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MISSION

The mission of Northfield Hospital is to provide exceptional healthcare to the communities we serve.

VALUES STATEMENT

We, the employees, volunteers, professional staff, and Board of Directors of Northfield Hospital and its associated services, are in partnership to provide caring, healing, and hope to all we serve, promising to uphold these values:

1. PATIENT AND FAMILY CENTERED CARE
We will care for each patient as an individual, not a medical condition to be treated, recognizing that each patient is a unique person, with diverse needs. We welcome patients as our partners in care, and we welcome involvement of their families and friends. We will provide understandable health information.

2. INTEGRITY
We will be honest, ethical, and fair. We will provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

3. RESPECT
We will treat each other and those we serve with courtesy, honor, and dignity, accepting and valuing each individual. We will provide care that is respectful of and responsive to individual patient preferences, needs and values, and ensure that patient values guide all clinical decisions.

4. COMPETENCE
We will diligently maintain high standards by performing our duties safely, with expertise and good judgment. We will provide services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit.

5. COOPERATION
We will work together as a team, striving to achieve common goals.

6. COMMUNICATION
We will be good listeners, as well as express clearly and concisely what is needed and expected.

7. STEWARDSHIP
We will work to reduce delays for those who receive and give care, and to avoid waste of equipment, supplies, ideas and energy. We will seek to apply our financial resources for the maximum benefit of our community and our broader service area.
DEFINITIONS

1. **Authorized representatives** include the CVO and any of the following individuals who have any responsibility for obtaining or evaluating the individual’s credentials, or acting upon the individual’s application or conduct in the hospital:
   a. The members of its Board and their appointed representatives;
   b. The CEO or his/her designees;
   c. Other hospital employees;
   d. Consultants to the hospital;
   e. The hospital’s attorney and his/her partners, associates or designees; and
   f. All appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual’s credentials, or acting upon the individual’s application or conduct in the hospital.

2. **Board** is the Board of Directors of the Hospital.

3. **CEO** is the individual appointed by the Board to act on its behalf in the overall leadership and management of the Hospital.

4. **CVO** (Credentials Verification Organization) is the organization with which the Hospital has an agreement for primary credentials verification.

5. **Hospital** is Northfield Hospital, and excludes clinics and the Long Term Care Center.

6. **Medical Staff** is the formal organization of practitioners who hold membership and/or are privileged to attend patients at the Hospital.

7. **Minimum number of patients per year** is established by the Board upon recommendation of the Medical Executive Committee.

8. **Patient** is anyone who receives services provided by the Hospital.

9. **President** is the president of the Medical Staff.

10. **Third parties** are all individuals and entities from which the Hospital or its authorized representatives have requested information.
CHAPTER ONE:  BYLAWS

INTRODUCTION

WHEREAS, the Board and Medical Executive Committee (MEC) of Northfield Hospital agree that:

1. Northfield Hospital is a municipal hospital and health system organized under the laws of the State of Minnesota; and
2. Each practitioner appointed to the Medical Staff has responsibility for the exercise of professional judgment in the care and treatment of patients; and
3. The Board, in accordance with legal and accreditation requirements, has delegated to the Medical Staff committees and services the functions set forth in this Medical Staff Manual for monitoring the quality of care provided by practitioners in the Hospital, and for making recommendations concerning applications for appointment, reappointment and clinical privileges; and
4. There must be collaborative efforts among the Board, the Medical Staff and the CEO to fulfill the Hospital’s mission.
5. By applying for membership and/or privileges, each applicant and member of the Medical Staff agrees that the content of this Manual is subject to the interpretation of the MEC and the Board.
6. In the event of a disagreement between the MEC and the Board regarding the interpretation the Manual, the MEC has the right to call a joint conference with equal representation from the Board and MEC.

THEREFORE, in order to discharge these functions set forth in this Manual and to provide guidelines for matters of election, meetings, and procedures; the officers, committees, service chiefs, medical advisors and practitioners of the Medical Staff assume the responsibilities delegated to them by the Board.
ARTICLE 1: PURPOSE AND ADDITIONAL RULES

1.1 Purpose

Chapter One establishes the structure of the Medical Staff.

1.2 Additional Rules

This Manual contains the following chapters describing the functions of the Medical Staff:

A. Chapter Two: Clinical Services and Standing Committees establishes guidelines for membership, responsibilities, and other requirements for clinical services and standing committees.

B. Chapter Three: Credentialing, Privileging, and Membership establishes guidelines for evaluation of practitioners applying for appointment or reappointment to the hospital’s Medical Staff and/or for clinical privileges.

C. Chapter Four: Investigation and Corrective Action establishes guidelines for:
   1. Investigation of concerns regarding a Medical Staff member,
   2. Suspension of privileges, and
   3. Hearing and appeal process when there is a recommendation for an adverse action that affects initial appointment, reappointment, or privileges as specified in Article 3.3 of Chapter 4.

D. Chapter Five: Rules and Regulations establishes guidelines for admission and discharge of patients, medical records and conduct of care.

It is the responsibility of each applicant and member of the Medical Staff to obtain, read, understand, and abide by all chapters of this Manual.

By applying for membership and/or privileges, each applicant and member of the Medical Staff agrees that these bylaws and additional rules of the Hospital are subject to the interpretation of the MEC and/or the Hospital, at their sole
discretion.
ARTICLE 2: MEMBERSHIP AND CATEGORIES

2.1 Conditions

Only practitioners who continuously satisfy the conditions defined in Chapter Three: Credentialing, Privileging, and Membership are qualified for membership on the Medical Staff.

No individual shall be entitled to appointment to the medical staff or to the exercising of particular clinical privileges in the Hospital (other than privileges to perform history and physical examinations) merely by virtue of the fact that such individual is licensed to practice his/her profession in this or any other state, is a member of any particular professional society, or has had in the past, or currently has, medical staff appointment or privileges in this or another hospital.

2.2 Medical Staff Dues

Annual dues are required for all members of the Medical Staff, established through a recommendation by the Medical Executive Committee (MEC) and approved by the Board. Failure to pay the required dues by the deadline established by the MEC is considered a voluntary resignation. Medical Staff dues are used to support Medical Staff services.

2.3 Nondiscrimination Policy

No individual shall be denied appointment solely on the basis of race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, disability, sexual orientation or age.

2.4 Intended Practice Plan

Each provider is required to complete an Intended Practice Plan at appointment and reappointment. This information is used to support decisions for appointment, reappointment, granting of privileges, and appointment to an appropriate category and committee(s).
2.5 Medical Staff Categories Grid
<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
<th>Volume Description</th>
<th>Membership Description</th>
<th>Dues</th>
<th>Clinical Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>MD, DO, oral surgeon, podiatrist</td>
<td>Meets NH volume threshold at NH</td>
<td>Voting membership</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Affiliate</td>
<td>MD, DO, oral surgeon, podiatrist</td>
<td>Meets NH volume threshold using volume at other acute care hospital(s) and/or ASC’s</td>
<td>Nonvoting membership</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Refer and Follow</td>
<td>MD, DO, oral surgeon, podiatrist</td>
<td>No volume requirement</td>
<td>Nonvoting membership</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Emeritus</td>
<td>Retired from active hospital service</td>
<td>No volume requirement</td>
<td>No membership</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>MD, DO</td>
<td>Meets NH volume threshold at NH or other acute care hospital(s) and/or ASC’s</td>
<td>Nonvoting membership</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health - Independent</td>
<td>APRN's (nurse midwives, nurse anesthetists, nurse practitioners), dentists, optometrists</td>
<td>No volume requirement</td>
<td>Nonvoting membership</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied Health - Dependent</td>
<td>PA's, O-PA's, dental surgical assts</td>
<td>none - privilege period runs with supervising provider's privileges</td>
<td>Nonvoting membership</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
2.6 **Active Staff**

A. Active staff shall consist of practitioners qualified and accepted for medical staff membership who:

1. Admit and/or are involved in the care of the minimum number of patients per year as defined by the Board; and

2. Request and are approved for such status.

B. Active staff shall have admitting privileges, with the exception of specialists in anesthesiology, pathology, psychiatry, radiology and telemedicine.

C. All Active staff are eligible to vote, and to serve on committees; however, only those Active staff who have completed their provisional period may hold office or serve as a Service Chief.

D. Active staff are encouraged to attend Medical Staff meetings held quarterly.

E. Active staff shall:

1. Participate in emergency service and other specialty coverage programs, unless otherwise exempted by the Medical Staff Rules & Regulations;

2. Comply with EMTALA regulations;

3. Participate in assigned committees, patient care quality activities, utilization review and quality evaluations and monitoring activities; and

4. Provide continuous care and supervision of assigned patients or arrange a suitable alternative practitioner.

2.7 **Affiliate Staff**

A. Affiliate staff shall consist of practitioners qualified and accepted for Medical Staff membership who

1. Admit and/or are involved in the care of the minimum number of patients per year as defined by the Board; and

2. Request and are approved for such status.
B. Affiliate staff shall have admitting privileges, with the exception of specialists in anesthesiology, pathology, psychiatry, and radiology.

C. Affiliate staff shall not be eligible to vote or hold office.

D. They may serve on standing or special committees when appointed by the President.

E. They are invited to attend Medical Staff meetings.

F. Affiliate staff, with the exception of specialists in anesthesiology, occupational medicine, pathology, psychiatry, and radiology, must be able to demonstrate that they admit and/or are involved in the minimum number of patients per year as defined by the Board either through their combined volume at the Hospital and another acute care hospital(s)/ambulatory surgery center(s), or through their volume at another acute care hospital(s)/ambulatory surgery center(s) alone. The other acute care hospital(s)/ambulatory surgery center(s) must have patient care evaluation processes, utilization review, quality improvement activities or other monitoring activities similar to those of this Hospital.

G. Affiliate staff shall:

1. Comply with EMTALA regulations;

2. Participate in assigned committees, patient care quality activities, utilization review and quality evaluations and monitoring activities;

3. Provide continuous care and supervision of assigned patients or arrange a suitable alternative alternative practitioner.

2.8 Refer and Follow Staff

A. Refer and Follow staff shall consist of practitioners qualified and accepted for medical staff membership who wish to follow the care of their patients at the Hospital,

B. Refer and Follow staff do not have admitting privileges and do not make entries into the medical record.

C. Refer and Follow staff privileges are limited to visiting their patients at the
medical staff discussing their patient’s condition and treatment with the managing practitioner and nursing staff, and viewing the medical record of their patients.

D. Refer and Follow staff are not eligible to vote or hold office, but may be appointed to standing or special committees, and attend meetings.

2.9 Telemedicine Staff

A. Telemedicine staff provide remote diagnosis and treatment of patients using telecommunications technology.

B. Telemedicine staff are not eligible to vote or hold office, be appointed to standing or special committees, or attend meetings.

2.10 Allied Health Staff

Allied Health staff shall consist of non-physician health care providers who are Independent or Dependent practitioners. Allied Health staff:

A. May serve on committees as appointed by the President;

B. Are invited to attend Medical Staff meetings;

C. Shall not have admitting privileges, with the exception of nurse midwives; and

D. Shall not be eligible to vote or hold office.

2.10.1 Independent

Independent Allied Health practitioners are individuals who are qualified by academic and clinical training and permitted by State law and by the Hospital to participate in the care of patients

A. Without the direct supervision of a Medical Staff member;

B. Within the scope of their licenses; and

C. In accordance with individually granted clinical privileges.

2.10.2 Dependent

A. Dependent Allied Health practitioners are individuals who are qualified by academic and clinical training and permitted by State
law and by the Hospital to participate in the care of patients

1. Only with the supervision of an Active or Affiliate Medical Staff member;
2. Within the scope of the supervising Medical Staff member's clinical privileges; and
3. In accordance with individually granted clinical privileges.

B. The supervising Medical Staff member must accept full responsibility and accountability for the conduct of the Dependent Allied Health practitioner within the Hospital.

C. The provisions of Chapter 4 do not apply to the Dependent Allied Health practitioner.

2.11 Emeritus Status

Practitioners who have retired from active hospital service and wish to be involved in Medical Staff activities may request Emeritus status.

A. The CEO assigns Emeritus status with the concurrence of the President and Board.
B. A practitioner with Emeritus Status is not a member of the Medical Staff.
C. No application process is required.
D. Emeritus status practitioners may not vote, hold office, admit, or attend patients.
E. They are invited to attend Medical Staff meetings.

ARTICLE 3: STRUCTURE OF THE MEDICAL STAFF

3.1 Officers

3.1.1 The Officers of the Medical Staff Shall Be:
A. President of the Medical Staff
B. Vice President of the Medical Staff

3.1.2 Qualifications of Officers
Officers must meet the following criteria:
A. Be members of the Active staff;
B. Have completed their provisional period at the time of nomination and election; and
C. Remain as Active staff in good standing during their term of office.

