Mary Lanning Healthcare

Medical Staff

General Rules and Regulations

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TABLE OF CONTENTS

Section 1: General Rules and Regulations

Part 1: Admission of Patients

1.1 Nondiscrimination

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

1.2 Admitting Prerogatives and Requirements

Only a member in good standing of the Active or Courtesy Staff, with appropriate privileges, may admit patients to MLH, subject to the relevant sections of Medical Staff Bylaws, associated documents and to such other policies of Mary Lanning Healthcare as may be in effect from time to time.

Each admitting physician is required to:

- Provide a provisional diagnosis or reason for admission
- Refer elective cases to the Admissions Department for advance arrangements
- Provide information required to secure payment of insurance or compensation claims by Mary Lanning Healthcare
- Record information required for billing
- Record information required by Admissions staff if the admission and/or proposed procedure requires pre-certification
- Record information known to the admitting physician regarding the presence of an advance directive executed by the patient
- Record information related to the presence and source of communicable or significant infection in the patient
- Record any behavioral characteristics exhibited by the patient that may disturb or endanger others
- Record any observed need for protecting the patient from self-harm
- Adhere to Mary Lanning Healthcare admitting policies and procedures including pre-admission laboratory tests, documentation and scheduling

1.3 Admission Category Priorities

The Admissions Office shall admit patients according to the following priorities:

- Emergency admissions may be admitted at any time when bed space is available
- Direct admissions may be admitted by contacting the Resource Coordinator when direct admission is designated and justified by the attending physician, bed space permitting
- Elective admissions are previously scheduled admissions for patient who

are directed to report to the Admissions Office

1.4 Admission Status

Patients are generally admitted to Mary Lanning as "inpatient" status or "observation" status. The admission status requires physician order identification, and assistance with status is available through Mary Lanning Management. The admission status is reviewable up to 24 hours after admission. In general:

- Inpatients are patients with medical conditions requiring inpatient acute care and generally are intended to stay for longer than 24-48 hours.
- Observation status describes an hourly service to patients, with Medicare allowance for observation generally limited to 48 hours or less.
- The assignment of status is best achieved in collaborative effort between attending physician and assigned Case Manager.

"Outpatients" are generally those individuals who present to Mary Lanning for a procedure or diagnostic test, the completion of which is not intended to require an overnight stay.

1.4.1 Admissions through the Emergency Department

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

The attending physician shall complete an admission note and provide initial orders at the time of a patient's admission and an appropriate history and physical examination shall be documented by the attending physician within 24 hours of admission. The history and physical examination shall clearly justify the need for emergency admission and these findings must be recorded in the medical record at the time of admission. Staff members shall, either by communication directly with the attending physician, or through reading attending physician documentation, be able to respond to any questions from the Utilization Review staff relating to the emergency nature of the admission.

Pregnant women who come to the Emergency Department with a question of active labor will be, in most cases, transported to the Family

Care Center for assessment by appropriate staff.

1.5 Timely visitation after patient admission/transfer

All patients who are admitted to MLH will be evaluated by the attending physician or his or her designee in a timely manner based on the severity of the patient's illness but no later than 24 hours after the time of admission.

Patients admitted or transferred to the ICU will be seen and evaluated in a timely manner, based on the severity of the patient's illness but no later than twenty-four (24) hours after admission/transfer. Documentation of the rationale for ICU admission/transfer and the planned treatment for the patient shall be completed by the attending physician at the time of evaluation. **(c.f. Joint Commission Standard RC 01.03.01 EP3)**

Part 2: Attendance of Patients

2.1 Attendance of Patients

Each patient shall be permitted to have the physician of his/her choice as his/her attending physician, except in the case of an assigned hospitalist providing care management by prior arrangement, appropriate clinical privileges notwithstanding. An emergently admitted patient, who does not identify a primary physician, will be assigned to the MLH Hospitalist Service. This is by verbal agreement between MLH, its Primary Care/Hospitalist service, and community physicians.

Assignment of attending physician is detailed in MLH Administrative Policy, "Care Management and Communication" Policy. (c.f. MLH Administrative policy ADM260.00)

2.2 Participation in the On-call Roster and EMTALA Responsibilities

Each employed physician/group and each private medical practice are responsible for jointly arranging for the establishment of a listing of staff members who will provide on- call coverage for the Emergency Department at MLH.

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

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

On call physicians are responsible for: 1) providing consultation, including diagnosis and treatment, when requested by the Emergency Department Physician(s); and 2) to provide medical screening examinations and assist with stabilization of emergently treated patients, as requested by the Emergency Department Physician(s). The expected response time and other details related to these requirements and requirements related to transfer of patients are specified within the Emergency Medical Treatment and Active Labor Act (EMTALA) policy, as approved by the MEC and the Board of Trustees (referred to herein as the EMTALA policy). (c.f. MLH Administrative policies, "EMTALA Policy," ADM 220.00)

2.3 Continued Hospitalization

The attending physician is required to document the medical necessity for continued hospitalization and specific acute care needs of the patient under his or her care, according to criteria adopted and utilized by Case Management and Utilization Management. Such documentation may be most efficiently rendered by collaboration with Case Management and/or Utilization Management when questions arise regarding the continuation of a hospital stay beyond reasonable expectation, or the conversion of a patient from observation status to inpatient status.

Inadequate documentation may result in the issuance of a notice of non-coverage to the patient or his/her legal representative, due to the lack of documentation of medical necessity for hospitalization. A pattern of non-compliance with these requirements will be brought to the attention of the Utilization Management Committee, which may refer individuals to the Medical Staff Excellence Committee, or to the Hospital Organizational Excellence Committee for further review. Ultimate management of repeated failures by any physician in this regard will rest with the Medical Executive Committee.

Part 3: General Responsibility for and Conduct of Care

3.1 General

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

3.2 Transfer of Care

Transfer of patients from one staff member or service to another ("reassignment of attending physician") shall be made only after there has been consultation with the recipient staff member or service and his/her agreement to accept the patient.

All transfers require a physician order, (in EMR, this order is simply "Attending Physician") and subsequent acknowledgement in the record by the accepting physician. The transfer and accepting physician shall discuss the case, in the form of a "hand-off." "Hand-offs" are to be completed at or before the time of actual reassignment of the role of attending physician. Hand-off documentation is appropriate in the medical record. (c.f. Joint Commission Standard, PC 02.02.01 EP 1&2)

Patients undergoing major surgery may be transferred to the care of the surgeon of record. Patients transferring to the ICU may be transferred to the care of the Intensive Care Specialist. Admission of patients, or transfer of patients to the Behavioral Services Unit or to the Acute Rehab Unit require formal medical screening in the case of admission directly to these units or discharge from the acute care floor and readmission to any of these units.

