podiatry is to be considered a service within the hospital and not a Department.
- 102.11-3 The Chairperson of the Department of Surgery has overall responsibility for supervision of all aspects of the podiatry service.

**102.12 Post Anesthesia Care Unit (Recovery Room)**

- 102.12-1 The Chairperson of the Department of Anesthesia shall be responsible for the operation and supervision of the recovery room. The anesthesiologists shall be responsible for discharging only their own patients from the recovery room. Other physicians using sedatives or tranquilizers for their operative procedures shall be responsible for discharging their patients from the recovery room after examining them.

**102.13 Emergency Room**

- 102.13-1 All patients presenting to the Emergency Department (EMD) will have a medical screening exam done by Qualified Medical Personnel (QMP). The medical screening examination shall be performed by a physician or a mid-level provider (Physician Assistant or Nurse Practitioner) who have been appropriately credentialed. The medical screening exam will either be performed in the emergency department or in Labor and Delivery (obstetric patients who meet the criteria specified in the CHS ED/OB policy.) Those patients presenting to the EMD to meet a private practitioner will be identified and their private practitioner called. If the patient is not seen by the private practitioner within a reasonable period of time, the EMD physician may see the patient and initiate any care deemed appropriate. When a pregnant female presents directly to the Labor and Delivery Unit, she will be assessed by a qualified RN.

An on call list of active staff specialists shall be maintained in the emergency department . The patient or patient's family wishes for a specialist if needed, will be considered, then the family physician preference if patient has none and lastly the on call schedule will be utilized for consultation. The on-call consulting physicians will be notified by the E.R. physician or a designee of his choosing. Once notified, the specialist's arrival or response to the emergency department should be within a reasonable timeframe. Generally, response is expected within 30 minutes. The emergency department physician, in consultation with the on-call physician, shall determine whether the patient's condition required the on-call physician to see the patient immediately in the Emergency Department. The determination of the emergency department physician shall be controlling in this regard. In the event that the emergency room physician cannot get an active staff physician to respond within an acceptable period of time (as determined by the emergency room physician, see paragraph above) the Emergency Room physician shall then utilize non-active staff physicians or, if necessary, may transfer the patient to a facility that has the specific specialty coverage and resources needed.

- 102.13-2 The attending E.R. physician shall be responsible for the contents of the instruction sheet given in the E.R.
- 102.13-3 The E.R. physician or ward clerk shall attempt to notify the referring physician of all admissions from his service.

**102.14 Pathologic Specimens**

- 102.14-1 All tissues removed shall be sent to the pathologic department for pathological examination with the exception of those exempted by the department of surgery.
- 102.14-2 All tissues submitted to the pathology department shall be sectioned and examined microscopically and the report shall read that gross and microscopic examination was normal or otherwise.

**102.15 Day Hospital**

- 101.15-1 Histories and Physicals must be done by the referring or attending physician prior to performing any surgical procedures in Day Hospital including procedures requiring moderate sedation. Medical procedures require an order and summary of medical condition.

**103.0 House Regulations**

**103.1 Smoking**

Practitioners shall adhere to the Hospital's tobacco-free campus policy.

**104.0 Medications**

**104.1 Antibiotics**

All antibiotic orders must be written on the basis of "every (q)\_\_\_\_\_ hours" or at specified times.

**104.2 Anticoagulants**

- 104.3-1 All orders for anticoagulants administered to patients must be reordered by the physician every seven (7) days.

**104.3 Schedule II Drug Orders**

- 104.4-1 Interns and residents who verbally order Schedule II drugs must sign the order before going off duty.

**104.4 Formulary**

- 104.4-1 The Pharmacy and Therapeutics Committee of the Medical Staff of the Hospital shall establish the Hospital Formulary and updated copies shall be available at each nurse's station, on the Intranet and the Pharmacy, and revisions shall be made available.

**104.5 Administration of Drugs**

- 104.5-1 Medications may be administered by a Registered Nurse, licensed practical nurse, certified cardio-vascular, radiology technologists and nuclear medicine technologists based on clinical competencies. Paramedics may be permitted to administer drugs only per state regulations (relating to emergency paramedic services).
- 104.5-2 Medications which are administered to the hospice patient for the relief of pain should be subject to the following rules:

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104.5-2.1 All Schedule II drugs must be recorded according to existing hospital policies.

104.5-3 If a medication is to be placed at a patient's bedside, it must be:

104.5-3.1 Ordered in writing on the patient's chart by the physician.

104.5-3.2 Recorded on the medication administration record the time consumed as can be determined by the nurse.

104.5-4 Patients' personnel pharmaceuticals will be administered per pharmacy policy.

### **105.0 Meetings**

#### **105.1 Department**

105.1-1 Each department shall hold meetings at least quarterly and submit minutes to the Medical Staff office.

105.1-2 Physicians joining the staff will be informed of the attendance requirements in their departments and staff obligations.

105.1-3 Any rules or regulations recommended which affect individual departmental rules and regulations shall be presented to that department prior to passage by the MEC.

#### **105.2 Committees**

Committee and departmental meeting minutes shall be reported to the Medical Executive Committee.

#### **105.3 Meeting Minutes**

105.3-1 All committee and department reports shall be submitted to the Medical Executive Committee first and not to the Board and/or Administration. All exceptions to this rule will be determined by the Medical Staff President and/or the Medical Executive Committee.

### **106.0 Privileged Information**

#### **106.1 Medical Staff Confidential Files**

106.1-1 Medical Staff files will be maintained on a strictly confidential basis.

#### **106.2 Medical Records**

106.2-1 No information from Medical Records is to be given to an outside agency without the appropriate authorization of the patient, unless it is reviewed by the Hospital administration or the Medical Records Committee-and the attending physician.

## **107.0 Medical Education**

### **107.1 House Staff - Interns, Residents, and Fellows**

- 107.1.1 Terms: The terms, “house staff”, “interns,” “residents,” and “fellows,” (hereinafter referred to collectively as “house staff”) as used in these Rules and Regulations, refer to Practitioners who are currently enrolled in a graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at the Hospital. House staff shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these rules and regulations. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:
- 107.1.2 All interns and residents shall attend staff meetings for educational purposes.
- 107.1.3 House staff shall not provide primary coverage in the absence of the trainers.
- 107.1.4 The program will be reviewed yearly by the Post-Doctoral Training Committee and approved by the Medical Executive Committee.

### **107.2 Medical Students**

- 107.2.1 All Medical Students are under the direction of the Director of Medical Education.
- 107.2.2 Medical Students may participate in the care of patients under the direct supervision and responsibility of an attending physician on the medical staff of the hospital.
- 107.2.3 No Medical Students may inappropriately use computer access codes at any time.
- 107.2.4 Medical Students shall have no rights or relief under Medical Staff Rules and Regulations.

### **107.3 Education**

#### **House Staff**

- 107.3.1 Medical Staff privileges may not be granted to a House Staff member. All training programs must be approved by the Director of Medical Education.
- 107.3.2 Applicable provisions of the professional licensure requirements of this state; All House Staff members must have an osteopathic training license in Pennsylvania. If eligible for an unrestricted license, then an OS license and DEA are required.
- 107.3.3 No House Staff member may inappropriately use computer access codes at any time.
- 107.3.4 House Staff members shall be under the supervision of an attending physician on the medical staff of The Hospital.

UPMC Pinnacle Lititz - Medical Staff Rules and Regulations

- 107.3.5 House Staff members shall be able to care for patients in the hospital under the supervision and responsibility of the attending physicians.
- 107.3.6 The care given by House Staff members will be governed by the rules and regulations of each clinical department and the bylaws of the medical staff.
- 107.3.6.1 The mechanism by which the supervisor(s) and graduate medical education program director make decisions about each participant's progressive involvement and independence in specific patient care activities is defined in each participant's monthly service evaluation and quarterly department evaluation. The GME policy on Evaluation and Promotion may also be referenced.
- 107.3.6.1 While functioning in the Hospital, House Staff Practitioners shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the DME or designee or the President of the Medical Staff or the CEO. House Staff Practitioners may perform only those services set forth in the training 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 or Hospital policies, and to the extent approved by the Board. A house staff Practitioner shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. House Staff Practitioners may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Divisions, or committees, but shall have no voting rights.
- 107.3.7 House Staff members may write orders for the care of patients under the supervision of the attending physicians.
- 107.3.7.1 Interns and Residents from institutions with a properly executed Affiliation Agreement in place may be involved in clinical activity to the following extent:
- 107.3.7.1.1 Performing and recording histories and physicals
- 107.3.7.1.2 Writing orders for the care of patients under the supervision of the attending physician
- 107.3.7.1.3 Scrubbing in surgery
- 107.3.7.1.4 Performing simple procedures under the direct supervision of the attending physician
- 107.3.8 The medical records of all patients with whom the intern/resident is involved shall contain documentation that the attending physician is involved in the supervision of the patient's care and shall include the attending physician's co-signature on written and verbal orders, history and physicals, operative reports and discharge summaries.

**107.4 Student Nurse Midwives**

- 107.4.1 All Midwife Students are under the direction of the Chairperson of the OB-GYN Department.
- 107.4.2 All Midwife students must be currently enrolled in an accredited nurse midwife program and must have an approved contract with the Hospital.

- 107.4.3 Midwife Students may participate in the care of patients under the direct supervision and responsibility of a credentialed nurse midwife and an attending physician on the medical staff of the hospital.
- 107.4.4 No Midwife Students may inappropriately use computer access codes at any time.
- 107.4.5 Midwife Students shall have no rights or relief under Medical Staff Rules and Regulations or Medical Staff Bylaws.
- 107.4.6 Midwife students are required to provide documentation of liability insurance
- 107.4.7 The mechanism by which the attending physician and chairperson of the OB-GYN department make decisions about each participant's progressive involvement and independence in specific patient care activities is defined in each participant's monthly and quarterly evaluations.
- 107.4.8 While functioning in the Hospital, Midwife Students shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Chairperson of the OB-GYN Department, or the President of the Medical Staff or the CEO or their designees. Midwife students may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Bylaws, Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A Midwife Student shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff as well a nurse midwife

**108.0 Staff Responsibilities**

**108.1 Insurance**

- 108.1-1 Members of the Medical staff shall carry malpractice insurance in compliance with Pennsylvania regulations and shall file copies of this coverage at the time of renewal of the policy with the office of the Medical Staff. Honorary and disabled staff members are not required to do so as long as they do not treat patients in the hospital.