3.1.3 President

The President shall:

A. Act in coordination and cooperation with the CEO and Vice President in all matters of mutual concern within the Hospital;
B. Call, preside over, and be responsible for the agenda of all general meetings of the Medical Staff;
C. Oversee the monitoring of quality, utilization, and risk management activities of the hospital as they relate to the Medical Staff;
D. Preside over the MEC;
E. Preside over the Patient Care Committee, which oversees clinical quality improvement initiatives.
F. Appoint Medical Staff members to all standing, special, and multi-disciplinary committees, and name chairpersons of these committees;
G. Appoint Medical Staff members to Medical Advisor positions;
H. Enforce the rules of this Medical Staff Manual, implement sanctions where these are indicated, and monitor compliance where corrective action has been instituted for a practitioner;
I. Represent the views, policies, needs and grievances of the Medical Staff to the Board and the CEO;
J. Attend Board meetings, report to the Board on Medical Staff quality improvement activities and serve as liaison between the Medical Staff and the Board;
K. Act as the spokesperson for the Medical Staff in its external professional and public relations; and
L. Oversee the use of Medical Staff funds.
3.1.4 **Vice President**

The Vice President:

A. In the absence of the President, shall assume all duties and have the authority of the President;

B. Shall be a member of the MEC;

C. Shall succeed the President when the latter fails to serve for any reason; and

D. Shall assume the position of the President on the completion of the preceding President’s term.

3.1.5 **Election**

A. Regular elections shall occur in every even numbered year. The members of the Active staff, through a balloting process, shall elect the office of Vice President from a list of one or more nominees submitted by the MEC. Election ballots shall be mailed to each member of the Active staff at least fourteen (14) days before the last quarterly meeting of an election year, and shall be returned in the envelopes provided. There shall be no voting by proxy. The ballots shall be opened and counted by individuals appointed by the President.

B. Any nomination made by a member not on the MEC must be submitted in writing to the MEC at least one month before the election in order to be included on the ballot.

C. The candidate who receives the majority vote of the returned ballots shall be elected.

D. Election results will be submitted for approval at the next regularly scheduled Board meeting.

E. The election of each officer shall become effective as soon as approved by the Board.

F. Each officer shall serve from the start of the next year for a term of two years or until a successor has been elected and the election
approved by the Board.

G. In any election, if there are three or more candidates for an office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until one candidate obtains a majority.

3.1.6 Removal of Medical Staff Officers

A. Grounds for removal include, but are not limited to:

1. Failure to perform the duties and responsibilities of the position assigned in this Medical Staff Manual, and/or
2. Failure to remain in good standing due to:
   a. Loss of Medical Staff membership
   b. Loss of licensure to practice

B. Removing an officer from office requires Board action and can be initiated by one of the following: Board resolution, MEC resolution, or petition by Active staff.

1. Board Resolution
   a. The Board may remove an officer by resolution of the Board upon recommendation by:
      i. a member of the Board, or
      ii. the CEO.
   b. The Board may remove the officer without recommendation from the Medical Staff.
   c. Notice of the meeting of the Board at which the Board resolution is to be considered shall be given to the officer at least ten (10) days in advance of the meeting.
   d. The officer subject to the removal proceedings shall be given the opportunity to speak prior to the taking of any vote of such removal.
   e. At the discretion of the Board, members of the MEC
or other members of the Active staff may be given the opportunity to speak.

f. The resolution for removal requires a majority vote of the members of the Board.

g. The removal shall be effective when the Board has approved it.

2. MEC Resolution

a. The MEC may initiate removal of an officer by resolution adopted by at least two-thirds of the members of the MEC.

b. An MEC resolution to remove an officer will be voted on at a special meeting of the Active staff, pursuant to Article 4.2.

c. Notice of the meeting at which the MEC resolution is to be considered shall be given to the individual officer and to all Active staff at least ten (10) days in advance of the meeting.

d. The officer subject to the removal proceedings shall be given the opportunity to speak prior to the taking of any vote of such removal.

e. The result of the vote by Active staff on the MEC resolution is forwarded to the Board.

f. The removal shall be effective when the Board has approved it.

3. Petition by Active staff

a. A petition signed by not less than 25% of the Active staff may initiate removal of an officer.

b. The signed petition is submitted to the President, which will prompt calling a special meeting of the Active staff.

c. The petition to remove an officer will be voted on at a
special meeting of the Active staff, pursuant to Article 4.2.

d. Notice of the meeting at which removal of an officer is to be considered shall be given to the affected officer and to all Active staff at least ten (10) days in advance of the meeting.
e. The officer subject to the removal proceedings shall be given the opportunity to speak prior to the taking of any vote of such removal.
f. The result of the vote by Active staff is forwarded to the Board.
g. The removal shall be effective when the Board has approved it.

3.1.7 Vacancies in Office

If there is a vacancy in the office of the President, the Vice President shall serve out the remainder of the term. Vacancies in the office of Vice President during the year shall be filled by election at the next regular meeting of the Medical Staff or at a special meeting.

3.2 Committees

The Medical Staff and its committees shall perform the Medical Staff’s peer review responsibilities, monitoring and evaluating patient care, providing programs of continuing education, developing and recommending policies, rules and regulations, and performing other functions as assigned by the President or the MEC.

3.2.1 Medical Executive Committee (MEC)

A. Structure of the MEC:

1. Voting members shall consist of at least the following members: the President, Vice President, and the
chairpersons of the Perinatology, Surgery, Emergency Services, General Medical, and Credentials committees.

2. The President may also appoint up to five non-voting members to the MEC.

3. The Vice President may serve as the chairperson of one of the medical staff committees.

4. The CEO and COO or designee may attend each MEC meeting on an ex-officio basis, without a vote.

B. The duties of the MEC shall be to:

1. Act on behalf of the Medical Staff in all matters subject only to the limitations set forth within the Medical Staff Manual and governing documents of the hospital.

2. Review medical staff committee reports, and make recommendations concerning them to the Board.

3. Coordinate the activities and general policies of the various clinical services.

4. Implement and enforce hospital policies and procedures and the rules of the Medical Staff Manual.

5. Serve as liaison among the Medical Staff, the Hospital, and the Board.

6. Keep the Medical Staff informed of accreditation and regulatory requirements.

7. Address situations involving questions of clinical competence, patient care and treatment, and/or inappropriate behavior of any Medical Staff member;

8. Implement the portion of the organization’s quality plan for which the Medical Staff assumes responsibility including reviewing summary reports of quality improvement, utilization management and risk management activities.

9. Support a continuing education program for members of the Medical Staff based on recommendations from services.
10. Review and revise processes of Medical Staff membership, delineation of clinical privileges, fair hearing and termination of membership as necessary.

11. Review and evaluate recommendations concerning qualifications of each applicant for initial appointment, reappointment or modification of appointment for Medical Staff membership and/or clinical privileges. The MEC may interview applicants as necessary.

12. Submit recommendations to the Board regarding the qualifications of each applicant with respect to:
   a. Appointment,
   b. Staff category,
   c. Service affiliation,
   d. Clinical privileges,
   e. Reappointment, including any special conditions, corrective actions, limitations or exceptions.

13. Review the safety and efficacy of medical procedures and practices, and recommend to the Board whether they should be performed at the Hospital.

14. Develop and maintain written criteria for the delineation of clinical privileges, and recommend these to the Board.

15. Review the overall practice of medicine at the hospital.

16. Oversee quality improvement initiatives as members of the Patient Care Committee.

17. Work collaboratively with other hospital and Medical Staff committees, and work groups to effectively complete these responsibilities.

18. Perform other duties and responsibilities as may be assigned by this Medical Staff Manual, the Medical Staff, the Hospital or the Board.

C. The MEC shall meet at least bimonthly and maintain a permanent
D. In order to vote on an action or recommendation, more than 50% of voting members of the Medical Executive Committee must be present. A simple majority of those voting members present shall be required to pass an action or recommendation.

3.2.2 Medical Staff Committees

The Medical Staff is organized into clinical service areas and utilizes committees to carry out the responsibilities of the Medical Staff. Committees are described in the Medical Staff Committees chapter.

3.2.3 Special Committees

Special committees shall be created as necessary to carry out the duties of the Medical Staff. The President appoints their members and chairperson. Special committees shall confine their activities to the purpose for which they were appointed, and shall report to the MEC.

3.3 Service Chiefs

Service Chiefs are Active members of the Medical Staff, are board certified, and have the following duties and responsibilities:

A. Serve as chairperson of their respective clinical service committee;
B. Responsible for clinically and administratively related activities of the service, unless otherwise provided by the hospital;
C. Continuing surveillance of the professional performance of all individuals in the service area who have delineated clinical privileges;
D. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the service;
E. Recommending clinical privileges for each member of the service;
F. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the service or the organization.
G. The integration of the service into the primary functions of the organization
H. The coordination and integration of interdepartmental and intradepartmental services
I. The development and implementation of policies and procedures that guide and support the provision of care.
J. The recommendations for a sufficient number of qualified and competent persons to provide care.
K. The continuous assessment and improvement of the quality of care.
L. Recommending space and other resources needed by the service.

3.4 Medical Advisors

Medical Advisors are Medical Staff members appointed to provide medical oversight and Medical Staff coordination for specific clinical areas. They have the following responsibilities:
A. Continuing surveillance of the professional performance of all individuals in the clinical area who have delineated clinical privileges
B. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the clinical area
C. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the clinical area or the organization.
D. The integration of the clinical area into the primary functions of the organization
E. The coordination and integration of interdepartmental and intradepartmental services
F. The development and implementation of policies and procedures that guide and support the provision of care.
G. The recommendations for a sufficient number of qualified and competent persons to provide care.
H. The continuous assessment and improvement of the quality of care.
I. The orientation and continuing education of all persons in the department
or clinical area

J. Recommending space and other resources needed by the clinical area

K. Recommending clinical privileges for each member of the clinical area when appointed to do so by the President.

ARTICLE 4: MEDICAL STAFF MEETINGS

4.1 Regular Meetings

Regular meetings of the Medical Staff shall be held once per quarter. A simple majority of voting members present shall be required to recommend an action to the Board.

4.2 Special Meetings

4.2.1 Calling a Special Meeting

A. The Board, the CEO, or the President may request a special meeting of the Medical Staff at any time.

B. The Active staff may request a special meeting by petition. The President shall call a special meeting when a petition has been signed by at least 25% of the Active staff.

4.2.2 Scheduling

A. The special meeting shall take place at least thirty (30) days, but not more than forty-five (45) days following the date of receipt of the special meeting request.

B. The President or designee will provide written notice stating the place, date, and hour of any special meeting of the Medical Staff. The notice will be delivered either personally or by mail to each voting member of the Medical Staff, not less than two (2) nor more than thirty (30) days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice.
## ARTICLE 5: ADOPTION AND AMENDMENT REQUIREMENTS

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<td>Majority vote of MEC members present and voting where a quorum exists. Results go to next meeting of the Active Medical Staff. Majority vote of Active members present and voting. Results must be ratified by the Board.</td>
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<td>Two</td>
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<td>Majority vote of MEC members present and voting where a quorum exists. Results go to next meeting of the Active Medical Staff. Majority vote of Active members present and voting. Results must be ratified by the Board.</td>
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<td>MEC and Board</td>
<td>Majority vote of MEC members present and voting where a quorum exists. Results must be ratified by the Board.</td>
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ARTICLE 6: ADOPTION AND AMENDMENTS

Initial adoption: 4/2006

Amendments:

7/27/2006
• Article 2.5 update to MS categories grid for occupational medicine
• Article 2.6 and 2.7: Change to admitting privileges exceptions to add occupational medicine
• Article 3.1.4: Vice President will serve as chair of Credentials Committee
• Article 5: for Chapters One and Two: Addition to Voting Groups- “MEC”; Addition to Method “Majority vote of MEC members …”

9/27/2007
• Articles 2.7, 2.8 and 2.9: changed “invited to attend” to “welcome to attend”
• Article 3.2.1: title change of VP of Patient Care Services to Chief Operating Officer (COO)

7/30/2009
• Article 2.1: added text in parentheses
• Article 2.5: deleted exemption of CRNA’s from emergency services and specialty coverage

12/16/2010
• Article 3.1.3: added appointment of Medical Advisors to President’s duties
• Article 3.1.4: removed requirement that VP serve as chair of Credentials Committee
• Article 3.2.1: added chair of Credentials Committee to MEC membership
• Article 3.4: Medical Advisors may recommend privileges for their clinical area when appointed to do so by President

12/18/2014
• Article 2.5: replaced grid to reflect new categories
• Article 2.7: replaced description of Courtesy category with Affiliate category
• Article 2.8: added Refer and Follow category
• Article 2.9: added Telemedicine category
• Article 2.11: changed “Honorary” category to “Emeritus” category
CHAPTER TWO – MEDICAL STAFF COMMITTEES

ARTICLE 1: PURPOSE

Chapter Two establishes guidelines for membership, responsibilities, and other requirements for medical staff committees.

ARTICLE 2: COMMITTEE DESCRIPTIONS

The Medical Staff is organized under the MEC into the following committees to carry out the responsibilities of the Medical Staff:

2.1 Emergency Services Committee

A. Membership

1. Voting members of the committee shall be Active Staff members, shall include the Medical Director of the Emergency Services, and include at least three (3) additional members appointed by the President.

2. Non-voting members shall include an administrative representative, the nurse director of the Emergency Department and other members appointed at the discretion of the President.

3. The chairperson of this committee is appointed by the President, shall serve on the MEC and shall act as the Chief of Service for the areas of the Emergency Department, Emergency Medical Services (EMS) and Outpatient Clinic.

B. Responsibilities

1. Approve the implementation of a planned, systematic and service-wide approach to designing, measuring, assessing, and improving performance in Emergency Department, EMS and Outpatient Clinic.