3.3 Alternate Coverage

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

3.4 Dentists and Podiatrists

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

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

- A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;
- A detailed description of the examination of the oral cavity (in the case of a dentist) or the foot or feet (in the case of a podiatrist) and a preoperative diagnosis;
- A complete operative report, describing the findings, technique, specimens removed, and the postoperative diagnosis;
- Progress notes as are pertinent to the dental or podiatric condition;
- Pertinent instructions relative to the dental or podiatric condition for the patient and/or significant other at the time of discharge;
- Making appropriate transfer of responsibility or coverage arrangements for the patient's dental/podiatric care as necessary and required under Sections 3.2 and 3.3 of these Rules and Regulations;
- Clinical resume or final summary note; and
- Authoring the discharge orders for the patient.

3.5 Policy Concerning Immediate Questions of Care

Patient safety is of utmost concern and a core commitment of every member of the MLH organization. If a nurse or other health care professional involved in the care of a patient has any reason to question the care provided to that patient by a particular physician or practitioner, or is of the opinion that appropriate consultation is needed and has not been obtained, or observes an immediate threat to patient safety and is unable to resolve the matter appropriately, such individual is directed to bring the matter to the attention of the nursing supervisor who will assist in resolution of the concern. If resolution cannot be obtained with assistance of the nursing supervisor, the nursing supervisor shall contact the Chief Medical Officer (CMO.) The CMO may involve the President of the Medical Staff as necessary to effect satisfactory resolution. (c.f. MLH Medical Staff Bylaws, Article VI, Section 4)

3.6 Consultations

3.6.1 Responsibility

The good conduct of medical practice includes the proper and timely use of consultation. The attending physician is responsible for ordering a consultation from a qualified staff member when indicated or required pursuant to the guidelines in Section 3.7-2 below. In an urgent or emergent situation, the attending physician is responsible for direct oral communication with the consultant. In all cases, it is required that the referring physician communicates pertinent information directly with the consultant or designee at the time of consultation.

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

3.6.2 Guidelines for Calling Consultations

Guidelines for calling consultations are as follows:

- When the policy of any hospital unit, including intensive or special care units, require it
- When required by state law;
- When requested by the patient or the patient's family;
- In complex cases where there is diagnostic uncertainty or when the treatment involves procedures for which the attending is not privileged; or
- When generally accepted standards of practice require consultation.

3.6.3 Qualifications of Consultant

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

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

3.6.4 Documentation

Consultation Request

When requesting a consultation, the attending physician must document the patient's condition and reason for the request in the record progress notes, along with a date and time the consultant was contacted (this can be reflected by the timed/dated order in the record.)

Consultant's Report

The consultant shall report his/her findings, opinions and recommendations in the medical record following evaluation and

examination of the patient. When operative or invasive diagnostic procedures are involved, a consultation note shall, except in true emergency situations, be recorded prior to the procedure.

Attending Physician's Response to Consultant's Opinion

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

3.7 Mass Casualty Assignments

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

3.8 Use of Seclusion or Restraints

All restraints, as defined by the hospital policy and procedure on Restraints and Seclusion, must have a written physician's order. For each use of restraint there must be a "time limited order" (i.e. each order shall have a "start time" and an "end time") and there must be justification for the use of the restraint documented in the patient's medical record. Other requirements regarding care of patients requiring restraints are found in hospital policy, as required by The Joint Commission and CMS Hospital Conditions of Participation. (c.f. MLH Administrative policy, "Restraint or Seclusion" ADM234.00)

Part 4: Transfer of Patients

4.1 Internal Physical Transfer of Patients

Internal transfers from one patient care area to another shall take place in

accordance with hospital policy and procedure on patient transfers. (c.f. MLH Nursing Policy, "Acceptance and Receiving of Transfers" ADM222 and "Transport of Patients within the Facility" SOP1-7).

4.2 Transfer of Service

Transfers from one service to another shall be consistent with Section 3.2

4.3 Transfer to another Facility with the Expectation of Returning

Patients may be transferred to another facility for diagnostic or therapeutic procedures and/or services that are not available at Mary Lanning Healthcare with an expectation that the patient will return. Prior to the patient leaving the hospital, the attending physician shall be notified, and arrangements shall be made to assure that the patient is safely transported to and from the facility.

When the patient is being transferred to another facility and there is no expectation that the patient will be returning to MLH, the patient will be considered discharged, as provided in Part 5.

All pertinent medical information necessary to ensure continuity of care must accompany the patient at the time of transfer. Appropriate staff and equipment must accompany the patient to the receiving facility to assure patient safety. (c.f. Joint Commission Standards PC.04.01.01 - PC.04.01.05).

4.4 Patient request for Short-Term Pass

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

Part 5: Discharge of Patients

5.1 Required Order

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

5.2 Discharge Procedures

The attending physician or designee is responsible for discharging his/her

patients according to MLH discharge and EMTALA policies. (c.f. MLH Administrative policy, "EMTALA Policy," ADM220.00)

5.3 Discharge Planning for Routine Discharges

In collaboration with the multidisciplinary team (including but not limited to Case Management, Social Services, Pharmacy, and Nursing Services) the attending physician shall make arrangements as early as possible after admission for anticipated discharge needs and post discharge care of patients who will likely require aftercare. (c.f. Joint Commission Standard PC 04.02.01)

5.4 Discharge to other Acute Care Facilities

Patients may be discharged from an outpatient or an inpatient area of MLH to another acute care facility. A decision to transfer a patient to another acute care facility shall factor into the decision the following: the capacity of the receiving hospital to care for the patient's needs and the informed choice of the patient having knowledge of the risks and benefit of transfer. The request for transfer may be expressed by the patient and/or his/her legal representative. Physicians (attending or Emergency Department, depending upon the location of the patient at the time of transfer) may also request and arrange for a transfer to another acute care facility when it is determined that the patient requires specialized services that are beyond the capacity of MLH.

5.4-1 General Requirements for Discharge to an Acute Care Facility

Appropriate arrangements between Mary Lanning Healthcare and the receiving facility must be communicated in advance and the receiving facility and the physician at the facility must accept the patient.

All pertinent medical information necessary to ensure continuity of care must accompany the patient. The medical record shall reflect a notation as to the type of medical information that accompanied the patient (such as discharge summary, radiology and laboratory summaries, etc.) Appropriate staff and equipment must accompany the patient to the receiving facility to assure patient safety.

5.4-2 Medically Unstable Patients

Transfers of medically unstable patients shall be avoided, whenever possible, especially if it is within the capacity of Mary Lanning Healthcare to care for the patient.

When a medically unstable patient and/or his legal representative or family requests transfer to another acute care facility, there shall be documented discussion with the patient, family and/or legal

representative regarding the seriousness of the patient's condition and the potential risks associated with the transfer.

If the patient or legal representative insists on the transfer, then written consent is required utilizing the EMTALA form. (c.f. "Certificate of Transfer").

When stabilizing treatment is necessary but it cannot be provided by Mary Lanning Healthcare because of inability or insufficient capacity, the attending physician or his/her designee must explain to the patient and/or his/her legal representative that transfer is needed. Consent is required. In addition, the Staff member or designee is responsible for certifying that based on the medical information available at the time; the medical benefits of transfer to another facility outweigh the risks of transfer.