**108.2 HIPAA**

Practitioners will comply with the Hospital's privacy and security policies.

**108.3 Clinical Review**

- 108.3-1 Clinical review shall be conducted at departmental levels.

**108.4 Signatures**

- 108.4-1 The use of stamped signatures is not accepted under any conditions.

**108.5 Autopsies**

108.5-1 The following are the recommended criteria from the College of American Pathology (CAP) for when an autopsy should be performed:

- 108.5-1.1 Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
- 108.5-1.2 All deaths in which the cause of death is not known with certainty on clinical grounds.
- 108.5-1.3 Cases in which an autopsy may help to allay concerns of and provide reassurance to the family and/or the public regarding the death.

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- 108.5-1.4 Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
- 108.5-1.5 Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
- 108.5-1.6 Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical justification.
- 108.5-1.7 Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at hospitals; deaths occurring in hospitals within 24 hours or admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- 108.5-1.8 Deaths resulting from high-risk infectious and contagious diseases.
- 108.5-1.9 All obstetric deaths.
- 108.5-1.10 All neonatal and pediatric deaths.
- 108.5-1.11 Deaths in which it is believe that autopsy would disclose a known or suspected illness that may have a bearing in survivors or recipients of transplant organs.
- 108.5-1.12 Deaths known or suspected to have resulted from environmental or occupational hazards.

108.5-2 Every member of the medical staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without written consent of the next of kin unless the autopsy has been ordered by the county coroner. The attending physician will be responsible for requesting permission for an autopsy and for documenting the request in the chart. All autopsies shall be performed by a hospital pathologist or by a physician to whom he may delegate the duty. When an autopsy is performed, the attending physician (by phone call) and the house staff (by announcement) will be notified.

**108.6 Staff Disputes**

108.6-1 The following protocol for settling staff disputes is adopted:

- 108.6-1.1 Discuss the problem directly with the person involved.
- 108.6-1.2 If the problem cannot be resolved between these parties, then the respective head of the department shall be called into the discussion to help resolve differences.
- 108.6-1.3 If the problem cannot be settled, the Medical Staff President will then enter into the discussion for resolution.
- 108.6-1.4 The Medical Staff President will then refer the problem to the appropriate committee if the problem has not been settled.
- 108.6-1.5 Under no circumstances are staff members expected to write letters or in any other way correspond directly with



administration or the Board of Trustees, thereby circumventing the duties and the authority of the Medical Executive Committee. Any violation of this protocol will be deemed unacceptable and appropriate action will be taken by the Medical Executive Committee.

### 108.7 Disabled Physicians

108.7-1 Staff dues shall be eliminated for disabled physicians.

### 108.8 On-Call Obligations

108.8-1 Members of the Active Staff have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities.

108.8-2 The respective Department Chairperson shall serve as the point person/liaison regarding all on-call issues. He/She will, in conjunction with the Medical Director of the Emergency Department, work with physicians to answer questions, mediate disputes and maintain schedules. This person shall have the authority to maintain a call schedule that meets patient quality-of-care-needs. Issues that cannot be resolved by the respective Department Chairperson or the Medical Director of the Emergency Department will be referred to the MEC.

108.8-3 The respective Department Chairperson, on behalf of the Hospital, shall be responsible for developing an on-call rotation schedule that includes the name and pager number of each physician in the department/section who is required to fulfill on-call duties. On-call rotation schedules shall be maintained in the emergency department.

- 108.8-3.1 Members of the Active Staff are only required to be on call, each month, the equivalent of one 24-hour period per week. Additional (voluntary) call responsibilities may be accepted and provided by any Active Staff member.
- i. **Active Staff:** Members who meet the Active status defined in the Medical Staff Bylaws.
  - ii. **Provisional Active Staff:** Provisional Active Members are not eligible for on-call rotation until they demonstrate after six (6) months that they are able to meet Active Staff requirements. The Department Chair shall place the Provisional Active Member in the on-call rotation when the member has been on staff for six (6) months and Active Staff requirements are met
  - iii. **Department Chair:** Department Chair may waive the above requirements with the approval of both the Medical Executive Committee and the Board of Trustees.

## UPMC Pinnacle Lititz - Medical Staff Rules and Regulations

- 108.8-3.2 The respective Department Chairperson may use members of the Courtesy Staff of the department/section to develop the on-call rotation schedule when call coverage needs cannot be met by the Active Staff physicians.
- 108.8-3.3 If an active member of the Staff refuses to fulfill the on-call duty obligation, this shall be considered a voluntary relinquishment of privileges and membership. A certified letter will be sent to the practitioner to inform him/her.
- 108.8-5 A refusal or failure to timely respond shall be reported immediately to the President of the Medical Staff and the Hospital Chief Executive Officer, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action. Otherwise, appropriate action may be imposed.

### **108.9- Performance Monitoring**

- 108.9-1 The Medical Staff will provide leadership for measuring, assessing and improving processes that primarily depend on the activities of one of more licensed independent practitioners and other practitioners credentialed and privileged through the medical staff process. The Medical Staff will participate in organization-wide performance improvement activities.

Approved by Medical Executive Committee 9/18/95  
Approved by Medical Executive Committee with no changes 10/19/98  
Approved by Medical Staff 2/20/2001  
Approved with changes by Medical Executive Committee 12/17/2003 BOT 1/12/2004  
Approved with changes by Medical Executive Committee 1/19/2004 BOT 2/10/2004  
Approved with changes by Medical Executive Committee 2/16/2004 BOT 3/12/2004  
Approved with changes by Medical Executive Committee 3/26/2004 BOT 4/13/2004  
Approved with changes by Medical Executive Committee 5/15/2004 BOT 5/22/2004  
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Approved with changes by Medical Executive Committee 5/18/09 BOT 6/24/09  
Approved with changes by Medical Executive Committee 9/21/09 and 10/19/09 BOT 10/28/09; 4/19/10, 063010, 092010, 022013

9/95, 10/98, 2/01, 12/03, 2/04, 3/04, 4/04, 5/04, 8/06, 12/07, 04/10  
APPROVED by the Governing Body on 10/29/08  
APPROVED by the Governing Body on 12/17/08  
APPROVED by the Governing Body on 10/28/09; 04/28/10. 063010, 102810,  
Approved 0712, approved 11/12 w/ no change, approved w/ changes 032013  
Approved 11/2013 with changes; Approved 12/2013 with changes Approved 03/2015 with changes  
Approved 01/2017 with changes



**Non-Staff Physician License and NPI Validation****Policy Number (1.82)**Department/Section: **Registration**

Issued (i) Review ( r) Revised (rv):

Performed By: **Registration Staff**

i: 01/09 r: 12/10, 1/12 rv:

In order to assure compliance with Pennsylvania Department of Health regulations (28 Pa. Code §127.32 of the hospital licensure regulations), the following procedure must be completed for each outpatient registration, pre-registration and patient scheduling. These steps will ensure that the ordering physician is either a member of the hospital's medical staff or a non-medical staff member who has a valid and current Pennsylvania license issued by the appropriate board in the Department of State, Bureau of Professional and Occupational Affairs.

A process monitor has been initiated to assure appropriate checks have been completed upon pre-registration and registration processes. The Radiology Department is checking all non-staff orders and taking immediate corrective action should any orders be presented without being verified. The monitored data is reported to quality council on a monthly basis.

**Registration Procedure:**

1. When registering patient for outpatient service, verify that ordering physician is listed in the Doctor Master Table. If listed the License and NPI checks have been done and proceed with normal registration process.
2. If the physician is not listed in the Doctor Master Table look up the physician's License and NPI number in the respective websites.
  - a. Print out the License and NPI website result screens
  - b. If the License is valid, register the patient with the 0999 – Non-Staff code and enter the information into the Non-Staff Doctor Database and complete the registration.
  - c. Note that License and NPI have been validated in registration system.
  - d. Apply a "License and NPI Validated" sticker to the Doctor Face Sheet.
  - e. Fill out "Non-Staff Physicians Request Form" for the Medical Staff Office, being sure to place a patient label on the bottom right hand corner.
    - i. Fax form and printed copies of the License and NPI information to the Medical Staff Office.
3. Medical Staff Office will complete validation of physician and enter into the Doctor Master Table, assigning a physician number. This assigned number will be written on the "Non-Staff Physicians Request Form" and faxed to the registration supervisor so that completed registration can be updated.

\*At any time during the checking process should a license come back unverified a supervisor shall be notified immediately and the registration process stopped.

Reference: 1.82.1 "Non-Staff Physician Request Form"

Policy Description: (1.52) <b>Staff Member Medical Records Delinquency</b>	Page 1 of 4 <b>Policy Number 1.52</b>
Department/Section: <b>Administrative</b> Performed By: <b>Medical Staff</b>	Issued (i) Review (r) Revised (rv): i: 9/98 r: 9/99, 1/01, 2/02, 10/09, 12/10, 1/12 rv: 2/04, 6/04, 3/06, 3/08, rv: <b>11/12, rv. 01/14; 05/17r</b>

**PURPOSE:**

Medical Staff members are responsible for incomplete/delinquent medical records.

**POLICY:**

Medical Staff members are notified of incomplete/delinquent medical records. Failure to complete records within 21 days after discharge, after appropriate notification from the Health Information Management Department (Medical Records Department), will result in the loss of admitting privileges and procedure scheduling privileges for non emergent cases. Staff members are responsible for incomplete/delinquent medical records.

**PROCEDURE:**

**MEDICAL RECORDS**

a) Medical Record Content

The attending staff member shall be responsible for **but not limited to:**

- Dictating or writing in the chart a record of the patient's history and physical examination,
- Dictating or writing daily progress notes in the patient's chart,
- Dictating or writing reports of procedures,
- Dictating or writing a discharge summary,
- Verification (by signature) of the portions of the record, which he has dictated or written.