2. Work collaboratively with other departments and services.

3. Identify goals for the services based on the work to be done,
customer needs, the organization’s mission and strategic plan, and
other business plans.

4. Recommend to the Medical Staff the criteria for clinical privileges in
this service.

5. Use the peer review process to evaluate patient care.

6. Evaluate and improve, as needed:
   a. Appropriateness and effectiveness of invasive procedures
      and medication,
   b. Use of blood and blood components,
   c. Clinical pertinence and timeliness of documentation,
   d. Utilization of resources,
   e. Customer satisfaction,
   f. Areas of potential risk in the clinical aspects of patient care
      and safety, and
   g. Other identified opportunities for improvement.

7. Assure that patients presenting with similar needs are given the
   same level of quality patient care by all individuals providing
   services in the Emergency Department, EMS and Outpatient Clinic,
   with particular attention to patients whose care may be given in
   several locations throughout the organization.

8. Establish, implement, and periodically update standard orders
   applicable to this service area.

9. Review ongoing workable and effective disaster response plan for
   the Medical Staff as a part of the overall hospital disaster response
   plan, and collaborate with the Emergency Management Task
   Force.

10. Recommend to the MEC:
    a. Appropriate topics for hospital sponsored continuing
       education activities, and
    b. Any policies related to Emergency Department, EMS and
       Outpatient Clinic.
11. Implement recommendations as they relate to all areas of responsibility after policies/procedures are approved by the MEC.

12. Review real-time staffing needs for acuity/volume of emergency department patients.

13. Report census to Emergency Services Committee as needed based on acuity.

C. Meeting, Documentation and Reporting Requirements

The Emergency Services Committee shall:

1. Meet at least quarterly,

2. Maintain a permanent record of its proceedings and action, and

3. Report all committee business to the MEC on a quarterly basis.

D. Communication

Approved policies and other pertinent actions are communicated to:

1. Members of the Medical Staff who practice in the Emergency Department, EMS and Outpatient Clinic,

2. All members of the Medical Staff if there are significant changes in Emergency Department operations, and

3. Employees if recommendations relate to necessary changes in practice, work flow, behavior and knowledge.

2.2 General Medical Committee

A. Membership

1. Voting members of the committee shall be Active Staff members, and include at least three (3) members of the Medical Staff appointed by the President.

2. Non-voting members shall include an administrative representative, the nurse director of acute care and other members appointed at the discretion of the President.

3. The chairperson of this committee is appointed by the President, shall serve on the MEC and act as the Chief of Service for the
B. Responsibilities

1. Approve the implementation of a planned, systematic and service-wide approach to designing, measuring, assessing, and improving performance in general medical services. These services include:
   a. Regular reports
   b. General Medical Care
   c. Critical Care
   d. Pharmacy
   e. Health Information Services
   f. Report as needed:
      i. Social Services
      ii. Imaging
      iii. Laboratory

2. Work collaboratively with other departments and services.

3. Identify goals for the service based on the work to be done, customer needs, the organization’s mission, and strategic plan, and other business plans.

4. Recommend to the Medical Staff the criteria for clinical privileges in this service.

5. Use the peer review process to evaluate patient care.

6. Evaluate and improve, as needed:
   a. Appropriateness and effectiveness of invasive procedures and medication,
   b. Use of blood and blood components,
   c. Clinical pertinence and timeliness of documentation,
   d. Utilization of resources,
   e. Customer satisfaction,
   f. Areas of potential risk in the clinical aspects of patient care and safety,
g. Other identified opportunities for improvement.

7. Assure that patients presenting with similar needs are given the same level of quality patient care by all individuals providing general medical services, with particular attention to patients whose care may be given in several locations throughout the organization.

8. Establish, implement, and periodically update standard orders applicable to this service area

9. Recommend to the MEC:
   a. Appropriate topics for hospital sponsored continuing education activities, and
   b. Any policies related to general medical services

10. Implement recommendations as they relate to all areas of responsibility after policies/procedures are approved by the MEC.

C. Meeting, Documentation and Reporting Requirements

The General Medical Committee shall:

1. Meet at least quarterly,

2. Maintain a permanent record of its proceedings and actions, and

3. Report all committee business to the MEC on a quarterly basis.

D. Communication

Approved policies, and other pertinent actions are communicated to:

1. Members of the Medical Staff who practice in general medical services,

2. All members of the Medical Staff if there are significant changes in general medical services operations, and

3. Employees if recommendations relate to necessary changes in practice, work flow, behavior and knowledge.

2.3 Perinatology Committee

A. Membership

1. Voting membership of the committee shall be Active Staff
members, and include at least three (3) members of the Medical Staff appointed by the President.

2. Non-voting members shall include an administrative representative, the nurse director of the First Touch Birth Center, and other members appointed at the discretion of the President.

3. The chairperson of this committee is appointed by the President and will serve on the MEC and act as the Chief of Service for the areas of obstetrics and neonatology.

B. Responsibilities

1. Approve the implementation of a planned, systematic and service wide approach to designing, measuring, assessing, and improving performance in obstetrics and neonatology.

2. Work collaboratively with other departments and services.

3. Identify goals for the service based on the work to be done, customer needs, the organization’s mission, and strategic plan, and other business plans.

4. Recommend to the Medical Staff the criteria for clinical privileges in this service.

5. Use the peer review process to evaluate patient care.

6. Evaluate and improve as needed:

   a. Appropriateness and effectiveness of invasive procedures and medications,

   b. Use of blood and blood components,

   c. Clinical pertinence and timeliness of documentation,

   d. Utilization of resources,

   e. Customer satisfaction,

   f. Areas of potential risk in the clinical aspects of patient care and safety, and

   g. Other identified opportunities for improvement.

7. Assure that patients presenting with similar needs are given the same
level of quality patient care by all individuals providing obstetrics and neonatology services, with particular attention to patients whose care may be given in several locations throughout the organization.

8. Establish, implement, and periodically update standard orders applicable to this service area

9. Recommend to the MEC:
   a. Appropriate topics for hospital sponsored continuing education activities, and
   b. Any policies related to obstetrics and neonatology.

10. Implement recommendations as they relate to all areas of responsibility after policies/procedures are approved by the MEC.

C. Meeting, Documentation and Reporting Requirements
   The Perinatology Committee shall:
   1. Meet at least quarterly,
   2. Maintain a permanent record of its proceedings and actions, and
   3. Report all committee business to the MEC on a quarterly basis.

D. Communication
   Approved policies and other pertinent actions are communicated to:
   1. Members of the Medical Staff who practice in obstetrics and neonatology,
   2. All members of the Medical Staff if there are significant changes in obstetrics and neonatology operations, and
   3. Employees if recommendations relate to necessary changes in practice, work flow, behavior and knowledge.

2.4 Surgery Committee

A. Membership
   1. Voting members of the committee shall be Active Staff members, and include at least three (3) members of the Medical Staff appointed by the President.
2. Non-voting members shall include an administrative representative, the nurse director of the operating room, a nurse anesthetist, and other members appointed at the discretion of the President.

3. The chairperson of this committee is appointed by the President and shall serve on the MEC and act as the Chief of Service for the areas of surgery and anesthesia.

B. Responsibilities

1. Approve the implementation of a planned, systematic and service wide approach to designing, measuring, assessing, and improving performance in surgery and anesthesia.

2. Work collaboratively with other departments and services.

3. Identify goals for the service based on the work to be done, customer needs and the organization’s mission, and strategic plan, and other business plans.

4. Recommend to the Medical Staff the criteria for clinical privileges in this service.

5. Use the peer review process to review patient care.

6. Evaluate and improve, as needed:
   a. Appropriateness and effectiveness of invasive procedures and medications
   b. Use of blood and blood components
   c. Clinical pertinence and timeliness of documentation
   d. Utilization of resources
   e. Customer satisfaction
   f. Areas of potential risk in the clinical aspects of patient care and safety, and
   g. Other identified opportunities for improvement.

7. Assure that patients presenting with similar needs are given the same level of quality patient care by all individuals working in surgery and anesthesia, with particular attention to patients whose
care may be given in several locations throughout the organization.

8. Establish, implement, and periodically update standard orders applicable to this service area.

9. Recommend to the MEC:
   a. Appropriate topics for hospital sponsored continuing education activities, and
   b. Any policies related to surgery and anesthesia.

10. Implement recommendations as they relate to all areas of responsibility after policies/procedures are approved by the MEC.

C. Meeting, Documentation and Reporting Requirements

The Surgery Committee shall:

1. Meet at least quarterly,
2. Maintain a permanent record of its proceedings and actions, and
3. Report all committee business to the MEC on at least a quarterly basis.

D. Communication

Approved policies, and other pertinent actions are communicated to:

1. Members of the Medical Staff who practice in surgery or anesthesia,
2. All members of the Medical Staff if there are significant changes in surgery or anesthesia operations, and
3. Employees if recommendations relate to necessary changes in practice, work flow, behavior and knowledge.

2.5 Credentials Committee

A. Membership

1. Voting members of the committee shall be Active Staff members, and at least two (2) additional members appointed by the President.
2. Non-voting members shall include at least one member of the Medical Staff Services Office. Other non-voting members may be appointed at the discretion of the President.
3. The chairperson of this committee is appointed by the President and will serve on the MEC.

B. Responsibilities

1. Review and investigate all applications for appointment and reappointment for staff membership and requests for clinical privileges and make recommendations to the MEC, using the rules and requirements in this Manual.

2. Recommend to the MEC any policies related to the credentialing process.

3. Implement recommendations as they relate to all areas of responsibility after policies/procedures are approved by the MEC.

C. Meeting, Documentation and Reporting Requirements

The Credentials Committee shall:

1. Meet as frequently as needed to conduct the business of the committee, but no less than bimonthly.

2. Maintain a permanent record of its proceedings and actions, and

3. Report all committee business to the MEC on at least a quarterly basis.

D. Communication

Approved policies and other pertinent actions are communicated to:

1. All members of the Medical Staff if there are significant changes in credentialing and privileging operations, and

2. Employees if recommendations related to necessary changes in practice, work flow, behavior and knowledge.

2.6 Infection Prevention Committee

A. Membership

Voting members of the committee shall consist of at least one (1) Active Staff member, the Chief Nurse Executive, the Director of Quality, the
infection prevention practitioner, a representative from the acute care
nursing staff, surgery, pharmacy, lab, emergency department,
housekeeping, and other members appointed by the President.

B. Responsibilities

1. Establish and maintain practical system for reporting and
   maintaining records of patient infections.
2. Review infections within the hospital, including proper management
   and epidemic potential.
3. Establish definitions of hospital-acquired infections for surveillance
   purposes to provide for early identification and reporting of
   infections.
4. Develop recommendations and action plans as indicated by
   surveillance data.
5. Define conditions requiring infection prevention and control
   precautions.
6. Review and evaluate aseptic and infection prevention and control
   processes.
7. Monitor procedures relating to the environment of care including
   sterilization and disinfection procedures, cleaning processes, food
   services, and waste management, and infection prevention related
   to construction and renovation.
8. Make recommendations and provide guidance to the employee
   health program.
9. Recommend inservice education for all services relating to infection
   prevention and control, including an orientation program for new
   employees.
10. Approve proposals and protocols for special infection prevention
    and control studies.
11. Recommend to the MEC:
    a. Appropriate topics for hospital sponsored continuing
education activities, and

b. Any policies related to infection prevention and control for all services

12. Implement recommendations as they relate to all areas of responsibility after policies/procedures are approved by the MEC.

D. Meeting, Documentation and Reporting Requirements

The Infection Prevention Committee shall:

1. Meet at least four times a year,

2. Maintain a permanent record of its proceedings and actions, and

3. Report all business to the MEC on at least a quarterly basis

E. Communication

Approved policies and other pertinent actions are communicated to:

1. All members of the Medical Staff if there are significant changes in infection prevention and control operations, and

2. Employees if recommendations related to necessary changes in practice, work flow, behavior and knowledge.
### ARTICLE 3: ADOPTION AND AMENDMENT REQUIREMENTS

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<tr>
<td>Two Clinical Services and Standing Committees</td>
<td>MEC, Active Staff Members and Board</td>
<td>Majority vote of MEC members present and voting where a quorum exists. Results to go next meeting of the Active Medical Staff. Majority vote of Active members present and voting. Results must be ratified by the Board</td>
<td>Written, proposed amendment or adoption is made available to all members of the Medical Staff at least seven (7) days before the meeting.</td>
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ARTICLE 4: ADOPTION AND AMENDMENTS

Initial adoption: 4/2006

Amendments:

7/27/2006
- Article 2: Change to all committee descriptions: Responsibilities section – addition to “Recommend to the MEC”; Addition of “Authority” section
- Article 2.5: Vice President is a member and chair of Credentials Committee
- Article 3: Addition to Voting Groups- “MEC”; Addition to Method “Majority vote of MEC members …”

9/27/2007
- Articles 2.1, 2.2, 2.3 and 2.4: changed “customer” to “patient”
- Article 2.2: updated “Regular Reports” list, added “Report as Needed” list

12/16/2010
- Article 2.5: Chair of Credentials Committee is appointed by the President and serves on the MEC
- Article 2.7: deleted LTCC Committee description
CHAPTER 3 – CREDENTIALING, PRIVILEGING AND MEMBERSHIP

ARTICLE 1: PURPOSE

Chapter Three establishes guidelines for evaluation of practitioners applying for appointment or reappointment to the hospital's Medical Staff and/or for clinical privileges.