5.5 Discharge to Subacute Level Facility

A patient may be discharged to a Subacute or skilled nursing facility only upon the order of the attending physician or designee. The attending physician or designee shall complete the discharge summary, the medication reconciliation, and the designated transfer forms prior to discharge.

5.6 Leaving Against Medical Advice

If a patient desires to leave the hospital against the advice of the attending physician or designee or without proper discharge, the attending physician or designee shall be notified and the patient or legally responsible individual shall be requested to sign the appropriate release form. The Mary Lanning AMA Policy provides the procedure for documentation of information related to the patient's departure. A patient leaving the hospital without a discharge order and without signing the AMA release form shall be considered officially discharged. (c.f. MLH Administrative Policy, "Refusal of Services/Leaving Against Medical Advice" ADM224.10)

5.7 Discharge of Minor or Incompetent Patient

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

Part 6: Orders

6.1 General Requirements

Computerized Physician Order Entry (EMR) is available on all units throughout the facility. All orders shall be entered directly by the ordering physician except as specified below (6.4). If for any reason EMR is unavailable (due to system reboot or temporary unavailability) orders shall be entered legibly, completely, clearly, signed, dated and timed on the standard blank order form by the physician or practitioner. All initial orders shall include identification of admitting diagnosis and attending physician.

When orders are written, all written medication orders must be clear, without the use of unapproved abbreviations, and should include complete medication name, dose, route of administration, frequency of use and indication for "prn" medications. Generalized orders such as "continue previous medications," "resume preoperative medications," or "medications as at home" are incomplete. Orders that are incomplete or illegible will not be carried out until rewritten or clarified with the prescriber.

All medications and treatments will be reviewed and continued, discontinued or changed as necessary at the time of admission, discharge or transfer to a different level of care such as transfer to or from the ICU or the OR, including medication reconciliation.

Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for this administration providing a policy is in place which identifies the medications or test substances to be used. Orders for diagnostic tests must also include adequate clinical information indicating the reason for the test as establishment of its medical necessity.

6.2 Order Sets

A Department Chair or the Medical Director of a special care unit (in consultation with other appropriate representatives of the medical staff and appropriate representatives of Patient Care Services and/or other hospital departments) may formulate order sets (also identified as "clinical pathways") for any Department or other clinical unit subject to approval by the MEC.

Order sets may be used either in preprinted format, or electronically as they become available in EMR. When used in paper format, the order set must be dated, timed and signed by the attending physician or designee. All order sets within a department must be reviewed by the originator at least annually for confirmation or change with reissuance of order set(s) by signature and date. The Pharmacy and Therapeutics Committee must approve any order set referencing medication. The MLH Forms Committee must endorse and recommend to the MEC all order sets to be included in the medical record

and/or built in EMR. Failure to respond within ninety (90) days to a request from the Department Chair to review order sets will automatically terminate the order set.

When available in EMR, electronic use of the order set is the preferred or recommended means of implementation. Printed order sets will not be routinely kept available for use once EMR implementation is achieved.

Order sets may be built in EMR by submitting requests to the EMR build team with advice and consent of the Patient Documentation Change Committee. EMR order sets shall be regularly reviewed by the Patient Documentation Change Committee but at a minimum of every 12 to 24 months of previous approval. Changes to order sets shall be regularly submitted to the MEC.

6.3 Patient Care Protocols

Patient care protocols may be developed through collaborative efforts involving physicians, patient care services and/or other hospital departments. Pharmacy and Therapeutics Committee must approve and review annually any protocol referencing medication. After review and approval of protocols by the MEC, they may be utilized in patient care on the order of a qualified practitioner. Approved protocols shall be maintained on the hospital intranet for easy reference by all involved in the delivery of care and where applicable may be built in EMR. Protocols built in EMR shall not be routinely available in printed format, as EMR is the referred/recommended means of implementation of any patient care protocol. Approved protocols shall be reviewed and approved by MEC within 12 to 24 months of previous approval.

6.4 Verbal Orders

6.4-1 By Whom and Circumstance

Verbal orders increase the risk of medical error and shall not be permitted except when circumstances require, such as during an invasive procedure, during CPR or other exceptional situation. Verbal orders shall be authenticated as soon as circumstances allow, and in any case within 7 days.

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

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

Registered Nurses may take all orders from a physician or designee.
Orthopedic Technologists may take orders for orthopedic equipment from a physician or designee.
Registered Dietitians may accept verbal orders related to diets and supplements to be administered orally or by feeding tube from a physician or designee.
Registered Pharmacists may clarify an existing medication order from a physician or designee who ordered the medication.
Registered Respiratory Therapists may take orders pertaining to respiratory therapy. These orders are to include:

- Mode of therapy
- Frequency of delivery
- Concentration of oxygen
- Dosage and type of medication

Administrative and technical staff of Laboratory Services and Diagnostic Imaging may take verbal orders for laboratory and/or radiological tests for outpatient procedures (excluding pathology), but only in unusual circumstances. Written orders given to the patient, or orders that are faxed from the physician's office to the department, or EMR orders entered directly by the physician when applicable are preferred over verbal orders. (c.f. Joint Commission Standard RC.02.03.07)

6.4-2 Documentation

Verbal and telephone orders may be documented in the record only by those qualified individuals identified in Section 6.4-1 upon receipt of the order(s).

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

All telephone orders for inpatients must be countersigned by the prescribing physician (or other responsible practitioner) at the time of his/her next visit or in any case within seven (7) days. Telephone orders provided for outpatients must be verified by acceptable electronic means, including fax, in a timely fashion.

6.5 Orders by Allied Health Professionals

An Allied Health Professional (AHP) may write orders only to the extent permitted by state licensing laws and as may be specified in MLH and Medical Staff policies.

6.6 Automatic Cancellation of Orders

All previous orders are automatically discontinued when the patient is transferred to and from the Intensive Care Unit or Surgery. Orders must be reviewed and either continued or changed at the time of transfer to or from the ICU or Surgery. Medication orders will be managed according to MLH Medication Reconciliation Policy. (c.f. MLH Administrative Policy, "Medication Reconciliation Policy," ADM243.00)

6.7 Stop Orders

6.7-1 Drugs/Treatments Covered and Maximum Duration

All medication orders trigger an automatic (therapeutic) stop date per MLH Hospital Pharmacy policy.

6.7-2 Notification of Stop

At least 24 hours prior to an automatic stop order, a notification will be sent to the Case Manager to allow the daily rounding health care team (physician, nurse, and pharmacist) to review the order. If the computer system is down, a stop order report is generated by the pharmacy to be placed in the medical record. If the medication is not reviewed, it will be discontinued.