Non-attending staff members who care for a patient shall be responsible, as appropriate for **but not limited to:**

- dictating or writing on the chart consultation reports,
- dictating or writing progress notes,
- dictating or writing reports of procedures,
- verification (by signature) of the portions of the record, which he has dictated or written.

Records shall be legible, and shall conform to standards or regulations of any accrediting or regulatory body or agency having jurisdiction. Contents shall be pertinent and current.

This record shall include, as appropriate:

- identification data;
- chief complaint;
- past medical history;
- family and social history;
- review of systems;
- history of present illness;
- physical examination;
- special reports such as consultations, clinical laboratory, x-ray and others;
- provisional diagnosis;
- medical or surgical treatment;
- pathological findings;
- progress notes;
- final diagnosis;
- condition on discharge;
- disposition;
- discharge summary;
- and autopsy when available.

Policy Description: (1.52) <b>Staff Member Medical Records Delinquency</b>	Page 2 of 4 <b>Policy Number 1.52</b>
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- b) Completion of Record and Medical Record Timeliness  
The medical records (including progress notes, final diagnosis and discharge summary, etc.) should be completed within thirty (30) days of discharge. No medical record shall be filed incomplete except by order of the Medical Records Committee.
- c) Medical Record Delinquency  
For purposes of monitoring delinquent medical records for regulatory and accrediting agencies, incomplete medical records greater than 30 days post discharge will be considered delinquent.
- d) Staff member Delinquency  
A staff member will be considered delinquent in completion of his medical records if the records are not completed, written or dictated and authenticated within twenty-one (21) days from ~~medical record availability. For purposes of determining if a staff member is delinquent in completion of medical records, chart patient discharge, availability is factored in favor of the staff member.~~  
  - Interns and Residents Delinquency – Medical Record Delinquency of interns and residents will be the responsibility of the attending physician and will count toward the attending's delinquency rate. Interns and residents will receive notification of delinquent records in addition to the attending physician as per the established schedule.
- e) Medical Record Status Member Notification Process  
The process of notifying staff members of medical record status will be approved by the Medical Executive Committee. ~~When determining if a staff member is delinquent in completion of medical records, chart availability is factored in favor of the staff member.~~ A Medical Staff member will be notified of impending suspension of clinical privileges when the patient record has charts have been available for fourteen (14) or more days post discharge.
- f) Automatic Suspension for Medical Record Delinquency  
If the medical records for which a Medical Staff member is responsible are incomplete after twenty-one (21) days written notice signed by the Administrator shall be sent to the staff member, notifying him/her of the automatic and immediate suspension, and that he/she shall remain suspended until all of his/her delinquent records have been completed.  
**Staff Member Notification of Automatic Suspension to the Appropriate Department's –**  
Staff members will be notified of suspension. The Health Information Management Department (Medical Records Department) will provide notification when a staff member's suspension has been lifted.  
**Suspension List Availability –** The list of those staff members on automatic suspension shall be prepared by the Health Information Management Department (Medical Records Department) according to the medical staff policy and procedure.  
**Suspension List Distribution –** Copies of the Suspension list and updates will be forwarded to the:  
  - Admissions Office,
  - Emergency Department,
  - Surgery,
  - Nurse Staffing Office,
  - All nursing units,
  - Administration,
  - President of the Medical Staff,
  - Medical Staff Office,
  - Pre-admission Nurse and
  - Others as appropriate.

Policy Description: (1.52) <b>Staff Member Medical Records Delinquency</b>	Page 3 of 4 <b>Policy Number 1.52</b>
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g) Suspension Process Due to Staff Member Delinquency

The President of the Medical Staff/designee or Executive Director/designee will provide written notification to those members whose clinical privileges are being suspended.

In the event of such a suspension, the procedure for assigning the responsibility for the care of patients as set forth in this policy shall apply.

Note: An adverse action as a result of a member going through the hearing or appeal process is required to be reported to the National Practitioner Data Bank

h) Suspension Under this Policy

Members whose clinical privileges are suspended or relinquished under this policy for more than fourteen (14) days shall be entitled to a hearing and appeal procedure per the Medical Staff Bylaws, upon request. The privilege suspension or privilege relinquishment shall remain in effect during the hearing or appeal process.

A record of suspensions will be kept in the staff member's file for consideration at the time of reappointment. Such suspensions may be considered grounds for non-approval during the evaluation for request of reappointment to the medical staff.

If a medical record or Medical Staff member is not available, such as patient readmitted and record checked out, physical illness or , availability days will be adjusted.

A Medical Staff member whose privileges have been suspended is prohibited from admitting patients and attending patients and from scheduling non emergent operations in the hospital. A suspended practitioner shall:

- 1) **Not** be permitted to admit any new patients;
- 2) ~~Not be permitted to attend present patients within the hospital~~  
~~a. Arrangements for present patients within the hospital – The President of the Medical Staff or if delegated to the Chairman of the staff member's Department, shall arrange for another member to act as attending staff member for the suspended member's patients then in the Hospital according to the requirements of the patients with consideration for the patient's wishes. The suspended member shall cooperate with the designated member whose privileges have been suspended shall be relieved of responsibility for the care of patients already in the Hospital as soon as this can be accomplished without hazard to the patients.~~
- 3) ~~Not be permitted to consult, write orders, progress notes, etc., on any new patients, including any patients being cared for by another practitioner for whom the suspended individual is providing coverage (i.e., a suspended practitioner may not provide any hospital coverage for members of his/her group or for any other practitioners);~~
- 4) ~~2) Not~~ take Emergency Department call;
- 5) ~~3) (deleted) Not make interpretive readings of diagnostic studies, such as EKG's;~~
- 6) ~~4) Not~~ schedule or perform procedures, either inpatient or outpatient, in surgery, GI Lab, or any other hospital department;
- 7) ~~5) Not~~ assist at any surgery on patients not already admitted at the time of suspension.

**EXCEPTION:** When a staff member's surgical privileges are temporarily suspended, an exception will be made for inpatients that have already been scheduled for surgery prior to the temporary suspension.

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Policy Description: (1.52) <b>Staff Member Medical Records Delinquency</b>	Page 4 of 4 <b>Policy Number 1.52</b>
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All emergency admissions must be authorized by the President of the Medical Staff, the Administrator, or Medical Staff Department Chairman. However, the courses of an emergency admission will not be interrupted or delayed while authorization is being sought.

- i) Clinical Privileges Reinstatement  
Clinical privileges will automatically be reinstated if all delinquent records are completed within thirty (30) days of the suspension. The Director of Health Information Department (Medical Records Department) shall inform the Admitting Office, Emergency Department, Surgery, Nurse Staffing Office, all nursing units, Administration, President of Medical Staff, Medical Staff Office, Pre-admission Nurse and others as appropriate. The Health Information Department (Medical Records Department) will be responsible for analyzing medical records for the purpose of administering this rule.

j) Suspension Over Thirty (30) Days and Relinquishment of Privileges

~~If the Medical Records for which the staff member was suspended have not been completed, written or dictated and authenticated after thirty (30) days of suspension, the suspended member will automatically voluntarily relinquish staff privileges. Staff member may reapply for clinical privileges and appointment under the Medical Staff Bylaws but is not eligible for Temporary privileges.~~

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~~k) This policy involves clinical privileges, not membership on the medical staff.~~

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j) Suspension Over Thirty (30) Days and Relinquishment of Privileges

If the Medical Record(s) for which the staff member was suspended have not been completed, written and/or dictated and/or authenticated after thirty (30) days of suspension, the name of the suspended member will be forwarded to Administration. The Medical Executive Committee has granted authority to the Administration to forward a certified letter to the suspended member indicating that if the record(s) remain incomplete after 5 days of the receipt of the certified letter, the suspended member will automatically voluntarily relinquish staff membership privileges. The staff member may reapply for membership and reappointment privileges under the Medical Staff Bylaws but is not eligible for temporary privileges.

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## Administrative Policy and Procedure Manual

**Section: Administration**

**Procedure/Policy Number: 1.73**

**Original Date:**

**12/03**

**Procedure Name: Harassment Policy (Medical Staff and Allied Health Staff)**

**Reviewed**

**5/04**

**11/09**

**12/10**

**01/14**

**03/17**

**Revised/Approved**

**6/06**

**08/11**

**Revised/Approved**

**POLICY:**

Heart of Lancaster Regional Medical Center and the Medical Staff are committed to providing a professional, non-discriminatory work environment for Hospital's employees and members of the medical staff.

The Hospital strictly prohibits any form of harassment (see Definition Section). Because harassment affects the mission of the Hospital, the delivery of excellent patient care and the personal well being of affected individuals, the timely and discreet investigation and resolution of complaints is in the best interest of all parties. Complaints of harassment by a member of the medical staff may be made by anyone who witnessed or was the victim of such an occurrence.

**SCOPE:**

This policy applies to all members of the medical staff and others with delineated clinical privileges in the workplace in how their behavior may affect employees, volunteers, students, residents, patients or fellow medical staff members.

**RESPONSIBILITY/APPLICABILITY:**

This policy applies to all members of the Medical and Allied Health Staff.

Implementation of this policy rests with the Chief Executive Officer and the President of the Medical Staff, or their designees. All members of the Medical and Allied Health Staff have a responsibility to follow this policy.

**DEFINITION:**

**Harassment**, as used in this policy, is conduct relating to an individual's race, age, religion, color, gender, pregnancy, sexual orientation, national origin, marital status, military/veteran status, or mental or physical handicap or disability, all of which are protected by federal, state and local law, which has the purpose or effect of creating a hostile, intimidating or offensive work environment. For purposes of this policy, harassment also includes any form of physical abuse or verbal abuse of such significant character and nature that no person of reasonable sensitivities should be expected to tolerate it in the workplace. While it is the intent of this facility to discourage rude or impolite behavior directed against any staff member or employee, it is not the intent of this policy to cover such incidents that a person of reasonable sensitivities should be expected to tolerate in the workplace.