ARTICLE 2: CREDENTIALING FOR MEMBERSHIP AND/OR PRIVILEGES

The credentialing process includes a series of activities designed to collect relevant data that serve as the basis for decisions regarding appointment to membership on the Medical Staff, and/or the granting of clinical privileges. Credentials review is the process of obtaining, verifying, and assessing the qualifications of an applicant to provide patient care, treatment, and services for Northfield Hospital.

2.1 Prescreen

An application will not be accepted under these conditions:

A. The applicant does not possess a current license or registration to practice in Minnesota.
B. The candidate is excluded from Medicare, Medicaid or other governmental programs.
C. The applicant has not completed internship and one year of residency.

2.2 Initial Dues

Initial applicant dues are required of all initial applicants to any category (Active, Affiliate, Refer and Follow, Telemedicine and Allied Health) of the Medical Staff. The amount is established through a recommendation by the MEC and approved by the Board. The application will not be considered complete and will not be submitted for credentials review until the dues are received. Dues are non-refundable.
2.3 Burden of Providing Information

The applicant shall have the burden of:

A. Producing adequate information for an evaluation of competence, character, ethics and other qualifications;

B. Resolving any doubts about qualifications;

C. Providing evidence that all the statements made and information given on the application are true and correct; and

D. Immediately reporting any changes to statements and information on the application.

Until the applicant has provided all information requested by the Hospital and Medical Staff, the application for appointment will be deemed incomplete and will not be processed.

2.4 Duration of Appointments

Appointment to the Medical Staff shall be made for a period not to exceed two (2) years.

2.5 Credentialing Applications

Application for appointment to the Medical Staff and/or for privileges shall be in writing and shall be submitted on forms approved by the Board upon recommendation of the Credentials Committee and MEC. All forms shall be obtained from the Hospital and/or CVO designated by the Board. The application for Active, Affiliate, Refer and Follow, Telemedicine and Allied Health shall require detailed information concerning the applicant’s professional qualifications:

A. Education, training and experience;

B. Names, addresses and dates of employment and appointments to past and present hospital staffs and/or clinics of any type;

C. The names and complete addresses of the applicant’s Service Chief/Department Chair and at least two (2) peers who have had recent experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant’s present
professional competence and character. At least one (1) peer reference shall be from the same specialty as the applicant. References are limited to one office associate and may not be personally related to the applicant. Applicants that are still in residency or fellowship training, and do not have a Service Chief/Department Chair, will use their Residency Director.

D. Copies of the applicant’s current license(s) or registration(s) to practice; 
E. Copy of applicant’s current Drug Enforcement Administration certification; 
F. Information as to whether the applicant is (1) Board certified, (2) an active candidate for Board certification, or (3) in a residency-training program in an area of medical practice appropriate for the clinical privileges being requested; 
G. Allied Health members will name their collaborative/sponsoring physician(s), and where a collaborative/sponsoring agreement is required by regulations shall include a copy of the agreement. 
H. Information as to whether the applicant’s Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced or not renewed at any other hospital or health care facility; 
I. Information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment, any clinical privileges, or resigned from a Medical Staff before final decision by a hospital’s or health care facility’s governing body regarding appointment, reappointment, or pending disciplinary action; 
J. Information as to whether the applicant’s membership in local, state or national professional societies, or license/registration to practice any profession in any state, or Drug Enforcement Administration certificate has ever been challenged, voluntarily or involuntarily suspended, modified, terminated, or relinquished; or if any matter is pending which may result in such action; 
K. A copy of the applicant’s malpractice insurance declaration, and information as to whether the applicant has currently in force professional
liability coverage at the levels required by the Board, the name of the insurance company, and the amount and classification of such coverage; including exceptions, conditions or limitations; and litigation experience, including any pending matters, settlements or final judgments;

L. Information as to whether the applicant has ever been or currently is named as a defendant in a criminal action and details about any such instance;

M. Information as to the applicant’s mental, physical and emotional health;

N. A recent photo is required of initial applicants; and

O. The applicant’s signature.

The completed application shall also include an acknowledgment that the applicant has received and has agreed to be bound by this Manual and to policies that are in force at the time of this application.

Submission of the credentialing application shall constitute authorization for the Hospital or its authorized representative to submit a request for information to verify the above.

2.6 **Authorization to Obtain Information**

The following statements shall be included with the credentialing application form and are express conditions applicable to any applicant seeking Medical Staff membership and/or seeking clinical privileges. By applying for appointment and/or clinical privileges, the applicant accepts these conditions during the consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment.

A. **Authorization of Investigation and Release of Information Concerning Application for Participation**

The applicant authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the
applicant’s professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on the applicant’s qualification for participation and authorize such third parties to release such information to the hospital and its authorized representatives.

B. Authorization of Release and Exchange of Disciplinary Information

The applicant further authorizes any health care organization at which the applicant has applied for, currently has or had participation or employment, to release Disciplinary Information about any disciplinary action taken against the applicant to the Hospital and/or its authorized representatives, and as otherwise may be required by law.

As used herein, Disciplinary Information means information concerning:

1. Any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict or condition the applicant’s participation or impose a corrective action plan;
2. Any other disciplinary actions involving the applicant including but not limited to discipline in the employment context; or
3. The applicant’s resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after the applicant has knowledge that such formal charges are contemplated and/or in preparation.

C. Release from Liability

The applicant further releases from liability the Hospital and its authorized representatives; state licensing board(s); health care organizations, including, without limitation, hospitals, clinics, and third party payers; medical malpractice insurance carrier(s), and any staff; and all individuals, institutions and entities providing information in accordance with this
authorization, for their acts performed in good faith and without malice in
connection with the gathering and release and exchange of information as
consented to above. This release shall be in addition to any other
applicable immunities provided by law for peer review activities.

2.7 Clinical Privileges

Each practitioner shall be entitled to exercise only those clinical privileges
specifically granted by the Board.

2.8 Requirements for Privileges and/or Membership

A. Appointment to the Medical Staff shall be extended only to professionally
competent individuals who meet the qualifications, standards and
requirements set forth in this Manual and in such policies as are adopted
by the Medical Staff or the Board.

B. An application received from an individual that does not contain this
information will be returned to the individual without action.

C. The Hospital may use a CVO to obtain and verify all information used as
part of the application process.

D. All applicants must:

1. Possess a license or registration to practice in the State of
   Minnesota;

2. Not be excluded from participation in Medicare, Medicaid or other
governmental payer programs;

3. Be a graduate of an accredited school appropriate to their specialty.
   (Medical, Dental, Osteopathic, Podiatric, etc.)

4. Have completed a residency, if applicant is an MD, DO, OMS, or
   podiatrist), except when specifically waived by the Board.

5. Registered with the DEA; except for practitioners whose scope of
   practice does not involve prescribing medications;

6. Bound by the consent and waiver, and statement of immunity, set
   forth on the application and requirements in this Manual;
7. Unless specifically waived by the Board or for practices for which there is no board certification, shall be board certified, an active candidate for board certification, or in a residency training program in an area of medical practice appropriate for the clinical privileges being requested; with board certification to be attained within the time frame established by the certifying board;

8. Worthy in character and matters of professional ethics and able to demonstrate and document the ability to work harmoniously with others;

9. Maintain their health status, including physical mental and emotional health, as necessary to perform the responsibilities associated with the requested privileges with reasonable skill and safety and provide current information regarding any condition that may limit or impair the applicant or member’s ability to perform such responsibilities;

10. Possess adequate professional liability insurance as required by the Board;

11. Not disqualified by the Minnesota Department of Human Services to practice at the Hospital without supervision or observation;

12. Unless specifically waived by the Board, able to provide continuous care and supervision by themselves or their credentialed designate for all their patients in the hospital;

13. Seek consultation when:
   a. Level of care needed is beyond scope of practice;
   b. Level of care needed has not been granted by privilege delineation;
   c. The patient needs services Northfield Hospital does not provide.

14. Be willing to provide information regarding clinical activity and privileges at other hospitals in which he or she has Medical Staff status;
15. Able to demonstrate competence, including current knowledge, judgment, and technique, through relevant recent training, quality assessment activities, or other reasonable indicators of competence for all privileges applied for;

16. Appear for personal interviews in regard to his/her application as requested;

17. Agree that the hearing and review procedures in this manual shall be the only remedy with respect to any action taken by the Medical Staff or the Board;

18. Abide by this Medical Staff Manual and policies of the Hospital;

19. Agree to maintain a patient’s privacy and confidentiality of patient medical information;

20. Abide by generally recognized ethical principles of the applicant’s profession;

21. Refrain from actions that would violate federal and/or state laws regarding medical billing;

22. Refrain from delegating responsibility for diagnoses or care of patients to any individual who is not qualified and credentialed to undertake this responsibility or who is not adequately supervised;

23. Refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

24. Accept committee assignments and such other reasonable duties as assigned.

25. Complete Medical Staff Orientation before beginning work at the Hospital.

Any misrepresentation or omission of information, whether intentional or not, may cause rejection of the application. In the event appointment or reappointment has been granted, discovery of such misrepresentation or omission may result in dismissal from the Medical Staff.

2.9 Procedure for Initial Appointment and/or Clinical Privileges
2.9.1 Submission of Forms

The applicant shall submit the application and privilege forms to the Hospital or the Hospital’s CVO. After receiving all information required, including verifications, the CEO or his/her designee shall pass the application to the Service Chief or Medical Advisor for review. An application shall be deemed incomplete if the need arises for new, additional or clarifying information anytime during the evaluation.

2.9.2 Service Chief or Medical Advisor Review

The Service Chief of the relevant service committee(s), or the Medical Advisor of the relevant clinical area:
A. Shall review the applicant’s qualifications for appointment and for clinical privileges;
B. Has the right to meet with the applicant to discuss any aspect of his/her application, qualifications and requested clinical privileges.
C. Has the right to request additional information and documentation. Further processing of the application shall be stayed until the meeting with the applicant, if requested by the Service Chief or Medical Advisor, is concluded and the additional information and documentation is received. It is the applicant’s burden to provide and ensure that such additional information and documentation is received;
D. Shall provide the Credentials Committee with a report containing an appraisal of the applicant’s qualifications for appointment and proposed clinical privileges.

2.9.3 Credentials Committee Review

A. The Credentials Committee shall review all pertinent information available to determine whether the applicant has established and satisfied all the necessary qualifications for membership and for the clinical privileges requested, including the report from the Service
B. If the Service Chief or Medical Advisor has not provided the Credentials Committee with his/her report, the Medical Staff Office will contact another member of the service committee to complete the report.

C. Based on the applicant’s disclosure of health status or other information regarding the applicants’ conduct or health, the Credentials Committee, may require a physical and/or mental examination of the applicant by a physician or physicians satisfactory to the committee and require that the results be made available for the committee’s consideration.

D. When evaluating clinical privileges, the Credentials Committee will take into consideration the ability of the Hospital to provide adequate facilities, staff, and support services for the applicant and his/her patients.

E. As part of the process of making this recommendation, the Credentials Committee shall have the right to require the applicant to appear for an interview to discuss any aspects of the applicant’s application, qualifications, or the clinical privileges requested.

F. If the Credentials Committee’s recommendation for appointment and/or clinical privileges is favorable, the Credentials Committee shall recommend provisional Medical Staff appointment and provisional clinical privileges. The Credentials Committee shall make a recommendation with respect to the applicant to the MEC. The recommendation will identify any requests for privileges that are not recommended by the Credentials Committee.

G. If the recommendation of the Credentials Committee is delayed, the chairperson of the Credentials Committee shall send a letter to the applicant explaining the delay.
2.9.4 Medical Executive Committee (MEC) Review

A. Upon receipt of the recommendation of the Credentials Committee, the MEC at its regular meeting shall determine whether to recommend to the Board that the applicant be
1. Appointed to membership with privileges;
2. Appointed to membership only;
3. Denied membership and privileges, or
4. The MEC may remand, with reasons stated, the application to Credentials Committee for further consideration.

B. When the MEC makes a recommendation contrary to the recommendation of the Credentials Committee, the MEC shall set forth in its recommendation to the Board the specific reasons for the MEC’s disagreement with the Credentials Committee’s recommendation, supported by reference to particular aspects of the individual’s record or the Credentials Committee’s report.

C. When the recommendation of the MEC would entitle the applicant to a hearing pursuant to Chapter 4 of this Manual, the CEO shall promptly notify the applicant by certified mail, return receipt request.

D. Following the recommendation by the MEC, and after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Chapter 4, the CEO shall forward to the Board:
1. The recommendation of the MEC;
2. The recommendation of the Hearing Panel, if a hearing was held; and
3. The application and all supporting documentation.

2.9.5 Board of Directors Procedure

A. The Board shall render a decision in writing that awards, modifies or denies membership and privileges. In addition, the Board may
return the application to the MEC for consideration.

B. When the decision of the Board would entitle the applicant to a hearing pursuant to Chapter 4 of the Manual, the CEO shall promptly notify the applicant by certified mail, return receipt requested. The CEO shall hold the application until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Chapter 4, section 3.4.

C. A decision of the Board to grant membership and/or privileges will include the effective dates of such, not to exceed two years.