6.8 Patient's Own Medications and Self-Administration

Medications brought into the hospital by a patient may not be administered unless the hospital pharmacist has identified the medications and there is an order authored by the attending physician or designee either in writing or by EMR to administer the medication(s). Self-administration of home medications by a patient is permitted only when patients are admitted under observation status and then only by order of the attending physician or designee, according to standard ordering protocol (c.f. Section 6.1)

Herbal supplements and other alternative medications (collectively referred to as herbal supplements) are not recommended for therapeutic use. If the attending physician or designee, based on the assessment of potential risks versus potential

benefits, approves the continued use of herbal supplements, an order is entered by the attending physician or designee in this regard, either by EMR or by standard written order protocol. The Pharmacy will add the herbal supplements to the patient's medication profile and screen for drug interactions, disease state interactions, potential adverse effects. The herbal supplements must be identifiable to the Pharmacy, labeled and appropriately dispensed by the pharmacy.

Patients may not take unidentifiable substances while in the hospital. (c.f. MLH policy "Self-Administration of Medications by Patients or Non-Staff Members", MM-601)

6.9 No CPR and Similar Type Orders

MLH policy regarding CPR has been reviewed and updated by the Medical Ethics Committee (c.f. CPR Policy ADM204.00). Likewise, the Advance Directive Policy has been reviewed and updated by the Medical Ethics Committee (c.f. Advance Directive Policy ADM202.00) Orders in this regard are subject to policy set forth in these documents.

6.10 Formulary and Investigational Drugs

6.10-1 Formulary

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

6.10-2 Non-Formulary Medications

Any medication that does not appear in the formulary is considered a non-formulary (NF) medication. When an NF drug is ordered, a pharmacist will inform the prescribing practitioner of those formulary agents which are similar or preferred by the Pharmacy and Therapeutics Committee. If medically necessary, the Pharmacy will obtain a small supply of the NF drug for the patient. In some cases, the patient's home supply of medication may be used after proper pharmacy identification.

6.10-3 Investigational Drugs and Devices

Use of investigational drugs and devices may occur only when the prescribing physician is identified as a Principal Investigator (PI) and then only after review by legal counsel to assure that requirements are met for the protection of human subjects.

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

6.10-4 Substitution Policies

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

6.11 Restriction of Specific Drugs

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

6.12 Medication-Food Interaction Monitoring

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

6.13 Discharge Medications

When medications are prescribed for a patient at the time of discharge, the patient will be informed of the important aspects of the medication, its proper use, side effects and storage requirements, and potential significant adverse drug-food interactions. The attending physician must document the discharge medications being prescribed including the dosage, frequency, and duration for time-limited medications, following MLH Medication Reconciliation policy. The individual responsible for providing the medication information to the patient

must record in the patient's medical record that the patient received and understood the information concerning the discharge medications.

Part 7: Medical Records

7.1 Required Content

The attending physician, other Medical Staff members, clinical staff and Allied Health Professionals involved in the care of the patient shall be responsible for the preparation of a complete and legible medial record for all patients admitted to MLH. All entries in the medical record shall be dated, timed, and authenticated. The record's content shall be pertinent, i.e. facilitate continuity of care; support treatment provided; provide appropriate documentation for performance improvement purposes; and be accurate, legible, timely and current. The specific requirements for a complete medical record are specified within accreditation standards and Medicare hospital conditions of participation.

7.2 History and Physical Examination and Admission Note

7.2-1 General

Inpatients

A history and physical examination as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy, is required for all hospital admissions and for procedures.

A. A complete history contains at a minimum:
    1. Clinically appropriate evaluation of the chief complaint;
    2. Present illness;
B. A complete physical examination includes, at a minimum:
    1. Clinically appropriate evaluation of the vital signs;
    2. Lungs;
    3. Heart; and
    4. The involved specific organ system or body part (in the case of a pre-operative evaluation)
C. Assessment and Plan of Treatment

Outpatients

A history and physical examination as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy shall be recorded for all outpatient procedures. These procedures shall include all those done with conscious/moderate sedation ("MAC anesthesia" or "light general anesthesia" at MLH) diagnostic and therapeutic invasive procedures, needle biopsy of an intra-abdominal or intra-thoracic organ and normal vaginal deliveries. If a history has been recorded and a physical

examination performed within thirty (30) days prior to a patient's admission, a durable legible copy of such a report may be used in the patient's hospital medical record in lieu of the history and physical examination. In such instances, an updated H&P may be completed as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy.

- Documentation that patient was examined
- H&P Reviewed
- Changes Noted

7.2-2 Use of Reports Prepared Prior to Current Admission

If an H&P has been performed within 30 days prior to the patient's admission to the hospital by an appropriate practitioner and is countersigned indicating review and acceptance by a qualified MLH Medical Staff member or qualified Licensed Independent Practitioner, a durable, legible copy of the report of such an examination may be used in the patient's hospital medical record, provided that the report is dated and follows the accepted format of the hospital record. An updated H&P must be concurrent with admission as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy.

7.3 Preoperative Documentation

7.3-1 History and Physical Examination

A relevant history and physical examination is required for each patient having surgery. Except in an emergency, certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed after the H&P is completed as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy. Elective surgery (whether to be performed on an inpatient or outpatient basis except if being performed under local anesthesia) will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record. In cases of emergency, if clinically possible, the responsible practitioner shall, prior to induction of anesthesia and start of the procedure, make at least a comprehensive note regarding the patient's condition stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done. The history and physical examination shall be recorded immediately after the emergency surgery has been completed.

7.3-2 Clinical Laboratory Tests and X-rays

Appropriate advance lab tests, EKGs, and x-rays must be performed within guidelines developed by the Department of Surgery for elective surgery and for outpatient or same day surgery and the results in the

chart prior to induction of anesthesia. Reports from laboratories outside MLH may be acceptable provided the laboratory is appropriately accredited, and the test is recent enough to be pertinent. Examinations or procedures (radiologic or pathologic) performed outside MLH may be submitted to the appropriate MLH Department for review at the discretion of the operating surgeon.

7.3-3 Anesthesia Evaluation A pre-anesthesia evaluation of the patient by an anesthesiologist or CRNA must be conducted and documented in the medical record and shall include: pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, the patient's allergies, previously medications, smoking or alcohol use history, ASA patient status classification, and orders for preoperative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered. The anesthesiologist or designee responsible for the patient's anesthesia care must also conduct and document in the record a post-anesthesia follow-up of the patient's condition. All practitioners providing anesthesia shall adhere to the "Standards for Basic Intra Operative Monitoring" established by the American Society of Anesthesiologists.

7.4 Progress Notes

7.4-1 General

Pertinent progress notes must be recorded as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy for all inpatients, outpatients, and observation patients to permit continuity of care and transferability. Except for Acute Rehab Units which have specific requirements, progress notes shall be documented at least daily by the attending physician or designee. For those patients awaiting extended care facility placement or admitted as inpatient Hospice status, progress notes shall be as frequent as medically indicated.

Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending physician. Progress reports shall be completed pers MSSD 3.21 Medical Records Completion & Enforcement Policy. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders, with reasons for instituting various tests or treatment given and results of test and treatments recorded.