Harassment can occur as a result of a single incident or a pattern of behavior. Harassment encompasses a broad range of physical or verbal behavior that can include, but is not limited to, the following:

- physical or mental abuse
- physical, psychological, written, or verbal intimidation
- racial insults or insults relating to age
- derogatory jokes, derogatory ethnic jokes, comments or slurs delivered in a manner that could be considered belligerent or threatening to another

- any unwanted touching, assault, deliberate blocking or any intimidating action that interferes with free movement
- comments or visually derogatory or demeaning posters, written words, drawings, novelties or gestures which create a hostile or offensive environment
- religious slurs
- taunting, intended to provoke another individual
- ostracizing or imposing special work burdens

**Sexual Harassment** - One specific kind of prohibited harassment is sexual harassment. Sexual harassment is unwanted sexual advances, requests for sexual favors and other communication (oral, written, including electronic mail) or physical conduct of a sexual nature where (1) submission to such conduct is implicitly or explicitly made a term or condition of employment or continued employment; (2) submission to such conduct or refusing to submit to such conduct is used as the basis for employment or continued employment decision affecting the individual; or (3) the conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment. Sexual harassment, like other forms of harassment, covers a broad range of conduct ranging from subtle forms of psychological pressure to actual physical abuse. Some examples of conduct that could constitute sexual harassment include, but are not limited to, the following:

- unwelcome and /or demands for sexual favors
- demands for sexual favors in exchange for favorable reviews, assignments, promotions, continued employment or promises of the same
- continued or repeated sexual jokes, language, epithets, flirtation, advances or propositions
- sexually degrading, demeaning, profane, intimidating, lewd or vulgar words to describe an individual or group of individuals
- graphic verbal commentary about an individual's appearance, sexual prowess or sexual deficiencies
- unwelcome whistling, touching, pinching, brushing the body, assault, coerced sexual acts, or suggestive, insulting or obscene comments or gestures
- the display of sexually suggestive objects, pictures, posters, cartoons or graffiti in the workplace
- name calling, relating stories, gossip, comments or jokes that may be derogatory toward a particular gender
- retaliation against employees for complaining about such behaviors
- in the absence of a doctor/patient relationship, asking questions about sexual conduct or sexual orientation or preference
- harassment consistently targeted at only one gender, even if the content of the verbal abuse is not sexual

## **PROCEDURES:**

### **A. Initiation of Complaint**

1. Complaints filed by a member of the medical / allied health staff alleging harassment by another member of the medical / allied health staff should be submitted directly to the clinical Department Chair. If the Department Chair is involved in the complaint, the complaint should be filed with the Medical Staff President, or designee. If the Medical Staff President is involved in the complaint, the complaint should be filed with Hospital CEO or an officer of the Medical Staff.
2. Complaints filed by any other individual alleging harassment by a member of the medical / allied health staff should be submitted by the complainant, appropriate supervisor or patient representative to the Medical Staff President. The medical staff shall handle the complaint in accordance with this policy and may seek the assistance of a Human Resources representative, if an employee is involved.

### **B. Investigation**

1. The parties involved should make every effort to resolve any issues of harassment as soon as possible after the incident. Management will be responsible for attempting to resolve minor issues on an informal basis, with input of involved parties, when appropriate. Management is defined as anyone deemed to be in charge of the particular unit or department at the time of the occurrence. This includes but is not limited to, CNOs, Charge Nurses, Nurse Manager, Supervisors,

Administrative Supervisors, Department Directors, or Administration.  
Management may call upon the medical staff Department Chair for assistance.

2. In cases where a repetitive pattern of minor harassment issues is identified or a single major issue has occurred, Management should notify the Medical Staff President of the incident. Management will submit a written report of the incident to the Performance Improvement Department who will include the report in the practitioner's confidential peer review file. If the incident involved an employee, a copy of the written report will also be sent to Human Resources.
3. The Medical Staff President, or designee, as representative of the Medical Staff and Medical Executive Committee, shall notify the CEO and convene a Medical Standards Committee as soon as practical. The Medical Standards Committee is a peer review panel of the medical staff.
4. The Medical Standards Committee shall initiate an impartial and discreet investigation of the allegations. Because a thorough and effective investigation may likely require questioning witnesses about interactions involving specific individuals, the hospital cannot guarantee that involved personnel will remain confidential. Involved parties should be informed of this fact, and assured that the hospital will tolerate no retaliatory behavior if names are revealed. Where possible, this investigation shall be undertaken with the goal of being completed in a timely manner.
5. The Medical Standards Committee shall separately interview the person who filed the complaint, the member of the medical / allied health staff allegedly involved and any other individuals who were present when the alleged harassment occurred. The member of the medical staff involved shall be given sufficient details concerning the complaint to allow the member to formulate a reasonable reply.
6. After completing their investigation, the Medical Standards Committee shall issue a letter to the medical staff member involved documenting the nature of the complaint and their findings. A copy of this letter shall be submitted to the Quality Department for inclusion in the practitioner's confidential peer review file.
  - If the findings of the Medical Standards Committee are that the alleged harassment probably did occur, this letter shall notify the medical / allied health staff member that the conduct will not be tolerated by the Hospital and may constitute a violation of applicable law. The letter may also state that such conduct must cease and, if appropriate, recommend that the medical staff member apologize to the complainant. The letter should also indicate that a copy of the letter will be submitted to the Quality Department for inclusion in the practitioner's confidential peer review file.
  - The medical / allied health staff member may submit a response to the letter from the Medical Standards Committee. If the member submits such a letter, a copy shall be provided to the Quality Department for inclusion in the practitioner's confidential peer review file.
7. The Medical Standards Committee shall make a report to the MEC for review and/or action. The report should include copies of correspondence described in 6.a and 6.b above, if applicable.
8. If the findings of the Medical Standards Committee reflect that the alleged harassment probably did not occur, the CEO (or designee) shall meet with the individual who filed the complaint and report an investigation was conducted under the peer review mechanism and a conclusion was reached. If the complainant was a member of the medical / allied health staff, this meeting shall be conducted by the Medical Staff President (or designee). A written letter of exoneration will be sent to the affected Practitioner and a copy of the letter will be filed in the practitioner's confidential peer review file.

C. **MEC Action**

The MEC shall review the report of the Medical Standards Committee and may request additional information and/or an interview with the affected practitioner. The MEC may also defer action and refer the matter back to the Medical Standards Committee with direction for further review. The MEC may accept the Committee's report and dismiss the matter. If the MEC determines that action should be taken, that action shall be in accordance with the Medical Staff Bylaws, the Medical Staff Rules and Regulations and the Medical Staff policies. Such action may include but is not limited to letters of

admonition, censure, reprimand or warning, imposition of terms of probation or special limitation, suspension or revocation of membership.

D. **Protection Against Retaliation**

The Hospital shall not tolerate any retaliation against or intimidation of any individual who has registered a harassment complaint or who has cooperated in connection with the investigation, and any violation of this policy shall be considered an independent cause for discipline, regardless of the merits of the underlying harassment charge.

E. **Time Limitations of Complaints of Harassment**

Any individual impacted by such conduct is encouraged to report the occurrence at the earliest possible moment and no later than 6 months following the occurrence.

F. **Responsibility and Applicability**

This policy is intended to provide guidance to those involved in this process, and all reasonable efforts will be made to adhere to the process set forth. However, the Medical Staff acknowledges that this policy may not be suitable for each and every circumstance. In furtherance of patient safety and quality of care, this policy is intended to include a certain amount of flexibility in order to conduct appropriate investigations. To the extent any Medical Staff Officer determines that this policy is not applicable or suitable regarding a specific set of circumstances, the Medical Staff Officer in collaboration with the Chief Executive Officer, may modify the process as needed and appropriate under the circumstances, or recommend to the Medical Executive Committee that the matter be subject to an entirely different process.



## Administrative Policy and Procedure Manual

**Section: Administration**

**Procedure/Policy Number: 1.74**

**Original Date:**

**1/04**

**Procedure Name: Impaired Practitioner (Medical and Allied Health Staff)**

**Reviewed**

**5/04**

**6/06**

**11/09**

**01/14**

**03/17**

**Revised/Approved**

**10/10**

**08/11**

**Revised/Approved**

**POLICY:**

It is the policy of the Hospital and its Medical Staff to address the issue of Practitioner impairment in such a way as to provide quality patient care while dealing with the impaired Practitioner in a comprehensive but compassionate and confidential manner in accordance with the Americans with Disabilities Act. (See also Medical Staff Disruptive Practitioner Policy)

**PURPOSE:**

This policy is intended to provide guidelines for the identification, review, intervention, action and rehabilitation of physically or psychologically distressed or impaired Practitioners, including Practitioners who are engaging in substance and/or alcohol abuse or other addictions, in order to provide quality patient care. It is in the sole discretion of the Hospital and its Medical Staff to use this policy. This policy is not intended to supersede or replace the corrective action or credentialing processes. It is within the sole discretion of the Hospital and its Medical Staff whether to impose corrective action or appoint or reappoint any Practitioner, including Practitioners who have or are suspected of having psychological or physical conditions which the Hospital and its Medical Staff believe may be detrimental to patient care, their professional practice or conduct or Hospital operations.

**RESPONSIBILITY/APPLICABILITY:**

This policy applies to all members of the Medical and Allied Health Staff.

Implementation of this policy rests with the Chief Executive Officer and the President of the Medical Staff. All members of the Medical Staff and Allied Health Professionals have a responsibility to follow this policy.

**DEFINITIONS:**

"Impaired" or "Impairment": Unable to perform professional services with the skill necessary to ensure quality patient care; a physical, medical, psychological or emotional illness or condition of a Practitioner posing a significant risk of substantial harm to the health or safety of patients, co-workers or, other individuals, including but not limited to loss of cognitive or motor skill, or excessive use or abuse of drugs including alcohol. These illnesses or conditions may be rehabilitated if appropriate treatment is received.

"Impaired Practitioner": Any member of the Medical Staff or any Allied Health Professional who is or was the subject of an investigation under this policy or who is participating in, or has undergone a rehabilitation program pursuant to this policy.

The terms "Medical Staff" and "Allied Health Professionals" shall have the definitions ascribed to them in the Medical Staff Bylaws.