D. Following final action of the Board, the CEO shall notify the applicant of the final action.

2.10 **Telemedicine Credentialing**

Information from a Joint Commission accredited or CMS certified facility may be used when credentialing a physician for telemedicine, as long as the decision to delineate privileges is made at Northfield Hospital. Primary source verification will be necessary for Minnesota license or registration information. Northfield Hospital will perform a National Practitioner Data Bank query, Minnesota background study, collect DEA registration and malpractice insurance information, and check the OIG exclusion list.

2.11 **Clinical Privileges for Podiatrists**

A. Podiatrists who are appropriately licensed may be granted clinical privileges based on documented training, experience, and current competence, and federal/state law.

1. Podiatrists are not granted admitting privileges

2. Podiatrists may:

   a. Write orders

   b. Prescribe medications within the limits of their licensure.

   c. Perform history and physicals when granted privileges to do so by the hospital
Patients who undergo surgery or who require admission to the hospital must be under the care of a doctor of medicine or osteopathy. The podiatrist’s care of these patients is limited to the scope of their podiatry privileges.

2.12 Allied Health Practitioner (AHP) Credentialing and Privileging

A. Allied Health – Independent Category

1. Patients under the care of a practitioner in this category who require services outside the scope of practice and license of the practitioner must be under the care of an MD or DO.

2. Patients requiring admission or undergoing surgery must have a history and physical performed by an MD, DO, OMS or other qualified person granted such privileges.

3. During surgery under general anesthesia when the operating/anesthesia team does not include an MD, DO or OMS, one must be immediately available in case of emergency.

4. The provisions of Chapter 4 of this Manual shall be fully applicable to Independent AHP. Adverse decisions regarding clinical privileges are subject to the procedural rights of hearing and appeal as provided in Chapter 4.

B. Allied Health – Dependent Category

1. The clinical privileges granted to a Dependent AHP shall be coterminous with the appointment and clinical privileges of the sponsoring/collaborative Medical Staff member.

2. The provisions of Chapter 4 do not apply to the Dependent AHP.

2.13 Medical Staff Orientation

Northfield Hospital provides a brief orientation program to all practitioners who will be practicing on site, in order to familiarize them with the hospital layout, organizational culture, and an introduction and security access to departments in which they will be providing patient care. Once the Service Chief or Medical Advisor has reviewed and recommended an applicant for approval, the new
provider will be notified to schedule the orientation. Orientation must be
completed before the provider may exercise privileges. The Board may approve
privileges subject to completion of orientation.

2.14 Provisional Status

All initial appointments to the Medical Staff for Active, Affiliate, Refer and Follow, Telemedicine and Independent Allied Health status, and initial clinical privileges for those categories, shall be provisional for a period of 12 months. During this term, the relevant Service Chief(s), Medical Advisor, or designee of the Medical Staff will monitor the individual’s competence, general behavior and conduct in the hospital. At any time, the MEC may adjust clinical privileges to reflect clinical competence. Such adjustments are not subject to any of the rights set forth in Chapter 4 of this Manual.

2.14.1 Initial Provisional Period

A. At the end of the first 12 month provisional period, a formal evaluation will be conducted by the relevant Service Chief(s) or Medical Advisor, consisting of:
   1. A review of the practitioner’s quality summary,
   2. A minimum 10-case review, which includes five cases reviewed for each hospital service.

B. Following formal evaluation, the Service Chief(s) or Medical Advisor will make a written recommendation to the Credentials Committee to:
   1. Advance the practitioner off of provisional status;
   2. Extend the practitioner’s provisional period; or
   3. Terminate the practitioner’s membership and/or privileges.

C. The recommendation of the Credentials Committee to the MEC will be based on:
   1. The factors set forth in Article 2.8,
   2. Use of the hospital in accordance with the practitioner’s
2.14.2 Extended Provisional Period

A. The initial provisional period may be extended for a period up to one year.

B. During the extended provisional period, another formal evaluation will be conducted by the relevant Service Chief(s) or Medical Advisor, consisting of:
   1. A review of the practitioner’s quality summary,
   2. A 10-case review, which includes five cases reviewed for each hospital service. If there are less than 10 cases, all cases will be reviewed.
   3. In the case of insufficient activity for an evaluation, verification that membership and privileges are in good standing at other hospitals will serve as a proxy for quality data.

C. Following this formal evaluation, the Service Chief(s) or Medical Advisor will make a written recommendation to the Credentials Committee to:
   1. Advance the practitioner off of provisional status, or
   2. Terminate the practitioner’s membership and/or privileges.

D. The recommendation of the Credentials Committee to the MEC will be based on:
   1. The factors set forth in Article 2.8,
   2. Use of the hospital in accordance with the practitioner’s Intended Practice Plan, and
   3. The Service Chief(s) or Medical Advisor evaluation.

E. In the event that the recommendation of the Credentials Committee differs from that of the Service Chief(s) or Medical Advisor, the following steps may be taken:
   1. A review of the practitioner’s quality summary,
   2. A 10-case review, which includes five cases reviewed for each hospital service. If there are less than 10 cases, all cases will be reviewed.
   3. In the case of insufficient activity for an evaluation, verification that membership and privileges are in good standing at other hospitals will serve as a proxy for quality data.

F. Following this formal evaluation, the Service Chief(s) or Medical Advisor will make a written recommendation to the Credentials Committee to:
   1. Advance the practitioner off of provisional status, or
   2. Terminate the practitioner’s membership and/or privileges.

G. The recommendation of the Credentials Committee to the MEC will be based on:
   1. The factors set forth in Article 2.8,
   2. Use of the hospital in accordance with the practitioner’s Intended Practice Plan, and
   3. The Service Chief(s) or Medical Advisor evaluation.
Medical Advisor, the Credentials Committee will provide to the MEC the rationale(s) for their differing recommendation.

2.14.3 Actions Taken During the Provisional Period

If any review or recommendation performed during the provisional period results in action to apply conditions to or terminate a practitioner’s appointment and/or privileges, such action shall be deemed a voluntary resignation and without any of the rights set forth in Chapter 4 of this Manual.

ARTICLE 3: SPECIAL PRIVILEGING SITUATIONS

3.1 Temporary Privileges

A. The CEO or designee may grant temporary clinical privileges to a practitioner upon recommendation of either the applicable Service Chief or Medical Advisor, or the President as outlined in the hospital’s policy on temporary privileges, in the following circumstances:
   1. To fulfill an important patient care need, or
   2. When an applicant with a complete application is awaiting review and approval of the MEC and the Board.

B. Any practitioner granted temporary clinical privileges under this policy shall read and agree to be bound by the Medical Staff Manual and Hospital policies and shall consent to the submission, investigation, and verification of information concerning his or her qualifications and experience.

C. Special requirements of supervision and reporting may be imposed on any practitioner granted temporary privileges.

D. Temporary privileges may be limited, suspended, or revoked at any time by the CEO or designee, upon recommendation from the appropriate Service Chief or Medical Advisor, or President. Such action shall not entitle the practitioner to a hearing under the Hearing and Appeal chapter.
3.2 Emergency Privileges

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

B. In an emergency, any Medical Staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of his or her Medical Staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the practitioner's license or registration.

3.3 Disaster Privileges

Disaster privileges may be granted when the Hospital's Incident Command System (HICS) has been activated, and the hospital is unable to provide all the care required by individuals seeking treatment at the Hospital. Under such circumstances, the Hospital's Disaster Privileging Policy is followed.

ARTICLE 4: REAPPOINTMENT

4.1 Duration of Reappointments

Reappointment to the Medical Staff shall be made for a period not to exceed (2) two years.

4.2 Application for Reappointment

A. CMS requires that terms of appointment may not exceed 2 years.

B. Each practitioner will be sent reapplication documents approximately 120 days prior to expiration.

C. The practitioner shall be responsible to complete the reappointment application and clinical privilege forms and return to the CEO or designee
at least 90 days prior to the expiration date of the appointment.

D. Failure to submit a complete re-application at least 90 days in advance of the date of expiration may prevent completion of processing and approval prior to the end of the two-year term. In this situation, membership and privileges will expire until the reapplication process is completed.

4.3 Requirements for Reappointment

A. Applicants for reappointment must update all information required on the initial application in Article 2 of this chapter and provide any new information related to the requirements set forth in Articles 2.3 and 2.5 of this chapter.

B. Each recommendation concerning reappointment and the clinical privileges to be granted upon reappointment shall be based upon the member's:

1. Professional competence and clinical judgment in the treatment of patients;
2. Quality assurance activities of the hospital or other facilities at which the applicant practices,
3. Ethics and conduct,
4. Participation in Medical Staff activities;
5. Compliance with the Medical Staff Manual and Hospital policies;
6. Utilization of hospital facilities consistent with applicant’s intended practice plan;
7. Cooperation with Hospital staff, other members of the Medical Staff and patients; and
8. Qualifications and adherence to requirements set forth in Article 2.5 of this chapter.

C. At any time during the process, the Credentials Committee, MEC or the Board may require a physical and/or mental examination of the applicant by a physician or physicians satisfactory to the committee and require that the results be made available for the committee’s consideration. Failure of
an individual seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the committee shall constitute a voluntary suspension of Medical Staff membership and all clinical privileges until such time as the committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation.

4.4 **Service Chief or Medical Advisor Review**

The Service Chief of the relevant service committee(s), or Medical Advisor of the relevant clinical area:

A. Shall review the completed reappointment application and clinical privilege forms;

B. Has the right to request additional information and documentation and to meet with the applicant to discuss any aspect of his/her application, qualifications, and requested clinical privileges;

1. Further processing of the application shall be stayed until the meeting with the applicant, if requested by the Service Chief or Medical Advisor, is concluded and the additional information and documentation is received,

2. It is the applicant’s burden to ensure that such additional information and documentation is provided;

C. Shall provide the Credentials Committee with a report containing a recommendation of the applicant’s qualifications for reappointment and proposed clinical privileges.

4.5 **Credentials Committee Review**

A. The Credentials Committee, after receiving the Service Chief(s) or Medical Advisor recommendation, shall review all pertinent information available for the purpose of determining its recommendations for:

1. Staff reappointment;

2. Staff category; and
3. Clinical privileges for the ensuing appointment period.

B. If the Service Chief or Medical Advisor has not provided the Credentials Committee with his/her report, the Medical Staff Office will contact another member of the service committee to complete the report.

C. The Credentials Committee shall forward its recommendations to the MEC, along with the reasons for any recommendation differing from that of the Service Chief or Medical Advisor or from those requested by the applicant. The report will include reasons for a recommendation differing from those requested by the applicant.

4.6 MEC Review

A. The MEC shall review the recommendation of the Credentials Committee, and any other information available, and forward its recommendations to the Board concerning the reappointment, clinical privileges and staff category of each applicant.

B. The MEC shall include in its recommendation the reasons for any recommendation that differs from the Credentials Committee recommendation.

C. When the MEC has determined to make a recommendation that differs from the recommendation of the Credentials Committee, the MEC will do one of the following:

1. If a denial of membership and/or privileges: notify the affected practitioner of the possible recommendation, and ask the individual if he/she desires to discuss the situation with the MEC prior to any final recommendation;

a. During this discussion, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to explain or refute it.

b. This interview shall not constitute a hearing.

c. No minutes will be kept of the discussion.
d. The MEC shall indicate as part of its report to the Board whether such a discussion occurred.

2. Remand the matter to the Credentials Committee for its further investigation and preparation of responses to special questions raised by the MEC, prior to the MEC’s final recommendation; or

3. Set forth in its report and recommendation to the Board the specific reasons for the MEC’s disagreement with the Credentials Committee’s recommendation, supported by reference to particular aspects of the individual’s record or the Credentials Committee’s report.

D. If a recommendation concerning reappointment is made by the MEC that would entitle the applicant to a hearing pursuant to Chapter 4 of this Manual, the CEO shall promptly notify the individual of the recommendation. The recommendation shall not be forwarded to the Board until the individual has exercised or has waived the right to a hearing as provided in Chapter 4.

4.7 Board of Directors Procedure

A. The Board shall either:

1. render a decision in writing that awards, modifies or denies membership and/or privileges, or

2. return the application to the MEC for consideration.

B. When the decision of the Board would entitle the applicant to a hearing pursuant to Chapter 4 of the Manual, the CEO shall promptly notify the applicant by certified mail, return receipt requested. The CEO shall hold the application until after the applicant has exercised or has waived the right to a hearing as provided in Chapter 4, section 3.4.

C. A decision of the Board to grant membership and/or privileges will include the effective dates of such, not to exceed two years.

D. Following final action of the Board, the CEO shall notify the applicant of the final action.
ARTICLE 5: EXPEDITED CREDENTIALING PROCESS

Expedited credentialing is available in accordance with defined criteria, which are set forth in the Medical Staff policy “Expedited Credentialing Process.”

ARTICLE 6: OTHER REQUESTS

6.1 Change in Clinical Privileges or Staff Category

A. During the term of an appointment to the Medical Staff, an individual may request a change in clinical privileges or category, by applying in writing to the CEO or designee on a form approved by the Board.

B. The application shall state in detail the specific changes desired and the appointee’s relevant recent training and experience that justify the request.