7.5 Operative, Special Procedure and Tissue Reports

7.5-1 Operative and Special Procedure Reports

Operative reports shall be completed as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy immediately following surgery and before the patient is transferred to the next level of care.

7.5-2 Immediate Postoperative Note

If the operative report is not placed in the medical record immediately after surgery due to transcription or filing delay, then a brief postoperative note shall be completed as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy.

7.5-3 Post-Anesthesia Assessment

The post-sedation evaluation of the patient is documented in the medical record no later than 48 hours following any therapeutic, diagnostic, or surgical procedure requiring sedation/ analgesia. This assessment shall be performed by the individual privileged to administer anesthesia will include assessment of respiratory function, cardiovascular function, mental status, neuromuscular function, pain control, nausea and vomiting.

7.5-4 Tissue Examination and Reports

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

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

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

7.6 Obstetrical Record

The current obstetrical record shall include the complete prenatal record, if a record is available or History & Physical as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy. The prenatal record may be a durable, legible copy of the attending physician's office or clinic record transferred to Mary Lanning before admission; but an interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be signed and dated by the responsible practitioner.

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

7.7 Observation Status

As in the case of inpatient admission, admission of a patient as observation status requires an initial history and physical examination (see Section 7.2). A discharge summary is recommended but is not necessary as long as the attending physician's progress note at the time of discharge addresses the final diagnosis (es), the patient's condition at discharge, and the plan for post-discharge management. Medication reconciliation is to be completed.

7.8 Entries at the Conclusion of Hospitalization

All diagnoses, co-morbidities, complications, and procedures must be recorded in full at the time of discharge, without the use of symbols or abbreviations, and must be dated and signed by the attending physician. The attending physician has the responsibility for the accuracy of this information. The following definitions are applicable to the terms used herein:

A. Principal Diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care. This can be considered the "first" discharge diagnosis when a list of diagnoses is constructed at discharge.

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

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

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

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

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

7.8-1 Discharge Documentation

In General

A discharge summary must be recorded for all hospital stays, all deliveries, and newborns as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy. Discharge documentation is contained in the Discharge Encounter Report and includes at a minimum:

Content:

1. Provider Discharge Instructions
    a. Specification of instruction to patient or caregiver, including physical activity, diet, and follow-up plans
        i. Will be recorded in patient friendly verbiage as the after visit summary
    b. Final medication reconciliation summary and instructions

Observation Status:

A discharge summary is recommended but not necessary as long as the attending physician's progress note at the time of discharge addresses final diagnoses, the patient's condition at discharge, and the plan for post-discharge management. Medication Reconciliation is to be completed.

1. Ambulatory surgery records do not require a discharge summary. Medication Reconciliation is to be completed.
2. Discharge summaries should not be prepared solely from memory. At the time of completion of discharge summaries or other similar records, the original source information should be in

the immediate possession of the person completing the records.

3. Final signed copy of discharge summaries will be sent to referring and primary care physicians.
4. The Provider Discharge Instructions Report with the discharge medication list and the discharge and follow-up instructions will be sent to referring and PCP.

A discharge summary, when necessary, is the responsibility of the physician authoring the order for discharge which will be, in most cases, the attending physician as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy. Reassignment of this responsibility may be initiated by the physician who authored the discharge order, with documentation of the reason for reassignment.

The physician is responsible for completing the applicable sections of the state mandated forms when discharge occurs to a practitioner-assisted level of care.

Exceptions

A final progress note may be substituted for the discharge summary in the case of the following categories of patients: 1) those with problems of a minor nature, admitted observation status; 2) normal newborn infants; and 3) patients having uncomplicated vaginal deliveries. The content of said progress must include: the final diagnosis, procedures, conditions on discharge, medications, instructions to patient and family and discharge disposition.

In those instances when an autopsy is performed, provisional anatomic diagnoses will be recorded in the medical record and the complete protocol shall be made part of the record as soon as possible, but not later than 60 days, unless otherwise required by state law.

7.8-2 Instructions to Patient

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

7.9 Authentication (as directed by MSSD 3.21 Medical Records Completion & Enforcement Policy)

Each clinical entry in the medical record must be accurately dated, timed and

individually authenticated. Authentication means to establish authorship by written signature, written initials, fax or electronic authentication. The use of rubber stamps is not permitted.

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

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

7.10 Medical Record Completion Requirements and Enforcement Policies

All portions of a patient's medical record must be prepared within the time frames provided in these Rules and Regulations. All portions of the medical record of a hospitalized patient should be complete at the time of discharge except when there are pending reports, transcriptions, and associated authentication.

Regarding procedure notes, the “immediate post-op note” requirement is applicable to those situations where patients are recovered in either PACU or Phase II prior to final disposition. Procedures that do not require recovery time (e.g. ECHO reports, sleep study reports, EEG reports, etc.) are not subject to the immediately deficient status.

It is the responsibility of the practitioner to provide notification to HIM, in advance, of any absence to postpone the time frame of suspension due to delinquencies.

Any physician who appears on the suspension list two times within a calendar year must appear before the Medical Executive Committee to explain the recurring suspensions. If the physician fails to appear or the MEC does not find the reasons provided satisfactory, the physician's privileges may be terminated. The MEC may institute a corrective action plan that may include the imposition of a fixed period of suspension of clinical privileges whenever a pattern of non-compliance with this section exists. Under Nebraska law and directives provided by the Nebraska Department of Health and Human Services, if a physician is suspended three times or more within a calendar year for failure to complete medical records, MLH is required to report this to the Nebraska Board of Medicine and Surgery. (c.f. 172 NACS Regs. Governing mandatory reporting by HCP; and Nebraska Medicine and Surgery Practice Act, 38-2001 - 38-2062)

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

A medical record shall not be permanently filed until the responsible attending physician completes it or it is ordered filed by the Director of Health Information Management. Medical records are considered delinquent if they are incomplete thirty (30) or more days after discharge. Discharge summaries are delinquent fourteen (14) after discharge. Physicians shall be notified of all incomplete records weekly. Delinquent record notification will be made to physicians/providers at the time of identification of delinquencies [i.e. thirty (30) days post discharge for the complete record; and fourteen (14) days post discharge for discharge summaries].

A physician/practitioner shall have a period of fourteen (14) days to complete delinquent records or face immediate suspension. Physicians/practitioners who meet suspension criteria will be informed via telephone and in writing. Notification will also be sent to the: Chief Executive Officer, Vice President of Medical Affairs (CMO), President of the Medical Staff, Department Chairs, Director of Admissions Services, Director of Emergency Services, Director of Surgical Services, Director of Nursing Services, the Director of Quality Improvement, and the Medical Staff Services Office.

If a suspended physician (practitioner) attempts to admit a patient, he/she will be required to complete all delinquent records within twenty-four (24) hours. If he/she is not willing to make this commitment, the Department Chair shall be contacted to help in processing the admission at hand. At that point, it is the Department Chair's decision as to how the admission is to be handled, i.e., delegate it to another physician in the Department, assume the admission him/herself, or allow the physician to admit and deal with the delinquency in a different manner.