## **PROCESS:**

### **Identification**

Concerns or suspicions regarding a possible physical or psychological impairment of any Practitioner holding Medical/ Allied Health Staff appointment and/or clinical privileges at the Hospital should be reported immediately to the Medical Staff President/designee and the CEO or designee. It is further noted that a practitioner can self-refer. The Medical Staff President/designee shall review the information provided, gather additional information as deemed appropriate, and determine whether further review is necessary. In reviewing the matter, the Medical Staff President/ designee may consult with the Department Chair, conduct interviews of individuals who may have relevant information and may meet with the subject Practitioner.

If the Medical Executive Committee believes there is a reasonable basis to investigate whether a physical or psychological impairment is present, the Medical Staff President /designee shall appoint a Medical Standards Committee that shall conduct a formal, confidential review of the matter. Where feasible, the physicians appointed to the Medical Standards Committee shall not be partners or associates of, or persons in direct competition with, the practitioner who is the subject of the investigation.

Any matter referred to the Medical Standards Committee shall include, if known, the following information:

- a) the date, time and location of the questionable actions or conduct, or when the medical condition became known;
- b) the nature of the actions or conduct and/or the nature of the medical condition;
- c) the names of any witnesses to the actions or conduct;
- d) whether the condition, actions or conduct affected or involved a patient in any way and, if so, the name and medical record number of the patient;
- e) the basis for questioning the actions or conduct, or for the concern with regard to the medical condition; and
- f) whether any action was taken at the time the questioned condition, action or conduct became known and, if so, what action was taken.

Identities of the person reporting or those persons named in the initial report will be kept anonymous to the extent possible.

### **Review**

The Medical Standards Committee may use discretion as to how to conduct the review. It may use outside resources, such as the Pennsylvania Physician Health Program. The matter may be referred for investigation for potential action, pending outcome of the review or investigation as applicable such as: corrective action, summary suspension or other appropriate action, in accordance with the Medical Staff Bylaws and/or all other policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff. Failure or refusal of a Practitioner to cooperate with a review initiated under this Policy may result in precautionary, automatic suspension, or termination of Medical / Allied Health Staff appointment and/or clinical privileges. The matter may also be processed under the corrective action processes outlined in the Medical Staff Bylaws and/or all other, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff. Failure or refusal to cooperate with a review under this Policy may, at the discretion of the Hospital in consultation with the MEC, be deemed to be a waiver of all procedural rights outlined in the Medical Staff Bylaws and/or all other policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff and other rights to which the affected Practitioner may otherwise have been entitled.

### **Report**

The Medical Standards Committee shall make a report to the MEC for review and action. The report of the Medical Standards Committee shall refer to the affected Practitioner by identification number, not by name, to protect the confidentiality of this matter and may suggest:

- a) that a discussion was conducted with the affected Practitioner to determine his/her level of awareness of the implications of the condition and what remedial steps he/she has taken and, to advise him/her of the range of possible recommendations;
- b) that immediate intervention be conducted;
- c) that conditions and/or limitations be imposed on the affected Practitioner's Medical / Allied Health Staff appointment, and/or clinical privileges; and/or
- d) other actions or recommendations as deemed appropriate by the Medical Standards Committee.

Since the Medical Standards Committee is advisory in nature only, the report of the Medical Standards Committee does not constitute an adverse action or recommendation and does not entitle the affected Practitioner to any of the procedural rights outlined in the Medical Staff Bylaws or other policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff.

#### Action of the MEC

The MEC shall review the report of the Medical Standards Committee and may request additional information and/or an interview with the affected Practitioner. The MEC may also defer action and refer the matter back to the Medical Standards Committee with direction for further review.

After the MEC completes its review, it may take action. The action of the MEC may include, but is not limited to:

- a) terminating the review, dismissing the matter, and writing a letter of exoneration;
- b) issuance of a formal letter of admonition or reprimand;
- c) imposition of requirements of training, education, consultation (other than concurring consultation) supervision, intensified review (including concurrent or retrospective review), or observation;
- d) imposition of requirements for physical and/or psychological examination and/or evaluations;
- e) imposition of requirements for treatment and/or monitoring; and
- f) such other actions deemed appropriate by the MEC.

If the MEC determines that intervention, in the form of examination, evaluation, treatment and/or monitoring is necessary, it shall recommend treatment, monitoring and support, as it deems appropriate. The affected Practitioner may be referred to outside sources, such as the Pennsylvania Physicians Health Program. All costs for treatment, monitoring and support shall be the responsibility of the affected Practitioner. The MEC may also recommend restrictions or limitations on Medical / Allied Health Staff appointment and/or clinical privilege and/or leaves of absences, as it deems appropriate. The MEC and other individuals as deemed appropriate by the MEC, shall meet with the affected Practitioner to present the action. Refusal or failure to abide by the actions of the MEC by the affected Practitioner shall, at the discretion of the MEC, be deemed to be a resignation of Medical /Allied Health Staff appointment and/or clinical privileges and a waiver of the procedural rights outlined in the Medical Staff Bylaws and/or all other policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff and other rights to which the affected Practitioner may otherwise have been entitled. Restriction or suspension of an Impaired Practitioner's privileges pursuant to this section may require notification to the National Practitioner Data Bank and State authorities, as appropriate.

#### Completion of Requirements

Once the affected Practitioner believes he/she has completed the requirements of the MEC, the affected Practitioner may submit a request for termination of the requirements. The MEC shall review such request for termination of the requirements to determine whether the requirements imposed and/or restrictions in, limitations of, or leave of absence from Medical / Allied Health Staff appointment and/or limited privileges should be terminated. If the MEC denies the request for termination of the requirements in whole or in part, the affected Practitioner shall be notified in writing. The affected Practitioner shall be given ten (10) days to notify the MEC, whether he/she will continue to comply with the requirements of the MEC or whether he/she wishes the MEC to take action or make a recommendation under the Fair Hearing process. If the MEC's recommendation or action is adverse as defined in Medical Staff Bylaws, the affected Practitioner is entitled to exercise or waive the procedural

rights as outlined in the Medical Staff Bylaws and/or all other policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and its Medical Staff.

#### Restoration Of Privileges

In the event the Impaired Practitioner's clinical privileges have been reduced, revoked, or suspended as a result of an impairment and he/she seeks restoration of such privileges, the Hospital and the Medical Staff shall comply with the following provisions:

- A. Upon sufficient proof that an Impaired Practitioner has successfully completed a rehabilitation program, the appointed Medical Standards Committee shall recommend to the Medical Executive Committee restoration of the Impaired Practitioner's privileges in accordance with the Medical Staff Bylaws.
- B. In considering an Impaired Practitioner for reinstatement, the Board of Trustees of the Hospital and its Medical Staff leadership must consider patient care, quality and safety.
- C. If all of the information received from the Program Director indicates that the Impaired Practitioner is rehabilitated and capable of resuming care of patients, the appointed Medical Standards Committee may make the following additional recommendation(s) regarding restoration of clinical privileges:
  1. The Impaired Practitioner shall identify two practitioners who are willing to assume responsibility for the care of the Impaired Practitioner's patients in the event of his or her inability or unavailability.
  2. The Impaired Practitioner may be required to obtain periodic reports as determined by the appointed Medical Standards Committee with input from the Program Director stating that the Impaired Practitioner is continuing treatment or therapy, as appropriate, and that the Impaired Practitioner's ability to treat and care for patients in the Hospital is not impaired.
  3. The Impaired Practitioner's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a practitioner appointed by the department chairperson. The method of monitoring shall be determined by the Medical Executive Committee as advised by the Medical Standards Committee after its review of all the circumstances.
  4. The Impaired Practitioner shall agree to submit to alcohol or drug screening test as appropriate and as per his/her agreement with the Medical Standards Committee.
- D. All requests for information concerning the Impaired Practitioner shall be forwarded to the Hospital President and the President of the Medical Staff for response.
- E. All information obtained regarding the medical condition or history of the Impaired Practitioner shall be collected and maintained on separate forms and in separate medical files and shall be treated as a confidential medical record, except as otherwise provided for by law.

#### Responsibility and Applicability

This policy is intended to provide guidance to those involved in this process, and all reasonable efforts will be made to adhere to the process set forth. However, the Medical / Allied Health Staff acknowledges that this policy may not be suitable for each and every circumstance. In furtherance of patient safety and quality of care, this policy is intended to include a certain amount of flexibility in order to conduct appropriate investigations. To the extent any Medical Staff Officer determines that this policy is not applicable or suitable regarding a specific set of circumstances, the Medical Staff Officer in collaboration with the Chief Executive Officer / designee, may modify the process as needed and appropriate under the circumstances, or recommend to the Medical Executive Committee that the matter be subject to an entirely different process. Education of licensed independent practitioners and other organization staff about illness and impairment recognition issues will be provided.





## Administrative Policy and Procedure Manual

<b>Section: Administration</b>	<b>Procedure/Policy Number: 1.75</b>					<b>Original Date:</b>	<b>12/05</b>
<b>Policy Name: Content, Examination and Removal of Credentialing Files</b>							
<b>Reviewed:</b>	<b>6/06</b>	<b>10/08</b>	<b>10/09</b>	<b>4/10</b>	<b>12/11</b>	<b>01/14</b>	<b>03/17</b>
<b>Revised:</b>							

**PURPOSE:**

The purpose of this policy is to clarify the requirements for content, examination and removal from the Medical Staff Office, of Credentials files.

**SCOPE:**

This policy covers Credentials files established and maintained in the Medical Staff Office for the intention of determining Medical Staff or Allied Health Staff membership and/or clinical privileges.

**PROCEDURES:**

**Content:**

- a. Completed and verified application for Medical Staff membership, including information on training, experience, references, current licensure and DEA registration, and request for clinical privileges.
- b. Evidence that the Medical Staff evaluated and acted upon the above information.
- c. Specific and current clinical privileges recommended by the Medical Staff and approved by the Board.
- d. Data pertinent to reappraisal and reappointment, including current licensure, DEA registration, liability coverage, certifications, if applicable, and documentation of continuing medical education, health status, training and/or education to support competency for special privileges requested.
- e. Patterns of care as demonstrated in findings of continuous performance activities, such as: operative review, blood usage evaluation, utilization review.
- f. Query results from the National Practitioner Data Bank, Office of Inspector General, and Excluded Parties List websites.