C. The application will be processed in the same manner as an application for initial clinical privileges.

D. Recommendations for a change in staff category shall be based on a revised intended practice plan.

E. Recommendations for additional clinical privileges shall be based on consideration of any or all of the following:
   1. Relevant recent training;
   2. Observation of patient care provided;
   3. Results of the hospital’s quality assessment and risk management activities; and
   4. Other reasonable indicators of the individual’s qualifications for the privileges in question.

F. The recommendation for additional privileges may contain requirements for supervision or consultation, or other conditions for a period of time considered necessary or desirable by the Credentials Committee or MEC.
### ARTICLE 7: ADOPTION AND AMENDMENT REQUIREMENTS

<table>
<thead>
<tr>
<th>Chapter</th>
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<td>Credentialing, Privileging, and Membership</td>
<td>Majority vote of MEC members present and voting where a quorum exists. Results must be ratified by the Board</td>
<td>Amendment or adoption may be voted on at any meeting of the MEC where a quorum exists.</td>
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ARTICLE 8: ADOPTION AND AMENDMENTS

Initial adoption: 4/2006

Amendments:

5/31/2007:
- Article 2.10.1: addition to list of practitioners who may perform an H&P
- Article 2.10.2: removed H&P restriction

9/27/2007:
- Article 2.12: rewritten to provide clarification of provisional process, responsibilities and options for advancing practitioners from provisional status.

2/21/2008:
- Article 2.9.6: addition of Expedited Credentialing Process.

7/30/2009:
- Article 2.10: added language to include CMS requirement that admitted patients need H&P by MD, DO, etc.
- Article 2.10.1: deleted; information is contained in Articles 2.5 and 2.10
- Article 2.12.2: removed language regarding query to other hospitals for quality concerns and replaced with verification language.
- Article 4.2: removed voluntary relinquishment language

12/16/2010:
- Article 2, 3 and 4: added language to allow Medical Advisor as well as Service Chief to participate in credentialing and privileging process for candidates in their service area
- Article 2.9.6: deleted and moved to Article 5

12/18/2014:
- Article 2.5: removed references to NPDB and Minn. Dept. of Health
- Article 2.8(D)(11): changed “Minnesota Department of Health” to “Minnesota Department of Human Services”.
- Article 2.9.4(A)(2): changed “granted privileges” to “appointed to membership”.
- Article 2.10: added “Telemedicine Credentialing”
- Article 2.11: added “Clinical Privileges for Podiatrists”
- Article 3.4: removed “Teleradiology Privileges”

1/28/16:
- Article 2.8(D)(7): changed “within 7 years of residency completion” to “within time frame established by the certifying board.”
CHAPTER 4 – INVESTIGATION AND CORRECTIVE ACTION

ARTICLE 1: PURPOSE AND CONFIDENTIALITY

1.1 Purpose

Chapter Four establishes guidelines for:

A. Investigation of concerns regarding a Medical Staff member,
B. Suspension of privileges, and
C. Hearing and appeal process when there is a recommendation for an adverse action that affects initial appointment, reappointment, or privileges.

This chapter shall not apply:

A. To recommendations regarding provisional status or temporary privileges;
or
B. When the contract provides for immediate termination of the practitioner's Medical Staff membership and privileges when the service is completed or the contract is terminated.

1.2 Confidentiality

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this chapter shall be considered covered by the provisions of Minnesota statute or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this chapter shall be considered to be acting on behalf of the Medical Staff, Hospital and/or its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

All documents shall be maintained confidential and information shall be provided
only on a reasonable need to know basis.

ARTICLE 2: INVESTIGATION OF CONCERN

2.1 Identification of Concern

A. Concerns regarding a Medical Staff member are identified through organizational processes which are defined in the following policies/procedures:
   1. Quality Concern / System Improvement
   2. Impaired Practitioner
   3. Complaint and Grievance Process
   4. Medical Staff Peer Review
   5. Harassment and Intimidating Behavior
   6. Compliance Plan
   7. Rules and regulations as specified in this Medical Staff Manual

2.2 Review of Concern

A. If grounds for investigation exist as specified in Article 2, Section 2.2, a written statement of the concern will be forwarded to the Service Chief, the President or the CEO for further review. Review methods may include:
   1. Discussion with the practitioner
   2. Interview of coworkers / staff
   3. External consult or peer review
   Following review, if further inquiry is warranted, the concern will be forwarded to the MEC.

B. After referral of a concern to the MEC, the MEC shall discuss the matter with the involved practitioner, and/or begin an investigation.

C. Only the MEC or the Board may initiate an investigation.

D. The initiating body will delegate the investigation to a Review Committee.

2.3 Grounds for Investigation
The following are grounds for investigation:

A. Concerns raised about clinical competence or clinical practice;

B. Concerns raised about the care or treatment of a patient or management of a case;

C. The known or suspected violation of statutes, applicable ethical standards or the chapters of the Medical Staff Manual, or policies of the Medical Staff or Hospital, and/or;

D. Behavior or conduct that is considered lower than the standards of the Hospital as defined by the Code of Conduct, or disruptive to the orderly operation of the Hospital, including the inability to work harmoniously with others.

2.4 Review Committee Selection

A. The MEC shall select the Review Committee, which can be an existing medical staff committee or an appointed ad hoc review committee.

B. The Review Committee shall consist of at least three (3) individuals, who may or may not be members of the Medical Staff, including at least one professional peer of the individual in the same specialty (e.g., physician, psychologist or dentist).

C. In selecting the Review Committee, the MEC shall, to the extent possible, minimize conflicts of interest.

2.5 Review Committee Duties

The Review Committee:

A. Shall conduct a reasonable investigation of all available information including but not limited to relevant literature and standard of care, interviews and opinions expressed, and any information or explanation provided by the individual under review;

B. Shall provide the affected individual an opportunity to meet with them.

1. At this meeting the affected individual shall be informed of the general nature of the evidence supporting the concern being
investigated and shall be invited to discuss, explain or refute it.

2. This meeting shall not constitute a hearing, and none of the procedural rules detailed in this chapter shall apply.

3. The affected individual being investigated may be represented by counsel at the meeting, provided that the individual has given the Chair of the Review Committee reasonable notice of his/her intent to bring legal counsel. If counsel represents the individual, the Review Committee shall request the presence of the Hospital’s legal counsel.

C. Shall have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants;

D. May require a physical and mental examination of the affected individual, performed by physicians satisfactory to the Review Committee, and shall require that the results of such examinations be made available to the Review Committee for consideration;

E. Shall keep the MEC and CEO updated on progress during the investigation;

F. Shall complete the investigation and submit a recommendation to the MEC, with a copy to the CEO, in a reasonable period of time, not to exceed 120 days unless conferring with or receiving a report from an outside consultant requires more time;

G. Shall keep written documentation of all proceedings.

ARTICLE 3: RECOMMENDATION AND PROCESS

3.1 Review Committee Recommendation

A. After the investigation, the Review Committee may recommend:

1. No further action;

2. Written warning or reprimand;

3. Additional training and/or education;

4. A requirement for consultation;
3.2 **MEC Recommendation**

A. The MEC shall consider the Review Committee’s recommendation and determine its own recommendation regarding action. At least one member of the Review Committee shall be available to answer any questions raised with respect to the Review Committee’s recommendations.

B. The following MEC recommendations entitle the affected individual to a hearing:

1. Imposition of a requirement for additional training which precludes the physician from exercising his/her clinical privileges for a period exceeding thirty (30) consecutive days.

2. Imposition of mandatory concurring consultation requirement (i.e., not only must the individual obtain a consult but must also reach agreement with the consult as to the course of treatment before that treatment can be pursued).

3. Denial, decrease, restriction, or limitation of requested clinical privileges, or denial of requested advancement in Medical Staff category.

4. Executive suspension of clinical privileges or Medical Staff membership.

5. Denial or revocation of Medical Staff appointment or reappointment.
entitle the affected individual to a hearing.

3.3 Notice of MEC Recommendation

A. If the MEC makes a recommendation other than those listed in 3.2 (B):
   1. The CEO shall promptly give written notice to the involved practitioner by certified mail, return receipt requested;
   2. The CEO shall provide this notice to the individual within ten (10) days from the date the recommendation was made. Notice requirements shall be met if mailings are sent to the address of record, even if the individual does not pick up a certified letter.
   3. This notice of recommendation shall contain:
      a. A statement of the recommendation made and the general reasons for it;
      b. Notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of the date on the notice; and
      c. A copy of this chapter outlining the individual’s rights in the hearing.

3.4 Right to a Hearing

An individual shall have thirty (30) days following the date of the written notice to request the hearing. The request shall be made in writing to the CEO. The individual’s failure to make a timely request shall be deemed a waiver of the right to a hearing, and acceptance of the MEC recommendation.

If no hearing is requested, the recommendation shall be submitted to the Board for action. The CEO shall notify the individual within seven (7) days of the Board action by certified mail, return receipt requested.

3.5 Hearing Panel

A. When a hearing is requested, the CEO appoints a Hearing Panel after consultation with the President.
B. The Hearing Panel shall be composed of at least three (3) individuals:
   1. Who have not actively participated in the consideration of the matter at any previous level, and
   2. Who are physicians, other health care providers, or qualified laypersons knowledgeable about some aspect of the issues to be reviewed by the panel.
   3. One member of the Hearing Panel must be a physician. Physician members of the panel may be members of the Medical Staff of the Hospital and/or of the Medical Staff of other hospitals.

C. The Hearing Panel shall not include:
   1. Any individual who is in direct economic competition with the affected person unless the affected person and the CEO agree in writing to such participation and waive any claim based upon such individual’s relationship with the affected person, or
   2. A partner or associate in a group practice with the affected person, unless the affected person and the CEO agree in writing to such participation and waive any claim based upon such individual’s affiliation with the affected person.

D. The CEO shall appoint a Hearing Officer from the members of the Hearing Panel.

E. Legal counsel to the Hospital may advise the Hearing Officer.

3.6 Hearing Officer

The Hearing Officer shall:
   A. Conduct the hearing;
   B. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides;
   C. Prohibit conduct or presentation of evidence that is excessive, irrelevant, abusive, or that causes delay;
D. Maintain decorum throughout the hearing;
E. Act in such a way that all relevant information is considered by the
   Hearing Panel in formulating its recommendations;
F. Participate in the private deliberations of the Hearing Panel; and
G. Be entitled to one vote.

3.7 Notice of Hearing

A. The CEO shall provide notice of the hearing date to the affected individual
   within twenty (20) days from the date the affected individual's timely
   request for a hearing is received.
B. The hearing date shall be no sooner than 30 (thirty) days from the date of
   the CEO's notice unless an earlier date has been specifically agreed to in
   writing by the parties.
C. The Notice of Hearing shall be sent by certified mail, return receipt
   requested, and shall include:
   1. The time, place, and date of the hearing;
   2. A proposed list of witnesses as known at the time, but which may
      be modified, who will give testimony or present evidence at the
      hearing in support of the MEC;
   3. The names of the Hearing Panel members and Hearing Officer if
      known; and
   4. A statement of the specific reasons for the recommendations, as
      well as the list of patient records and information supporting the
      recommendation. The list of patient records and other supporting
      information may be revised or amended at any time, even during
      the hearing, so long as the additional material is relevant to the
      matters at issue in the hearing.

3.8 Preparation For Hearing

A. There is no right to discovery in connection with the hearing. However,
request and in compliance with all applicable laws, to the following:

1. Copies of, or reasonable access to, all patient medical records referred to in the Notice of Hearing, at the individual's expense;
2. Reports of experts relied upon by the Review Committee, or the MEC;
3. Redacted copies of relevant committee minutes (such provision does not constitute a waiver of the Minnesota peer review protection statute); and
4. Copies of any other documents relied upon by the Review Committee, or the MEC.

B. No later than 10 days prior to the pre-hearing conference, on dates agreed upon by both sides, each party shall provide the other party with:
1. A list of proposed exhibits; and
2. A list of the witnesses (including names, addresses and a brief summary of the anticipated testimony) expected to offer testimony or present evidence on their behalf.

C. Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the MEC's witness list concerning the subject matter of the hearing, unless specifically agreed to by the CEO.

D. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing to the Hearing Officer no later than 5 days in advance of the pre-hearing conference.

E. Witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

3.9 Pre-hearing Conference

Both parties are required to participate in a pre-hearing conference at a date and time appointed by the Hearing Officer. At the pre-hearing conference, the Hearing Officer shall:

A. Resolve objections regarding witnesses and documentary evidence to be
introduced at the hearing;

B. Exclude evidence and testimony unrelated to the reasons for the unfavorable recommendations, or unrelated to the individual's qualifications for appointment, or the relevant clinical privileges;

C. Limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative;

D. Finalize the witness and documentary evidence list of each party;

E. Determine an estimate of the time required for each witness' testimony and cross-examination;

F. Resolve all other procedural questions; and

G. Inform the parties of the matters, either technical or scientific, on which the Hearing Officer will take official notice. Such matters shall be noted in the record of the hearing. Any such matters shall not be subject to dispute on their merits unless either party submits to the Hearing Officer a notice refuting such matters within three (3) days after the pre-hearing conference.

ARTICLE 4: HEARING

4.1 Failure to Appear

Failure, without good cause as determined by the Hearing Officer, of the individual requesting the hearing to appear and proceed at the hearing shall be deemed voluntary acceptance of the MEC's recommendations. In this case the MEC recommendation shall be forwarded to the Board for final action.