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

A record of each suspension imposed shall be made part of the practitioner's quality file after verification with the Director of Health Information

Management.

7.11 Use of Symbols and Abbreviations

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

A list of unsafe abbreviations approved by the MEC is maintained by the Pharmacy and Therapeutics Committee. This list is reviewed annually and presented to the MEC for approval. All entries in the medical record using unacceptable abbreviations must be clarified prior to medication administration, diagnostic testing or therapeutic interventions.

7.12 Errors

If an error is made on a paper entry in the medical record, a single line shall be drawn through it, and the correct entry written in along with the date and authentication of the physician (practitioner). The error is not to be obliterated or erased but will be identified as an error. Under no circumstances is the record to be mutilated by tearing, taping over, or stapling.

If an error is made in an electronic medical record, documentation should reflect appropriate corrections.

7.13 Filing of Incomplete Records

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

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

7.14 Ownership and Removal of Records

All original medical records, including x-ray films, pathological specimens and slides are the property of the hospital and the information contained in them is the property of the patient. Medical records and the information contained therein may be removed only in accordance with hospital policy. Unauthorized

removal of a medical record or any portion thereof from the hospital is grounds for disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the MEC and Board of Trustees.

7.15 Access to Records

7.15-1 By Patient

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

7.15-2 On Readmission

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

7.15-3 To Former Medical Staff Members

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

Part 8: Consents

8.1 General

Patients have the right to consent to or to refuse treatment. Physicians (practitioners) performing procedures or administering treatments are responsible for explaining the risks, benefits and alternatives of such treatment. The process of informed consent or informed refusal should be documented in the medical record in accordance with MLH Informed Consent Policy (c.f. MLH Administrative Policy "Informed Consent for Treatment" ADM201.00). Exception: Consent can be obtained by the specialty trained RN for non-surgical procedures being performed by the specialty trained nurse (e.g., PICC).

Part 9: Special Units and Programs

9.1 Designation

Special units and programs include, but are not limited to, the following:

- Intensive Care Unit

- Progressive Care Unit
- Family Care Center
- Newborn Nursery
- Newborn Intensive Care Unit (NICU)
- Surgical Services
- Post Anesthesia Care Unit (PACU)
- Emergency Department
- Infusion Center
- Acute Rehab Unit
- Behavioral Services Unit

9.2 Policies

The policies of the various units and programs related to clinical care and practice are to be reviewed by and are subject to the approval of the MEC and Board of Trustees

Part 10: Surgical Requirements

10.1 Assistants at Surgery

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

10.2 Perioperative Evaluation

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

10.3 Surgery Scheduling

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

10.4 Presence of Non-Staff During Invasive Procedures

Hospital and Surgical Services policies address who may be present during invasive procedures.

Part 11: Hospital Deaths

11.1 Hospital Deaths

11.1-1 Pronouncements

In the event of a death, the deceased shall be pronounced dead by the attending physician, another licensed practitioner, or two registered nurses in accordance with Nebraska state law. The body may not be released from the hospital until an entry has been made and signed in the deceased's medical record by the individual(s) pronouncing. If an anticipated death occurs in the hospital, two registered nurses, one of whom was attending at the last sickness may pronounce the person dead. A physician order is required for release of the body to a mortuary/funeral director. (c.f. Nebraska Rev. Stat. 71-605 - covers only responsibility for signing the death certificate. The statute is silent on pronouncement of death. See Advisory Opinion on Pronouncement of Death; MLH Policy 210.00 Determination of Death).

11.1-2 Death Certificate

The attending physician or his/her designee is required to complete the death certificate. In Nebraska, this is done online through the Nebraska Department of Health and Human Services or on paper when the mortuary does not participate in the online service.

Release or removal of the body, reporting of deaths, and issuance of the death certificate are to be done in accordance with current hospital policy and Nebraska law.

11.1-3 Notification of Next of Kin

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

11.2 Autopsies

11.2-1 Responsibility

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

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

11.2-2 Autopsy Criteria

Autopsy Criteria approved by the Medical Executive Committee include:

- Deaths in which the autopsy may help to explain unknown and unanticipated medical complications to the attending physician
- Deaths in which the cause of death is unknown or unexpected Stillborns
- Neonatal or pediatric deaths in which the cause of death is unknown
- Obstetric deaths in which the cause of death is unknown
- Deaths resulting from a suspected infectious condition, but questions remain as judged by the attending physician such as etiology or circumstances
- Deaths in which autopsy results may have some bearing on the transplantation of organs
- Cases in which the family might have some special realistic concerns or questions
- Other cases that the clinician believes might be helpful

Part 12: Infection Control

12.1 Patients with Infectious/Communicable Diseases

Any patients with a suspected infectious or communicable disease will be placed on appropriate precautions in accord with provisions of Mary Lanning Infection Control policies. Infection control personnel will call to the attention of the attending physician (practitioner) those cases that may require isolation.

12.2 Reporting of Infections/Communicable Disease

All cases of reportable infectious diseases shall be reported in accord with the provisions of the hospital's Infection Control Policy, to the Infection Control Department, and as required by Nebraska State law for review by the Infection Control Committee. Perceived disease outbreaks will be assessed in accord with the Infection Control Policy.

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

12.3 General Authority

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

Part 13: Review and Amendment

13.1 Review and Amendment

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

Part 14: Enforcement of these Rules

14.1 Enforcement of these Rules

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

Part 15: Adoption

15.1 Adoption

These General Rules and Regulations were adopted and recommended to the Board of Trustees by the Medical Staff on 5/20/2013 and were adopted by the Board of Trustees on 05/23/2013.

Section 2

Medical Staff Organization

Part A: Medical Staff Departments

A.1. Functions of Department Chair

A.2. Functions of Department Chair-Elect

Part B: Medical Staff Committees

Part A: Medical Staff Departments

A. Medical Staff Departments

Per the Medical Staff Bylaws, Article X, the Medical Staff of Mary Lanning Healthcare is a departmentalized Medical Staff. Future departments may be created, or current departments may be eliminated or consolidated by the recommendation of the Medical Executive Committee with the Board of Trustees' approval. Members of the Medical Staff will be assigned to departments based on their area of primary clinical practice. This may or may not correspond with their area of academic training, e.g. adult inpatient hospitalists will all be assigned to the Department of Medicine, or Family Practice physicians in the practice of obstetrics will be assigned both to the Department of Family Practice and the Department of Women and Children. A practitioner shall have a vote in each assigned department.

Current Medical Staff Departments:

- Department of Medicine
- Department of Surgery
- Department of Women and
- Department of Family Practice

A Department Chair-Elect is elected biennially (every two years) at the September quarterly meeting of each department. The Chair-Elect moves into the Chair of the Department after serving a two-year term.