**Examination:**

Any documents and/or other material acquired for Credentialing and received by either the Board, or any of its individual members; the Administration or any Hospital associate; or the Medical Staff, or any of its individual members, shall be delivered in its entirety to the Medical Staff Office as soon as reasonably possible. Medical Staff personnel (or designee) shall file the documents and/or material in the proper credentials file.

The content of the credentials file can only be removed from the Medical Staff Office by the President of the Medical Staff, the CEO, or Medical Staff personnel and then only for the proper evaluation procedures set forth in the Medical Staff Bylaws. Such documents and material, including any and all copies, are to be returned immediately upon the completion of the evaluation procedure.

The Chairman of the Board or his designee, the CEO or designee, the chairman of the Credentials Committee and the chairman of the individual member's respective department, may examine the content of any individual's credentials file within the confines of the Medical Staff Office or in the presence of the Medical Staff office personnel and make handwritten notes but may not remove any materials from the file.

A practitioner may review from his /her own file, up to 2 times in a 12 month period, any documentation that he/she previously submitted. Copies may be made of those same documents at that time. This review shall take

place in the Medical Staff office or in administration during normal business hours with a representative from the Medical Staff office or an approved member of administration present. The practitioner may also review NPDB response and medical record suspension letters.

**Removal:**

Credentialing files will be maintained in the Medical Staff office and areas specially secured and designated for storage for the Medical Staff Office. Files may be moved to appropriate meeting rooms for review and/or signature when under the direct observation of Medical Staff Office personnel/designee. In the event that a file needs to be delivered to a department chairperson, Credentials Committee member, or Board member for review at a location outside of the Hospital, it will be delivered under the direct supervision / approval of the Medical Staff Office personnel or the CEO/designee. Credentialing files are maintained indefinitely.

Policy Description: (1.76) <b>Disaster Credentialing Policy</b>	Page 1 of 3 <b>Policy 1.76</b>
Department/Section: <b>Administrative and Medical Staff</b>	Issued (i) Review (r) Revised (rv): i:12/20/2004 r: 10/06, 5/08 rv: 10/06, 10/09, 08/11, r: 01/14, r 03/17
Performed By: <b>All Staff</b>	

**PURPOSE:**

Practitioners who do not possess medical staff privileges at Heart of Lancaster Regional Medical Center may be granted temporary emergency privileges during a declared state of emergency (local, state, or national) and when the organization is unable to handle immediate patient-care needs without additional clinical assistance. It should be understood this is a voluntary commitment with no monetary compensation.

**SCOPE:**

This policy covers temporary emergency privileges to be granted to a licensed practitioner during a declared state of emergency (local, state, or national) and when the organization is unable to handle immediate patient-care needs without additional clinical assistance.

**AUTHORITY TO GRANT EMERGENCY PRIVILEGES:**

The Chief Executive Officer of the hospital, the Medical Staff President, or an individual designated by either of the foregoing has the authority to grant emergency privileges to a licensed practitioner.

**DURATION AND DELINEATION OF PRIVILEGES:**

Emergency privileges are effective only during the duration of the emergency. Volunteer practitioners may only perform procedures within their scope of practice for their particular specialty.

**PROCEDURES:**

The following documentation must be completed and information provided by the practitioner prior to the granting of emergency privileges:

1. **The following “Key Identification Documents” must be produced**
  - Photo ID – preferably a hospital photo ID card and a valid drivers license  
*and one of the following:*
  - Valid Pennsylvania medical license or valid medical license from another state
  - ID that certifies the individual is a member of a state or federal disaster medical assistance team
  - ID that certifies the individual has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies
  - HLRMC Medical Staff member who can vouch for the identity of the practitioner
  
2. **Volunteer practitioner must complete the “Emergency Credentialing Form” (Attachment #1)**  
The completed application must be given to the Medical Staff Office for immediate processing.

Policy Description: (1.76) <b>Disaster Credentialing Policy</b>	Page 2 of 3 <b>Policy 1.76</b>
Department/Section: <b>Administrative and Medical Staff</b>	Issued (i) Review (r) Revised (rv): i:12/20/2004 r: 10/06, 5/08 rv: 10/06, 10/09, 08/11, r: 01/14, r 03/17
Performed By: <b>All Staff</b>	

**3. Practitioners will be assigned duty stations by the Medical Commander**

The volunteer practitioner should be paired with an HLRMC-credentialed practitioner. HLRMC Medical Staff members will oversee the professional performance of volunteer practitioners who receive disaster privileges through direct observation, mentoring and clinical record review.

**4. Medical Staff Credentialing Procedure:**

a. When the Medical Staff Office Personnel receive the “Emergency Credentialing Form”, the following references and verifications will be requested as soon as possible:

- ◆ AMA Profile or AOA Profile when applicable
- ◆ National Practitioners Data Bank Report
- ◆ Medical License Verifications
- ◆ Sanctions Verification through Office of the Inspector General
- ◆ Telephone reference from Physician’s Primary Institution of Practice
- ◆ DEA when possible

Note: The practitioner’s privileges will be immediately terminated in the event any adverse information is uncovered during the credentialing process. This will be reported to the individual who authorized the emergency privileges.

b. Primary source verification of licensure will begin as soon as the immediate situation is under control and should be completed within 72 hours from the time the volunteer practitioner presents to the organization. In extraordinary circumstances that the primary source verification cannot be completed within 72 hours, it should be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and an attempt to rectify the situation as soon as possible.

c. A decision to continue disaster privileges for the volunteer practitioner will be made within 72 hours of the initial granting of privileges by the Medical Staff President or designee and / or the Chief Executive Officer or designee.

d. Volunteer practitioners, who have been granted disaster privileges, will be identified by a badge labeled as “Volunteer Physician” or “Volunteer Practitioner”. This badge must be worn and obviously displayed by the volunteer practitioner at all times.

ATTACHMENT #1

**HEART OF LANCASTER REGIONAL MEDICAL CENTER  
EMERGENCY CREDENTIALING FORM**

*Please Print*

**Medical Specialty:** \_\_\_\_\_

**Practitioner's Name:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Current State Medical License: (Primary State of Practice)**

**State:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

**DEA #** \_\_\_\_\_

**Current Malpractice Carrier:** \_\_\_\_\_

**Name of Primary Institution of Practice:** \_\_\_\_\_

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

\_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

I certify that I am licensed as a Practitioner in the state of \_\_\_\_\_. I certify that I have the training, knowledge, and experience to practice in the specialty of \_\_\_\_\_.

I hereby volunteer my medical/clinical services to HLRMC during this emergency and agree to practice, as directed and under the supervision of a member of the medical staff of HLRMC.

I acknowledge that my privileges at this hospital shall **immediately terminate** once the emergency has ended, as notified by the hospital.

I verify that I do not have any mental or physical conditions that would interfere with my ability to treat patients.

**Release From Liability Statement**

**I authorize the Hospital to consult with members of other hospitals or organizations which I have been associated and with others who may have information bearing on my competence, character, and ethical qualifications. I release from liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith, when evaluating me. I also release from liability individuals and organizations that provide information to the Hospital concerning my competence, ethics, character and other qualifications for staff privileges.**

Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Attach Photo ID and copy of medical license to this application**

.....  
The information as provided by the practitioner has been reviewed and verified, as possible, by the Medical Staff Services personnel. On this basis, this practitioner is hereby granted emergency privileges to treat patients presenting to Heart of Lancaster Regional Medical Center during this disaster.

Signatures:

Medical Staff President or designee: \_\_\_\_\_ Date \_\_\_\_\_

*and/or*

Chief Executive Officer or designee \_\_\_\_\_ Date \_\_\_\_\_

Policy Description: (1.77) <b>Focused and Ongoing Professional Practice Evaluation</b>	Page 1 of 4 <b>Policy 1.77</b>
Department/Section: <b>Medical Staff</b>	Issued (i) 12/07 Review (r) Revised (rv): 10/08 10/09 12/11. R.01/14(rv) 11/30/2016
Performed By: <b>All Staff</b>	

## **PURPOSE:**

The intent of focused and ongoing professional practice evaluations is to define the process by which the Medical Staff monitors, evaluates and reports the quality of patient care provided by members of the Medical and Allied Health staffs, identify practice trends that adversely impact quality and patient safety and to implement changes to improve performance of individual practitioners.

## **SCOPE:**

A period of focused professional practice evaluation will be implemented for all practitioners initially granted privileges, current practitioners adding additional privileges, or when additional information is needed to assess safe, quality patient care. The Medical Staff will conduct periodic performance reviews (ongoing professional practice evaluation) for all current Medical and Allied Health staff.

## **POLICY:**

The Medical Staff has a leadership role in hospital performance improvement activities. The Medical Staff is actively involved in the measurement, assessment and improvement in the following:

- Medical assessment and treatment of patients
- Use of information about adverse privileging decisions for any practitioner privileges through the medical staff process
- Use of medications
- Use of blood and blood components
- Operative and other procedures
- Appropriate clinical practice patterns
- Significant departures from established patterns of clinical practice
- The use of developed criteria for autopsy
- Sentinel Event data
- Patient Safety

The Medical Staff participates in the following performance improvement activities:

- Education of patients and families
- Coordination of care, treatment, and services with other practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient
- Accurate, timely and legible completion of the patient's medical records
- Review of findings of the assessment process that are relevant to an individual's performance. The Medical Staff is responsible for determining the use of this information in the ongoing evaluation of a practitioner's competence.
- Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body

## **PROCEDURES:**

Focused Professional Practice Evaluation will be implemented on all initially requested privileges. FPPE for new practitioners must be completed as soon as possible. FPPE on all other new privileges must be completed as soon as feasibly possible. FPPE can be extended upon recommendation of the department chairperson, MEC and /or the Board of Trustees.