4.2 Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a tape or video recording or by a stenographic reporter. The cost of such recording shall be borne by the Hospital, but copies of the record shall be provided to each party requesting the copy, at that party's expense.

4.3 Rights of the Parties
A. At a hearing, both sides shall have the right to be represented by counsel.

B. Both sides shall also have the following rights, subject to limits determined by the Hearing Officer:

1. To call and examine witnesses;

2. To present evidence, including
   a. Witness testimony,
   b. Rebuttal of testimony, and
   c. Documentary evidence, including exhibits;

3. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence; and

4. To submit a written statement at the close of the hearing.

C. Any individual requesting a hearing who does not testify in his or her own behalf may be called and examined as if under cross-examination.

D. The Hearing Panel may question the witnesses; call additional witnesses; and/or request documentary evidence.

E. The individual requesting the hearing may be accompanied at the hearing by a person of the individual’s choice in addition to legal counsel.

F. All members of the Hearing Panel must be present throughout the hearing and deliberation.

G. The parties shall be entitled to review any relevant material available to the MEC, the Hearing Panel, or the individual requesting a hearing.

4.4 New Evidence

New evidence and/or testimony shall be admitted if:

A. It is relevant;

B. It is evidence on which reasonable persons would rely, regardless of the admissibility of such evidence in a court of law; and

C. Notice of the new evidence and/or testimony to be admitted is given to the other party.

4.5 Postponements and Extensions
Postponements and extensions of time beyond any time limit set forth in this chapter may be requested by anyone, but shall be permitted only by the Hearing Officer on a showing of good cause.

4.6 Adjournment and Conclusion

A. The Hearing Officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants.
B. The Hearing Officer shall conclude the Hearing when presentations of evidence and questions by the Hearing Panel have been completed.

4.7 Basis of Decision

The Hearing Panel shall recommend in favor of the Review Committee or the MEC unless it finds that the individual who requested the hearing has proved their case by a preponderance of evidence.

4.8 Deliberations and Recommendation of the Hearing Panel

The Hearing Panel shall:

A. Request a copy of the hearing record be provided to the Hearing Panel;
B. Conduct its deliberations in private.
C. Arrive at a recommendation by majority vote.
D. Render a recommendation within twenty (20) days of the date the Hearing Panel received the hearing record. The recommendation shall be written and contain a concise statement of the reasons for the recommendation.

4.9 Notice of Hearing Panel Recommendation

A. The Hearing Panel shall deliver its written recommendation to the CEO who shall send a notice of the Hearing Panel recommendation by certified mail, return receipt requested to both parties within ten (10) days from the date the recommendation was made.
B. The notice shall contain:
   1. A statement of the recommendation made and the general reasons
for it;

2. A statement that the individual has the right to request an appellate review of the recommendation within ten (10) days of date of this notice.

C. Notice requirements shall be met if mailings are sent to the address of record, even if the individual does not pick up the certified letter.

ARTICLE 5: APPEAL

5.1 Request for Appeal of Hearing Panel’s Recommendation

A. Either party may request an appeal.

B. An appeal must be requested within ten (10) days of the date of the notice of the Hearing Panel’s recommendation.

C. The request shall:

1. Be in writing;

2. Be delivered to the CEO either in person or by certified mail, return receipt requested; and

3. Include a statement of the reasons for appeal and the specific facts or circumstances that justify further review.

D. If an appeal is not requested within the required time frame, both parties shall be deemed to have waived the right to appeal, and the CEO shall forward the Hearing Panel’s recommendation to the Board for final action.

5.2 Grounds for Appeal

The grounds for appeal shall be that:

A. There was substantial failure to comply with the hearing process so as to deny due process; or

B. The recommendations of the Hearing Panel were made arbitrarily, capriciously, or with prejudice; or

C. The recommendations of the Hearing Panel were not supported by a preponderance of the evidence.
5.3 Scheduling the Appeal

A. Whenever an appeal is requested the CEO shall forward the request to the Chair of the Board, or designee.

B. The Chair shall, within ten (10) days after receipt of such request, schedule and arrange the date of the appellate review and appoint the Appellate Panel, after consultation with the President and CEO. In the alternative, a Committee of the Board shall hear the appeal

C. The Appellate Panel shall be composed of at least three (3) individuals:
   1. Who have not actively participated in the consideration of the matter at any previous level; and
   2. Who are physicians, other health care providers, or qualified laypersons.
   3. One member of the Appellate Panel must be a physician.

   Physician members of the panel may be members of the Medical Staff of the Hospital and/or of the Medical Staff of other hospitals.

D. The Appellate Panel shall not include:
   1. Any individual who is in direct economic competition with the affected person unless the affected person and the Chair of the Board agree in writing to such participation and waive any claim based upon such individual’s relationship with the affected person, or
   2. A partner or associate in a group practice with the affected person, unless the affected person and the Chair of the Board agree in writing to such participation and waive any claim based upon such individual’s affiliation with the affected person.
   3. Within a reasonable time prior to the date of appellate review, both parties shall have access to the reports, records, and all other materials considered by the Hearing Panel in making its recommendation.

E. The date of appellate review shall be not less than ten (10) days, nor more
than thirty (30) days from the date of receipt of the request for appellate review.

F. The time for appellate review may be extended for good cause by the Chair of the Board.

5.4 **Appellate Review**

A. Either or both parties may be represented by counsel during all parts of the appeals process.

B. The Appellate Panel shall consider the Hearing Panel’s recommendation and determine whether the record supports it.

C. Each party shall have the right to present a written statement in support of its position on appeal.

D. In its discretion, the Appellate Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

E. The Appellate Panel shall recommend final action to the Board.

5.5 **Final Decision of the Board**

A. Within thirty (30) days after receipt of the Appellate Panel’s recommendation or within thirty (30) days of the expiration of the time for appeal if either party brings no appeal, the Board shall:

1. Render a final decision in writing that affirms, modifies, or reverses the recommendation before it; or

2. Return the matter for further review to the appropriate body with instructions for further considerations or with questions to be answered. The Hearing Panel would review questions of fact, while the Appellate Panel would review procedural questions. The matter must be returned to the Board within thirty (30) days of the date of the meeting at which the request for further review was made.

3. The Board will make a final decision within 30 days of receipt of the above information.
B. Copies of the final decision of the Board, including specific reasons for the decision, shall be delivered by the CEO in person or by certified mail-return receipt requested to the affected individual, to the President, and to the Chair of the Board.

C. The final decision of the Board following an appeal shall be effective immediately and shall not be subject to further administrative review or appeal.

5.6 **Right to One Hearing and One Appeal Only**

A. No applicant or Medical Staff appointee shall be entitled to more than one (1) hearing and one (1) appellate review on any matter that may be the subject of a hearing.

B. If, as the result of a hearing, the Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, the individual may not apply for staff appointment or for those clinical privileges at this hospital for a period of five (5) years unless the Board provides otherwise.

**ARTICLE 6: SUSPENSIONS**

6.1 **Precautionary Suspension**

A. A precautionary suspension is a suspension of all or any portion of clinical privileges when prompt action is necessary in the interests of patient care and safety.

B. The MEC has granted authority of issuing a precautionary suspension to the President or in his/her absence the Vice President/designee, the CEO/designee, or the Chairperson of the Board.

C. Such suspension shall become effective immediately.

D. The issuer shall give prompt notice of the suspension in writing to the affected practitioner, the CEO, the MEC and affected service departments.
E. The President or applicable Service Chair shall immediately ensure alternate medical care for the Hospital patients of the suspended practitioner. The wishes of the patient shall be considered in the selection of an alternate practitioner.

F. Within ten (10) days of the imposition of the precautionary suspension, the MEC shall convene to review and consider whether the precautionary suspension is warranted. The MEC shall initiate an investigation and make a determination to either:

1. Continue or modify the terms of the suspension, in the form of an executive suspension, or
2. Lift the suspension and reinstate the practitioner's privileges.

G. A precautionary suspension is lifted by the majority vote of the MEC. Prompt notice of the lifting of the suspension shall be given to all parties as were notified in D above.

H. The precautionary suspension does not entitle the practitioner to hearing rights.

6.2 Executive Suspension

A. An executive suspension is issued by the MEC:

1. after the MEC has convened to review and consider whether a precautionary suspension should be continued or modified; or
2. has determined a suspension is necessary in the interests of patient care and safety.

B. An executive suspension is effective immediately and may affect all or a portion of the affected practitioner's clinical privileges.

C. The MEC shall give prompt notice of the suspension in writing to the affected practitioner, the CEO, the MEC and affected service departments, using the procedure in Article 3.3 of this chapter.

D. The affected practitioner shall have hearing rights as afforded in this chapter.

6.3 Automatic Suspension
A. An automatic suspension of privileges is imposed when a practitioner has violated certain Medical Staff administrative or procedural requirements.

B. The MEC has granted authority of issuing an automatic suspension to the CEO or designee.

C. Such suspension shall become effective immediately.

D. Privileges of a practitioner shall be suspended for any of the following events:

1. Failure to maintain professional liability insurance coverage as required.

2. Failure to maintain any active certificate, license or registration required to practice. The suspension would apply only to those privileges related to the certificate, license or registration.

3. Failure to provide requested information regarding continuing qualifications.

4. Failure to complete medical records in accordance with the rules and regulations of the Medical Staff.

5. Disqualification by the Minnesota Department of Human Services to provide direct contact services to patients in a licensed hospital without supervision.

6. Exclusion from any federal or state health care program, including Medicare.

7. Suspension of license or registration, or authorization to practice in the State of Minnesota from the issuing authority. The date of suspension shall be the date the state action becomes effective.

E. Prompt notice of the suspension shall be given in writing to the affected practitioner, the CEO, the President, Chief of Service and affected service departments.

F. The automatic suspension does not entitle the practitioner to hearing rights.

G. An automatic suspension is lifted when the reason for the suspension is corrected. Prompt notice of the lifting of the suspension shall be given to
all parties as were notified in E of this section.

H. Automatic suspensions that remain unresolved for a period of two (2) months or more may be declared a voluntary resignation at the discretion of the MEC.

6.4 Automatic Actions Following State Disciplinary Actions

6.4.1 Limitation or Restriction

A. When the State of Minnesota has limited or restricted the practitioner’s license or registration, or authorization to practice, those privileges which have been granted and which are within the scope of said limitation or restriction shall be limited or restricted similarly limited or restricted.

B. The date of the limitation or restriction shall be the date the state action becomes effective.

C. Prompt notice of the limitation or restriction shall be given in writing to the affected practitioner, the CEO, the President, Chief of Service and affected service departments.

D. This action does not entitle the practitioner to hearing rights.

E. The restriction or limitation is lifted when the state removes the limitation or restriction. Prompt notice shall be given to all parties as were notified in C of this section.

6.4.2 Revocation

A. When the State of Minnesota has revoked the practitioner’s license or registration, or authorization to practice, the practitioner’s privileges and Medical Staff membership are revoked.

B. The revocation date shall be the date the state action becomes effective.

C. Prompt notice of the revocation shall be given in writing to the affected practitioner, the CEO, the President, Chief of Service and affected service departments.
D. This action does not entitle the practitioner to hearing rights.

E. Should the practitioner regain licensure or authorization to practice from the State of Minnesota, he/she may reapply for membership and privileges through the initial application process.
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ARTICLE 8: ADOPTION AND AMENDMENTS

Initial adoption: 4/2006

Amendment:

7/30/2009:

- Article 2.4: Deleted “protect against” and substituted “to the extent possible, minimize”. Deleted prohibited members language.
CHAPTER 5 – RULES AND REGULATIONS

ARTICLE 1: PURPOSE

Chapter Five establishes guidelines for admission and discharge of patients, medical records and conduct of care.

ARTICLE 2: ADMISSION AND DISCHARGE OF PATIENTS

These Rules and Regulations are only applicable to acute care unless otherwise specified.

Only Active or Affiliate Medical Staff members, and Nurse Midwives may admit and discharge patients.

2.1 Admission

A. Subject to the hospital’s capacity, the hospital shall accept all patients whose care and treatment fall within the hospital’s capabilities as defined in its Plan for Provision of Care and the Medical Staff member’s scope of practice.

B. The official admitting policies of the organization shall govern all Medical Staff members.

C. An MD, DO, or oral maxillofacial surgeon (hereafter referred to as the attending practitioner in section 2.1 of this chapter) is responsible for the patient until the patient is discharged, or until such time as the attending practitioner transfers the care of the patient to another attending practitioner who has agreed to assume responsibility for the care of the patient.

D. No patient shall be admitted to the hospital unless a provisional diagnosis or other valid reason for admission has been stated.

E. An attending practitioner shall be responsible for the care of each patient in the hospital, for the completeness and accuracy of the medical record,
and for necessary special instructions and orders.

2.2 Frequency of Required Visits

A. All inpatients will be seen by a physician or midwife each day and a note will be made in the progress notes regarding the patient’s status.

B. Patients in Swing Bed status, as defined by Medicare, must be seen by a physician at least once per week.

2.3 Discharge

A. Patients shall be discharged on order of the attending practitioner.

B. Should a patient leave the hospital against medical advice, a notation shall be made on the medical record and the patient or responsible party shall be requested to sign a “Release from Responsibility” form.