A.1. Function of Department Chair - The chair's responsibilities includes:

A.1.a. Governance/Leadership

A.1.a.i. Serve as chair of all department meetings;

A.1.a.ii Represent department at all Medical Executive Committee meetings;

A.1.a.iii Work collaboratively with the President of the Medical Staff in the general medical staff governance process;

A.1.a.iv Encourage completion of at least one formal medical staff leadership educational process during the tenure of office;

A.1.b Credentialing

A.1.b.i. Critically review all applications/reapplications to the medical staff for content and completeness

A.1.b.ii. Have familiarity with the FPPE and OPPE processes and their importance in credentialing;

A.1.b.iii. Participate in FPPE and OPPE processes as necessitated by occurrence;

A.1.b.iv. Communicate with Medical Staff Services Coordinator regarding perceived deficiencies or questions regarding the completeness of any application/reapplication;

A.1.b.v. Provide signature of approval to all applications/reapplications deemed appropriate for advancement to the Credentials Committee;

A.1.b.vi. As much as possible, have all departmental medical staff applications reviewed monthly, at least one (1) week prior to the scheduled Credentials Committee meeting in order that all applications may be submitted to the Committee in a timely manner for their review prior to each meeting;

A.1.c. Administrative/compliance

A.1.c.i. Have familiarity with Medical Staff Bylaws, Rules and Regulations, and Policies in general and in particular as they apply to departmental function;

A.1.c.ii. Review departmental privilege set(s) during the tenure in office;

A.1.c.iii Collaborate when necessary with Medical Staff President in assigning medical staff coverage of patients by department staff when an individual medical staff member, for whatever reason, becomes unable to provide coverage (c.f. Medical Staff Rules and Regulations, Section 3.4);

A.1.c.iv. Collaborate when necessary with Medical Staff President in resolving conflict of opinion between attending and consulting physicians regarding any patient care matter (c.f. Medical Staff Rules and Regulations, Section 3.7-4);

A.1.c.v Participate in review/processing of reported practitioner health issues as they impact the quality of patient care and patient safety in the organization (c.f. Medical Staff Policy Regarding Practitioner Health Issues);

A.1.c.vi. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization

A.1.c.vii. Integration of the department or service into the primary functions of the organization

A.1.c.viii. Coordination and integration of interdepartmental and intradepartmental services

A.1.c.ix. Recommending space and other resources needed by the department or service

A.1.d Clinical

A.1.d.i. Participate as opportunity arises in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services

A.1.d.ii. Assist with orientation of all new members of the department;

A.1.d.iii. Discharge of such additional responsibilities as may be imposed by the Medical Staff President or President-Elect, from time to time;

A.1.d.iv. Conduct surveillance of the professional performance of all appropriately privileged individuals in the department;

A.1.d.v. Review and distribute practitioner quality data/performance profiles in a timely manner.

A.2. <u>Functions of the Department Chair-Elect.</u> The chair-elect's responsibilities include:

A.2.a. Governance/Leadership

A.2.a.i. In the absence of the Department Chair, serve as chair of all department meetings;

A.2.a.ii. Represent department at all Medical Executive Committee meetings;

A.2.a.iii. Work collaboratively with the President of the Medical Staff in the general medical staff governance process;

A.2.a.iv. Complete at least one formal medical staff leadership educational process during the tenure of office.

A.2.b. Administrative/Compliance

A.2.b.i. Have familiarity with Medical Staff Bylaws, Rules and Regulations, and Policies in general and in particular as they apply to departmental function;

A.2.b.ii. With the Department Chair, review departmental privilege set(s) during the tenure in office.

A.2.c. Clinical

A.2.c.i. Participate as the opportunity arises in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

Department meetings will occur at least three (3) times per year either concomitant with the General Medical Staff meeting schedule, or according to a schedule determined by department chairs and approved by the Medical Staff President.

Part B: Medical Staff Committees

B. Medical Staff Committees

The Medical Executive Committee is established, and its function is governed by Medical Staff Bylaws, Article XI.

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

B.1 Credentials Committee Composition

The Credentials Committee of Mary Lanning Healthcare shall consist of:

- At least 3 members of the Active Staff all of whom shall not be department chairs
- The Chief Nursing Officer, ex officio without vote
- The Chief Medical Officer, with vote
- The Medical Staff Services Coordinator shall attend as staff support, without vote
- The Medical Staff President may attend, ex officio, without vote, but is not required to attend

Members of the Credentials Committee shall have served at least two (2) years on the Active staff and have expressed interest and/or experience in the function of the committee and have served in

some other Medical Staff leadership activity. All new members will be provided an orientation to the roles and responsibilities of the committee and will also be provided an opportunity for Medical Staff leadership training. Representatives may be re-appointed for additional terms without limit.

The Chair of the Credentials Committee is appointed by the Medical Staff President and shall serve a two-year renewable term. Qualifications for the Chair are the same as qualifications for any member of the Committee (outlined above) with the additional requirement that the Chair must have at least two (2) years' experience as a member of the Committee.

Functions and Responsibilities

The responsibilities of the Credentials Committee are as follows:

- To receive and analyze applications and recommendations for initial appointment, reappointment, return from leave of absence, clinical privileges, and changes therein and recommend action thereon.
- To review and recommend qualifications and criteria for granting clinical privileges.
- To conduct review of professional character or competence of any licensed independent practitioner, applicant or Medical Staff member. Focused Professional Performance Evaluation (FPPE-1) and Ongoing Professional Performance Evaluation (OPPE) processes shall serve as the basis of competency assessments rendered by the Committee.
- To develop, recommend, maintain and consistently implement contemporary policies and procedures for all credentialing activities at Mary Lanning Healthcare by recommending standards for the content and organization of the credentials files including periodically reviewing and revising the Credentials Procedure Manual.
- Proctoring.

Confidentiality

The Credentials Committee shall function as a peer review committee consistent with Neb. Rev. Stat. 71-7904. All members of the Credentials Committee shall, consistent with the Medial Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee. Members of the Credentials Committee will be able to obtain certain minutes and information to review before each regularly scheduled meeting. Such materials are confidential and must be managed accordingly.

Meetings and Minutes

The Credentials Committee will meet monthly in order to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions and shall report to the Medical Executive Committee. (See Attachment A - Medical Staff meeting master plan).

B.2 Clinical Care Committee

The Clinical Care Committee shall consist of physician representatives to the following Mary Lanning Hospital committees:

- Pharmacy and Therapeutics
- Cancer
- Tissue & Transfusion
- Infection Control
- Nuclear Medicine/Radiation Safety
- Critical Care
- Psychiatry
- Emergency Department
- Trauma
- Stroke
- Wellness

Functions and Responsibilities

The Medical Staff Clinical Care Committee members shall serve at least one (1) year in their appointed role, with appointments by the Medical Staff President. Any individual may serve as long as is mutually desired by the staff member and the Medical Staff President.

The committee members shall have the responsibility to participate actively as the voice and the ear of the medical staff in the hospital clinical care committee to which they are assigned. In addition, members of this committee shall compile all accumulated data, minutes, action plans, and outcomes from each hospital committee on which the members of the Clinical Care Committee serve. The information will be assembled into a formal report for submission to the Medical Executive Committee on a regular basis.