The following criteria may be used to evaluate clinical competency:

- Chart review

Policy Description: (1.77) <b>Focused and Ongoing Professional Practice Evaluation</b>	Page 2 of 4 <b>Policy 1.77</b>
Department/Section: <b>Medical Staff</b>	Issued (i) 12/07 Review (r) Revised (rv): 10/08 10/09 12/11. R.01/14(rv) 11/30/2016
Performed By: <b>All Staff</b>	

- Clinical Staff interviews
- Peer review data
- Peer evaluations
- Simulation
- Proctoring
- Complaints
- Peer review (internal and external)
- National Practitioner Data Bank results
- Review of malpractice claims, final judgments and settlements
- Maintenance of licensure, malpractice insurance, board certification
- And other data as determined applicable by the Department Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees

Criteria for FPPE for new providers will be developed by each department and approved by the MEC.

The department chairperson will be responsible for completion of the FPPE either through personal evaluation or by assignment to another Medical Staff Member. If assigned to complete FPPE by the Department Chair, the Medical Staff member is obligated to complete the FPPE on the new provider, per the approved criteria, on a timely basis, noting that evaluation is usually expected on the FIRST cases/ patient contacts if possible and practical. Completed FPPE forms should be returned to the Medical Staff Office Disputes regarding assignment should be directed to the Department Chairperson. If agreement cannot be reached, the Medical Executive Committee will make the final decision regarding assignment of FPPE. Assigned non-compliant Medical Staff members shall be subject to disciplinary action. Completed FPPE results will be reviewed by the Department Chairperson and forwarded to the Credentials Committee. Additional FPPE may be requested and the review period may be extended by the Department Chairperson, MEC or the Board of Trustees upon review of the results.

The Medical Executive Committee and the Board of Trustees may require monitoring by an external source in the following circumstances:

- When there is an conflict of interest between involved parties
- When further experience from outside sources is beneficial

The following triggers may mandate that a practitioner's performance be reviewed by the Peer Review Committee:

- Any event that triggers a sentinel event report
- Any unexpected outcome
- Any criteria listed as appropriate for peer review per the Performance Improvement Hospital Peer Review Policy

The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the privilege requested. This will be determined by the department chairperson and/ or the MEC and / or the Board of Trustees.

The criteria for determining which type(s) of monitoring shall be conducted will be determined on an individual basis by the department chairperson and / or the MEC and / or the Board of Trustees. The following measures may be employed to resolve performance issues with approval of the Medical Executive Committee and the Board of Trustees:

- Proctoring
- Privilege specific re-training
- Simulation
- Appropriate forms of education including policy review, CME, and others as recommended
- Other educational forms of training and re-direction not noted above

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Department/Section: <b>Medical Staff</b>	Issued (i) 12/07 Review (r) Revised (rv): 10/08 10/09 12/11. R.01/14(rv) 11/30/2016
Performed By: <b>All Staff</b>	

#### Low Volume Providers

The following measures may be employed to review low volume providers:

- Proctoring
- Chart Review
- Peer references
- Hospital affiliation letters
- Simulation
- Clinical staff interviews
- National Practitioner Data Bank results
- Maintenance of licensure, malpractice insurance, board certification

#### No Volume Providers

The following measures may be employed to review no volume providers:

- Peer references
- Hospital affiliation letters
- Simulation
- National Practitioner Data Bank results
- Maintenance of licensure, malpractice insurance, board certification
- Number of new legal claims/cases

Ongoing professional practice evaluation will be conducted periodically for all current Medical and Allied Health staff at least every nine months. The-required time-frame must be more frequent than annually. Completed OPPE forms will be reviewed by the respective department chairperson and will be a part of the Credentialing file at re-appointment time. The information resulting from the OPPE is used to determine whether to continue, limit, revoke any existing privilege(s).

The information used on the OPPE may be acquired through the following:

1. Periodic chart review
2. Direct observation
3. Monitoring of diagnostic and treatment techniques
4. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants in surgery, nursing and administrative personnel
5. Other means approved by the department chairperson and/or the MEC

The following types of data may be used in the evaluation:

- Review of operative and other clinical procedures and their outcomes
- Pattern of operative and other clinical procedures and their outcomes
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioners use of consultants
- Any other data deemed relevant by the department chairperson or MEC

#### Low Volume Providers

The following measures may be employed to review low volume providers:

- Proctoring
- Chart Review
- Peer references
- Hospital affiliation letters
- Simulation
- Clinical staff interviews
- National Practitioner Data Bank results



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Performed By: <b>All Staff</b>	

- Maintenance of licensure, malpractice insurance, board certification
- OPPE from hospital(s) where the practitioner has activity

No Volume Providers

The following measures may be employed to review no volume providers:

- Peer references
- Hospital affiliation letters
- Simulation
- National Practitioner Data Bank results
- Maintenance of licensure, malpractice insurance, board certification
- Number of new legal claims/cases
- OPPE from hospital(s) where the practitioner has activity

Policy Description: (1.83) <b>Medical And Allied Health Staff Background Checks</b>	Page 1 of 5 <b>Policy 1.83</b>
Department/Section: <b>Administrative and Medical Staff</b>	Issued (i) 10/09 Review (r) 01/14 Revised (rv): 04/10, 0811, 0212, 0712. 03/13; 11/15; 09/16; 01/17
Performed By: <b>Affected Medical and Allied Health Staff</b>	

## Purpose

To establish a systematic process to ensure that due diligence is performed for practitioners who apply or re-apply for membership and/or privileges and those who have returned from an extended leave of absence, by verifying the accuracy of required statements on their applications related to criminal records/behavior. Heart of Lancaster Regional Medical Center requires background checks to protect patients and staff members from potential harm and to safeguard the organization from risk management concerns and institutional liability.

## Policy

The medical staff organization of Heart of Lancaster Regional Medical Center carefully considers background information as part of its investigation of applicants who have applied for membership and/or privileges.

It is the policy of the medical staff to require confirmation of all material information provided on initial applications and re-applications. Consequently, in addition to conducting background checks, all medical staff applicants will be subject to verification of all answers regarding prior criminal records/behavior. In addition background checks may be performed for cause or for practitioners returning from an extended leave of absence at the discretion of the Credentials Committee or Medical Executive Committee (MEC).

Background checks are done in accordance with this policy and with state and federal laws. To avoid invasion of privacy concerns, all practitioners subject to this policy are to be informed that the organization will conduct background investigations and that the continued processing of their application or request for privileges is dependent upon the findings in accordance with this policy.

## Procedure

1. **Scope:** HLRMC has determined that the following elements may be included as part of an applicant's background check:
  - a. Jurisdiction/type of reports/agencies to query:
    - Social Security number check
    - County Criminal search
    - County criminal repository search
    - Federal criminal district court records search
    - National wants and warrants search
    - National or state sex offender search
  - b. Types of crimes:
    - Infractions/violations
    - Traffic offenses (e.g., speeding, DUIs)
    - Misdemeanors
    - Felony convictions

Policy Description: (1.83) <b>Medical And Allied Health Staff Background Checks</b>	Page 2 of 5 <b>Policy 1.83</b>
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- c. Geographic location:
- County
  - State (may include all where the physician has practiced or lived, state or healthcare organization only, surrounding states)
  - Federal
  - International
- d. Time frame:
- Lifetime
2. **Permission:** Consent from the applicant must be signed in order to conduct the background search. If a practitioner does not give permission to conduct a background search and does not provide the required elements to conduct the background search, the application/reapplication will be considered incomplete and not be processed.
3. **Confidentiality:** The following individuals/groups have access to the information: Department Chairs, Credentials Committee, MEC, Medical Staff Office personnel, and Board of Trustees. The background information is maintained within the credentials file. Note: The same policies and procedures for maintaining the confidentiality of peer review information will apply to the results of background checks, including criminal background checks.
4. **Use of Information:** A record containing “hit” information is evaluated by the Department Chair, utilizing the following guidelines and based on the potential risk to the patient and staff:
- Omission of information: If the practitioner did not disclose the information on his or her application or re-application, (in accordance with the medical staff bylaws), the application or re-application is deemed incomplete and is unable to be processed. The Department Chair and / or the Credentials Committee will allow the practitioner the opportunity to correct the application or re-application and then will evaluate the application (in accordance with the established credentials process).
  - Zero tolerance offenses: Due to the potential risk to patient care and to healthcare workers, Heart of Lancaster Regional Medical Center has a zero tolerance policy for certain offenses. Practitioners who are determined to have a conviction in the following categories of crimes are ineligible to apply or to remain on staff at Heart of Lancaster Regional Medical Center:
    - All felony convictions
    - Sex crimes
    - Crimes against children
    - Extreme violent crimes

Policy Description: (1.83) <b>Medical And Allied Health Staff Background Checks</b>	Page 3 of 5 <b>Policy 1.83</b>
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Performed By: <b>Affected Medical and Allied Health Staff</b>	

- Other offenses: Other than the categories of crimes where there is zero tolerance as stated, the Department Chair will evaluate records for practitioners containing “hit” information in accordance with this policy. Decisions regarding the same types of convictions should be handled in a consistent manner. Decisions related to credentialing and privileging will be based on the following:
  - How long ago was the offense committed?
  - What is the potential risk to patient care?
  - Are there any indications of behavior indicating potentially recurring conduct?  
Note: If indicated legal council will be obtained related to disability discrimination regarding the Americans with Disabilities Act.
  - Expunged cases.
  - Cases that were settled without a finding will require additional information from the applicant.

5. **Hearing and appeal procedure:** Applicants are not entitled to the right of a fair hearing and appeal when the background check results fall under any of the Zero Tolerance Offenses.