C. If a patient is transferred from the hospital to another facility, provisions will be made for safe transfer according to the policies of the hospital and in compliance with all regulatory standards.

D. In the event of death in the hospital, the patient shall be pronounced dead by a physician member of the Medical Staff or a registered nurse employed by Northfield Hospital.

2.4 Autopsies

In the event of death, the MD, DO or OMS responsible for the care of the patient shall secure an autopsy whenever appropriate. An autopsy may be performed only after obtaining proper legal consent, except for coroner cases that do not require consent.

ARTICLE 3: MEDICAL RECORDS

These Rules and Regulations are only applicable to acute care unless otherwise specified.

3.1 Content
All practitioners are responsible for maintaining a complete and legible medical record for each patient. The record shall include:

A. Identification data,
B. Current history and physical examination,
C. Date and times of entries,
D. Provisional diagnosis,
E. Diagnostic and therapeutic orders,
F. Reports of procedures, tests and their results,
G. Final diagnosis,
H. Evidence of informed consent,
I. Discharge summary or death summary and report of autopsy when performed.

3.2 Authentication

A. All medical entries in the patient’s record shall be accurately dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
B. The date of the written note must reflect the actual date of documentation; pre and post-dating of progress notes is not acceptable.
C. Information not documented at the time of occurrence can be added, but the date of the actual entry shall be indicated and, if appropriate, reference made to a previous entry.

3.3 History and Physical

A. History and physical assessments are performed or co-signed by a physician, oromaxillofacial surgeon, or other practitioner who is qualified to perform an H&P in accordance with state law and hospital policy.
B. H&Ps and co-signatures are accepted from the following individuals:
   1. MD
   2. DO
   3. Oromaxillofacial surgeon
4. Other qualified practitioners who have been granted privileges by the hospital to perform a history and physical

C. For an MD, DO, or oromaxillofacial surgeon who has not been granted privileges to perform an H&P, licensure must be verified.

D. The history and physical shall include

1. Chief complaint;

2. Details of the present illness,

3. Past medical and surgical history

4. Allergies

5. Medications

6. Assessment of the patient’s emotional, behavioral, and social status when appropriate;

7. Relevant past social and family histories;

8. Inventory of body systems;

9. Comprehensive physical examination;

10. Statement of conclusions or impressions; and

11. Statement of the course of action planned.

E. A history and physical examination shall be completed within thirty (30) days prior to an admission, within twenty-four (24) hours following an admission to inpatient or observation status, or within thirty (30) days prior to an outpatient surgery.

F. A physical examination performed within thirty (30) days prior to admission is permissible if an updated examination is completed and documented in the medical record within 24 hours after admission but before a surgical procedure. This update must be completed by a qualified individual who is credentialed and privileged by the medical staff to perform an H&P.

G. An appropriate history and physical, including a pre-operative diagnosis, shall be dictated or written prior to any surgery, or any procedure requiring moderate or deep sedation or anesthesia, except when delay would jeopardize the patient’s condition or treatment. Failure to do so may result in cancellation of the scheduled procedure.
3.4 Progress Notes

Progress notes clearly identify the patient’s clinical problems, and correlate with specific orders, and results of tests and treatments. Inpatient and swing bed progress notes shall be recorded daily at the time of observation, sufficient to permit continuity of care and reflect any change in condition and response to treatment.

3.5 Operative and Labor/Delivery Notes

A. Operative and labor/delivery notes shall be dictated or written immediately after the surgery/delivery is performed and should contain:

1. Patient identification data,
2. Date and times of the surgery,
3. Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks,
4. Pre-operative and post-operative diagnosis,
5. Name of the specific surgical procedure(s) performed,
6. Type of anesthesia administered,
7. A description of techniques, findings, and tissues removed or altered,
8. Complications, if any,
9. Estimated blood loss,
10. Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues),
11. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

B. When dictated, hence not immediately available, a short, written summary
of the operative procedure shall be entered into the record immediately after the procedure.

C. The anesthetist or anesthesiologist shall perform and document a pre- and post-anesthetic evaluation.

3.6 Consultation Notes

Consultation notes shall show evidence of a review of the patient’s record and an evaluation of the patient by the consultant, as well as the consultant’s opinion and recommendations. The report shall be written or dictated within twenty-four (24) hours of the visit and made a part of the patient’s record.

3.7 Prenatal Record

The obstetrical record shall include a prenatal record. The prenatal record may be a legible copy of the practitioner’s office record.

3.8 Discharge Summary

A. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants.

B. The discharge summary shall include:

1. Reason for hospitalization,
2. Significant findings,
3. Procedures performed and treatment rendered,
4. Condition of the patient on discharge, and
5. Any specific instructions given to the patient and/or family, as pertinent. Consideration is given to instructions relating to physical activity, medication, diet and follow-up care.

C. A final progress note may be substituted for the discharge summary in the case of patients who require less than forty-eight (48) hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note includes any
instructions given to the patient and/or family.

3.9 Delinquent Medical Records

Records of discharged patients not completed within thirty (30) days of discharge will be considered delinquent.

A. A notice of delinquency will be sent to the practitioner.

B. If the records are not completed within forty-eight (48) hours after the notice is sent, suspension of privileges will result.

C. The President may designate the chart as complete by submitting a letter to Health Information Services explaining the reasons the attending physician is not able to complete the chart (e.g. has moved away, has expired or has a serious illness).

3.10 Recordkeeping

Original records may not be removed from the Hospital’s premises unless in accordance with a court order, subpoena or statute.

ARTICLE 4: PATIENT CARE

4.1 Consent Forms

A. Consent for treatment forms signed by or on behalf of every patient admitted to the hospital shall be obtained at the time of admission.

B. The practitioner is responsible for obtaining and documenting informed consent including potential risks and benefits of the procedure or treatment, the likelihood of success, potential problems related to recuperation, the possible results of nontreatment, any significant alternative therapy, and, when applicable, that other credentialed practitioners will be performing assigned tasks (opening, closing, dissecting/removing tissue, or implanting devices).

4.2 Orders for Treatment
A. Verbal orders are strongly discouraged except in life threatening situations or in circumstances where it would be difficult to transmit the order by hard copy, such as during a sterile procedure.

B. Verbal orders specific to their areas may be accepted by the following within their scope of practice:
   1. Registered nurse
   2. Licensed practical nurse
   3. Physical therapist
   4. Occupational therapist
   5. Speech therapist
   6. Lab Staff
   7. Medical Imaging Staff
   8. Dietician
   9. Pharmacist
   10. Social Worker
   11. Respiratory Therapist

C. Standard orders are reviewed and approved by the appropriate Medical Staff committee.

D. Orders must be recorded clearly, legibly and completely. Illegible or improperly written orders will not be carried out until clarified.

E. Symbols and abbreviations may not be used if they appear on the unacceptable abbreviation list.

F. A DNR (Do Not Resuscitate) order is not automatically suspended during surgery. The patient’s physician – family physician, surgeon, or anesthesiologist- is responsible for discussing and documenting issues with the patient and/or family to determine whether the DNR order is to be maintained or completely or partially suspended during anesthesia and surgery.

G. All orders, except for DNR status, are canceled when a patient goes to surgery.
4.3 **Medications**

A. Medications used meet the standards of the U.S. Pharmacopoeia, National Formulary or New and Nonofficial Drugs, with the exception of medications approved by the hospital’s Institutional Review Board.

B. Medications are dispensed by their generic names.

C. Therapeutic substitutions are made according to a list approved annually by the Medical Staff. The attending practitioner is notified when a substitution is made.

D. Medications brought into the hospital by patients will be administered by hospital staff.

E. There is an automatic stop of controlled substances, antibiotic orders, anticoagulants and insulin after seven (7) days for hospitalized patients. The attending practitioner is notified before the drug is discontinued.

4.4 **Care Resolution**

If a disagreement arises related to the management of a patient that cannot be resolved by the attending practitioner, the matter shall be resolved according to the Hospital policy “Resolution of Patient Care Issues” and the Code of Conduct.

4.5 **General Rules Regarding Surgical Care**

A. A patient admitted for dental or podiatry care is the dual responsibility of the dentist or podiatrist and the MD, DO, or oromaxillofacial surgeon.

1. An appropriate medical history and physical examination of the patient shall be performed and recorded by an MD, DO, oromaxillofacial surgeon, or other qualified practitioner who has been granted privileges by the hospital to perform an H&P or by an MD or DO, or oromaxillofacial surgeon whose licensure has been verified prior to surgery being performed.

2. The dentist’s or podiatrist’s responsibilities shall include a detailed description of the oral cavity or feet, respectively, and a preoperative diagnosis, a complete operative report and progress
notes as are pertinent to the condition.

3. The MD, DO, or oromaxillofacial surgeon’s responsibilities shall include supervision of the patient’s general health status while hospitalized, and discharge.

B. All tissues and specimens removed from a patient, except those exempted by the Surgery Department, will be sent to the laboratory for pathology evaluation. The pathologist’s report is a part of the patient’s medical record.

4.6 **Emergency Services**

A. The Medical Staff shall provide medical coverage in the emergency service area in accordance with the hospital’s Plan for Provision of Care.

B. A medical record is maintained on every patient receiving emergency service and is incorporated in the patient's medical record.

C. There is a plan for the care of mass casualties in the event of a major disaster, based upon the hospital’s capabilities in conjunction with other medical and emergency resources in the community or region.

D. The hospital will comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations in the following manner:

1. A medical screening examination (MSE) will be provided for any individual presenting to the hospital requesting evaluation or treatment of a medical condition.

2. MSE will be performed by a physician or a “Qualified Medical Person” (QMP). The QMP may be either a Nurse Practitioner or a Physician’s Assistant who is licensed and privileged to perform a MSE. A qualified Registered Nurse (RN) in the Obstetrics Department may serve as QMP to provide a MSE for obstetric patients under the supervision of a physician.

3. Patients admitted directly to obstetrics must have an examination that meets the standards of an emergency medical screening examination prior to discharge or transfer.
4. A QMP may not transfer a patient with an unstable emergency medical condition without prior consultation with a physician.

5. All physicians, by virtue of their Medical Staff privileges, assume responsibility to participate in the on-call system. All medical services offered to the public shall be available either at the hospital or through on-call coverage.

6. An on-call specialist asked to present to the ED must do so within timeframes established by hospital policy. In the event the on-call specialist disagrees with this request, the on-call specialist must come to the ED irrespective of the disagreement, and address the disagreement with the Medical Director of Emergency Services at a later date.

7. An on-call specialist must not refuse to appear based on the patient’s ability to pay or the patient’s insurance status and must not direct the patient to an alternative off-campus site such as the physician’s office or a different hospital.

8. The on-call specialist may defer a response to another physician only if circumstances exist beyond the on-call specialist’s control. When the on-call specialist is unable to respond, all reasonable efforts must be made to contact an alternative physician provider who can provide the appropriate care.

9. A list of all on-call specialists will be maintained and available in the Emergency Department. The list will be kept on file for five (5) years.
## ARTICLE 5: ADOPTION AND AMENDMENT REQUIREMENTS

<table>
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<td>Majority vote of MEC members present and voting where a quorum exists. Results must be ratified by the Board.</td>
<td>Amendment or adoption may be voted on at any meeting of the MEC where a quorum exists.</td>
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ARTICLE 6: ADOPTION AND AMENDMENTS

Initial adoption: 4/2006

Amendments:

5/31/2007
- Article 3.3: revisions to H&P timeframes, addition of H&P update requirement, expansion of list of providers who are allowed to perform the H&P

7/30/2009
- Article 2.2: added that swing bed patients will be seen daily
- Article 3.3: added that H&Ps are required for observation patients
- Article 3.5: added that Anesthesia will perform and document a pre-and post-op anesthetic evaluation.

12/16/2010:
- Articles 2.2, 2.3, 3.3, and 3.4: Removed references to LTCC

12/18/2014:
- Article 4.4: Removed “Organizational Ethics” substituted “Resolution of Patient Care Issues and Code of Conduct”
PROFESSIONAL LIABILITY INSURANCE COVERAGE RESOLUTION

Be it hereby resolved that practitioners who are appointed to the medical staff of Northfield Hospital must show proof of current professional liability insurance coverage in the amount of not less than $1 million per occurrence and $3 million in aggregate and must maintain that insurance throughout the term of their appointment.

Initial Ratification: 01/92
Reviewed: 09/95
09/01
09/02
05/04
05/06
06/07
06/09
06/10
06/11
06/12
06/13
06/14
06/15
06/16
PATIENT CARE MINIMUM RESOLUTION

Be it hereby resolved that practitioners who apply/reapply for medical staff membership at Northfield Hospital will be involved in the care of at least fifteen (15) patients per year in order to be eligible for appointment to the Active staff category. Applicants who are involved in the care of at least fifteen (15) patients per year either through their combined volume at the Hospital and another acute care hospital(s)/ambulatory surgery center(s), or through their volume at another acute care hospital(s)/ambulatory surgery center(s) alone are eligible for appointment to the Affiliate staff category.

Initial Resolution: 09/02
Reviewed: 05/05
Revised: 11/06
Revised: 05/07
Revised: 06/09
Reviewed: 06/10
Reviewed: 06/11
Reviewed: 06/12
Reviewed: 06/13
Reviewed: 06/14
Revised: 07/15
Reviewed: 06/16