6. **Review Process:**

- a. Background check records can be clear of information, or the record may contain information also known as a “hit”. Reports that are clear of information will be filed in the practitioner’s credentials file.
- b. Any report that contains a “hit” will be referred to the Department Chair for review and recommendation. The actions of the Department Chair will include:
  - Notification to the applicant/re-applicant of the findings with an opportunity to withdraw the application or refute the findings through written statement and provide information to assist the Medical Staff Office and / or the Hospital to resolve the issue.
  - If the applicant is the offender, confirmation is received that he or she did/did not disclose the information on his or her application, “Omission of information” will apply.
  - Recommendation to the Credentials Committee/MEC regarding the granting or re-granting of appointment and/or privileges or communication with the applicant that he or she is ineligible to apply.
- c. MEC actions:
  - Determination that the applicant/re-applicant is not eligible to apply/reapply
  - Imposition of conditions on appointment/reappointment and/or granting or re-granting of privileges with a recommendation to the Governing Body

Policy Description: (1.83) <b>Medical And Allied Health Staff Background Checks</b>	Page 4 of 5 <b>Policy 1.83</b>
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Performed By: <b>Affected Medical and Allied Health Staff</b>	

## **7. State Criminal History Record Report** *PATCH- Pennsylvania Access to Criminal History*

All Medical Staff and Allied Staff providers and new applicants assigned / applying to the following departments/specialties are required to submit a State Criminal History Record Report: Family Practice with admitting privileges, Anesthesia, Surgery, Emergency Medicine, OB-GYN, and Pediatrics. New applicants in the above noted departments/specialties must provide the clearance or documentation of submission prior to approval of their application requests. A copy will be maintained in the Credentialing file. Expense is the responsibility of the provider. Updated reports must be provided on an ongoing basis within 5 years of the date of the previous report. Providers who do not fall within the criteria of care, supervision, guidance, control or routine interaction that includes regular and repeated contact with pediatric patients that is integral to a person's employment may request, in writing, an exemption to this requirement from the Medical Executive Committee. The definition of a pediatric patient will be defined in the Bylaws of the Department of Pediatrics. Telemedicine providers are exempted from this requirement. Background checks are considered current for 60 months from the date on the certificate.

Criminal convictions do not automatically preclude an applicant for membership and/or privileges unless they fall under the Zero Tolerance Offensives.

## **8. Child Abuse History Clearance/Pennsylvania Child Protection Services Law:**

All Medical Staff and Allied Staff providers and new applicants assigned / applying to the following departments/specialties are required to submit a Child Abuse History Clearance: Family Practice with admitting privileges, Anesthesia, Surgery, Emergency Medicine, OB-GYN, and Pediatrics. New applicants in the above noted departments/specialties must provide the clearance or documentation of submission prior to approval of their application requests. A copy will be maintained in the Credentialing file. Expense is the responsibility of the provider. Updated clearances must be provided on an ongoing basis within 5 years of the date of the previous clearance. Providers who do not fall within the criteria of care, supervision, guidance, control or routine interaction that includes regular and repeated contact with pediatric patients that is integral to a person's employment may request, in writing, an exemption to this requirement from the Medical Executive Committee. The definition of a pediatric patient will be defined in the Bylaws of the Department of Pediatrics. Telemedicine providers are exempted from this requirement. Background checks are considered current for 60 months from the date on the certificate.

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Performed By: <b>Affected Medical and Allied Health Staff</b>	

## 9. Federal Criminal History Clearances:

All Medical Staff and Allied Staff providers and new applicants assigned / applying to the following departments/specialties are required to submit a Federal Criminal History Clearance: Family Practice with admitting privileges, Anesthesia, Surgery, Emergency Medicine, OB-GYN, and Pediatrics. New applicants in the above noted departments/specialties must provide the clearance or documentation of submission prior to approval of their application requests. A copy will be maintained in the Credentialing file. Expense is the responsibility of the provider. Updated clearances must be provided on an ongoing basis within 5 years of the date of the previous clearance. Providers who do not fall within the criteria of care, supervision, guidance, control or routine interaction that includes regular and repeated contact with pediatric patients that is integral to a person's employment may request, in writing, an exemption to this requirement from the Medical Executive Committee. The definition of a pediatric patient will be defined in the Bylaws of the Department of Pediatrics. Telemedicine providers are exempted from this requirement. Background checks are considered current for 60 months from the date on the certificate.

## 10. Provisional Status:

During the time period that results are pending for PA Child Abuse Clearances and Federal Criminal History Clearances, practitioners may complete the application process and be granted for privileges for a provisional period of 90 days when the following conditions are met:

- The practitioner provides evidence of having completed the required initial documentation and affirms in writing that he/she is not disqualified.
- The hospital must not be aware of any information that would disqualify the provisional practitioner.
- The provisional practitioner must work in the immediate presence of a regular practitioner or employee and not work alone with children.
- If information is obtained that reveals that the provisional practitioner is disqualified from access to children, the practitioner must immediately have his/her privileges suspended pending review by the President of the Medical Staff and the Chief Executive Officer.

If documentation of completed PA Child Abuse Clearances and Federal Criminal History Clearances are not received within the 90 day provisional period the practitioner's privileges are automatically suspended until all required documentation is received and the file is deemed complete.



## Administrative Policy and Procedure Manual

**Section: Administrative**

**Procedure/Policy Number: 1.85**

**Original Date:**

**10/10**

**Policy Name: Evaluation of Resources for Privileging**

**Reviewed:**

**12/11**

**01/14**

**03/17**

**Revised:**

**PURPOSE:**

The intent of this policy is to define the process by which the Medical Staff determines whether there is sufficient space, equipment, staffing, and financial resources to support specific privileges.

**SCOPE:**

The Medical Staff will evaluate the resources needed to support clinical privileges for approved practitioners such that they provide for patient safety and represent the needs of the Hospital.

**PROCEDURES:**

When a new privilege is requested by the member of the Medical Staff or the Allied Health Staff, the department chair will make a recommendation to the Credentials Committee and the MEC after evaluating whether there is sufficient space, equipment, staffing, and financial resources in place and available within a reasonable period of time to support the requested privileges. An affirmative recommendation will be in the form of the department chairperson's signature on the privilege request form.

The Credentials Committee will evaluate the request and make its recommendation to the Medical Executive Committee, who will in turn, make its recommendation to the Board of Trustees for final approval.

Policy Description: () <b>Medical Staff Conflict Management Process</b>	Page 1 of 1 <b>Policy 1.86</b>
Department/Section: <b>Medical Staff</b>	Issued (i) 4/11 Review (r) 01/14 , 03/17 Revised (rv):
Performed By: <b>All Staff</b>	

**PURPOSE:**

The intent of this policy is to define the process by which the Medical Standards Committee will work with the Medical Staff and the Medical Executive Committee to resolve conflict.

**SCOPE:**

When there is conflict between the Medical Staff and the MEC regarding a proposed change to Medical Staff rules, regulations, policies or amendments, the Medical Standards Committee will serve as liaison and a mediator to work with the two (2) groups to resolve the conflict.

**DEFINITION:**

Conflict is defined as a disagreement between the Medical Executive Committee and a 51% majority of the active non-provisional medical staff members regarding, changes in policy, rules and regulations and bylaws.

**PROCEDURES:**

A 51% majority of the active non- provisional Medical Staff has the right to make proposals directly to the Board of Trustees. They must first communicate the proposal, in writing, to both the Medical Executive Committee and to the Board of Trustees at least 30 days prior to the next regularly scheduled meeting of the Board of Trustees (not executive session). The Board of Trustees will determine all further paths of communication.

The Medical Standards Committee shall make all reasonable efforts to obtain and review the information and documentation regarding the proposal which is in conflict.

The Committee will utilize the following steps:

- Meet independently with two (2) physicians appointed as representatives from the Medical Staff and with two (2) physicians appointed as representative of the Medical Executive Committee.
- Meet with the CEO and the appointed representatives of both parties jointly.
- As necessary, meet with other Administration and other parties (internal or external).
- If resolution is reached between the two (2) parties the Medical Standards Committee will present the resolution, in writing, to the Board of Trustees. The Board of Trustees will review this proposal for approval.
- If three (3) subsequent joint meetings do not provide for resolution of the issue, the Medical Standards Committee will submit a written report of all findings and recommendation(s) to the Board of Trustees with a detailed and comprehensive summary of all information gathered, considered and relied upon in support of the recommendation(s). The Board of Trustees, based upon data provided by and recommendation by the Medical Standards Committee, will determine acceptance of the proposal.



Policy Description: (1.87) <b>Ordering of Outpatient Services by Non Staff Physicians</b>	Page 1 of 3 <b>Policy Number (1.87)</b>
Department/Section: <b>Registration</b>	Issued (i) Review ( r) 01/14
Performed By: <b>Registration Staff / Medical Staff Office</b>	Revised (rv): i: 05/12 r: rv:

## **POLICY:**

Select outpatient services at Heart of Lancaster Regional Medical Center may be ordered and patients may be referred for outpatient services by a non-staff practitioner who:

- Is responsible for the care of the patient
- Has a valid active license in the jurisdiction where he/she sees the patient
- Is not on the OIG (Office of the Inspector General) List of Excluded Individuals and entities and / or the GSA/EPLS (General Services Administration) List of Parties Excluded from Federal Programs
- Holds a valid NPI (National Provider Identifier)
- Is acting within his/her scope of practice under State Law; and
- Is authorized by the Medical Staff to order the applicable services under a written policy that is approved by the governing body.

## **PROCEDURE:**

Services that can be ordered by non-staff practitioner include:

- Diagnostic Studies: laboratory, radiology, cardiopulmonary
- Outpatient services for Respiratory and Rehabilitation

Services that cannot be ordered by non-staff practitioner:

- Blood and Blood components
- Medications
- IV Fluids
- Chemotherapy

Results of diagnostic testing will be communicated to the ordering practitioner in a timely manner.

Registration Process:

- Verify if ordering practitioner is in the Doctor Master Table. If the provider is listed, proceed with patient registration.
- If the provider is not listed, they must be entered as a new non-staff practitioner via the following steps:
  - NPI validation: look-up practitioner number, print copy
  - State License validation: look-up practitioner license number, verify clear (active) status, print copy

Policy Description: (1.87) <b>Ordering of Outpatient Services by Non Staff Physicians</b>	Page 2 of 3  <b>Policy Number (1.87)</b>
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- **OIG validation:** look-up practitioner name and verify no match, print copy
  - **GSA/EPLS validation:** look-up practitioner name and verify no match
- If at any time during the verification and validation process should a license, OIG, or GSA/EPLS come back with negative or questionable information, the Director of Registration or designee will notify the Compliance Officer or the Medical Staff Office for assistance in the verification process.
- All documents will be forwarded to the Medical Staff Office.
- A copy of the verifying information will be maintained.

Policy Description: (1.87) <b>Ordering of Outpatient Services by Non Staff Physicians</b>	Page 3 of 3  <b>Policy Number (1.87)</b>
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