The Chair of the Clinical Care Committee shall attend the Medical Executive Committee meeting subsequent to each Clinical Care Committee meeting. Attendance at MEC will be in a non-voting capacity, with the purpose of relating the Committee report to members of the MEC.

Meetings and Minutes

The committee shall meet at least three (3) times per year on a schedule set in the Medical Staff meeting master plan and shall compile a permanent record of its proceedings. (See Attachment A - Medical Staff meeting master plan)

B.3 Compliance and Regulatory Committee

The Compliance and Regulatory Committee shall be comprised not more than seven (7) members, who will be appointed by the Medical Staff President. Members of the Compliance and Regulatory Committee shall have served at least two (2) years on the Active staff and have expressed interest and/or experience in the function of the committee and have served in some other Medical Staff leadership activity.

Functions and Responsibilities

The Medical Staff Compliance and Regulatory Committee shall serve at least two (2) years in their appointed role, with staggered terms appointed on an annual basis. Members may be reappointed for additional terms.

The committee shall have the responsibility for monitoring changes in Standards of the Joint Commission, state and Federal regulations, and CMS Conditions of Hospital Participation and make recommendations to the Medical Executive Committee regarding the impact of identified changes in regard to Medical Staff Bylaws, Rules and Regulations, and policies. The committee shall also have the responsibility for managing those matters of physician/provider impairment and health, emphasizing prevention, diagnosis and treatment of physical and psychiatric illness.

The Chair of the committee shall, by invitation of the MEC Chair, attend the MEC meeting subsequent to any committee meeting to report minutes of the committee's proceedings when attendance is deemed necessary for purposes of reporting/clarification of minutes.

Meetings and Minutes

The committee shall meet at least two (2) times annually on a schedule according to the Medical Staff meeting master plan and shall compile a permanent record of its proceedings. (See Attachment A - Medical Staff meeting master plan)

B.4 Medical Staff Excellence Committee

The Medical Staff Excellence Committee shall be comprised of the

following members:

- Medical Staff Chair-Elect, who shall serve as the Chair, with vote
- At most eight (8) other members of the medical staff, none of whom sit on the Medical Executive Committee, each with vote
- MLH CMO shall sit on the committee ex officio, with no vote

Members of the Committee shall have served at least five (5) years on the Medical Staff and shall have had at least three (3) years' experience in a Medical Staff leadership position. The President of the Medical Staff can make an exception to these requirements should the need arise. Physicians for which an exception can be made have met requirements by having served in a medical staff leadership role, or by having served on a Peer Review Committee at a prior hospital and shall have served at least two (2) years as an Active Staff member of the MLH Medical Staff. Appointments will be for two (2) years, with staggered terms, appointed by the Medical Staff President. All new members will be provided an orientation to the roles and responsibilities of the committee and will also be provided an opportunity for Medical Staff leadership training. Representatives may be re-appointed for additional terms without limit.

<u>Functions and Responsibilities</u>

The Medical Staff Excellence Committee is charged with the responsibility of patient safety and the oversight of delivery of quality care to patients through the assurance of the clinical competence of privileged practitioners. The committee members shall have familiarity with Medical Staff Rules and Regulations, policies and Bylaws, and shall have further expertise and/or understanding of the Focused Practice Performance Evaluation (FPPE) process and the On-going Practice Performance Evaluation (OPPE) process and the applicability of these processes to credentialing and privileging of medical staff at Mary Lanning.

Primary responsibilities shall include:

- Receipt, review and processing of all cases referred for concern regarding physician (provider) performance, misconduct, and/or impairment.
- Establishment of appropriate monitoring processes in those cases where appropriate.
- Referral of cases, as necessary, to the Medical Executive Committee for definitive intervention/management.
- To develop, recommend, maintain, and consistently implement contemporary policies and procedures for all peer review activities at Mary Lanning Healthcare by recommending standards for the

content and organization of the hospital and medical staff department peer review policies and periodically reviewing and revising the Peer Review Procedure Manual.

Confidentiality

The Medical Staff Excellence Committee shall function as a peer review committee consistent with Neb. Rev. Stat. 71-7904, and all other applicable statutes. All members of the Medical Staff Excellence Committee shall, consistent with the Medial Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee. Members of the Medical Staff Excellence Committee will be able to obtain certain minutes and information to review before each regularly scheduled meeting. Such materials are confidential and must be managed accordingly.

Meetings and Minutes

The Medical Staff Excellence Committee shall conduct monthly meetings, at a time to be determined by the Chair, and shall compile a permanent record of all its proceedings. The committee shall report to the Medical Executive Committee.

B.5 Nominating Committee

The Nominating Committee shall consist of:

- Immediate Past Medical Staff President, who shall serve as the Chair
- The previous two (2) Past Medical Staff Presidents
- Chief Executive Officer or designee, ex officio, without vote
- CMO, ex officio, without vote
- Medical Staff Services Coordinator, as recorder, without vote

Functions and Responsibilities

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

Nominations shall be submitted to the Medical Staff President.

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

which election is to be held.

Meetings and Minutes

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

Section 3

Medical Staff Policies and Procedures

1. Policy Regarding Practitioner Health Issues
2. Medical Staff Application/Reapplication Fees
3. Code of Conduct Policy
4. Clinical Privileges for New Procedures or Treatments
5. Immunization of Medical Staff and Advanced Practice Providers (APPs)
6. Medical Staff Ongoing Professional Practice Evaluation Policy
7. Medical Staff Focused Professional Practice Evaluation Policy
8. Policy on Confidentiality of Medical Staff Records
9. TB Testing Policy
10. Corporate Compliance Policy
11. Failure to Comply with Corporate Compliance Policy
12. Leave of Absence
13. Medical Staff Leadership Stipends
14. Senior Active Staff Responsibilities
15. Resident and Healthcare Students Policy
16. Medical Staff Education Regarding Restraints and Seclusion of Patients
17. Telemedicine Application
18. Medical Student Roles and Supervision
19. Resident Roles and Responsibilities
20. Clinical Rotations and Observations
21. Medical Records Completion & Enforcement Policy

3.1 Policy Regarding Practitioner Health Issues

Introduction

The Medical Staff Excellence Committee has been established by the Medical Staff of Mary Lanning Healthcare in part to provide a confidential mechanism for dealing with those matters of impairment and health that emphasize prevention, diagnosis and treatment of physical and psychiatric illness. A practitioner, for purposes of this policy, is defined as a physician or Licensed Independent Practitioner (psychologist, oral surgeon, dentist, podiatrist, APRN) who is a privileged member of the medical staff and who is independently licensed and regulated by the Nebraska Board of Medicine and Surgery or the appropriate licensing board of their specialty, or a licensed dependent practitioner (CRNA, PAC) who is a credentialed member of the Allied Health Professional Staff and who is licensed and regulated by the appropriate Nebraska licensing board. For all conditions, but especially those involving substance abuse, the MSEC seeks to assure that all practitioners are treated with a consistent, fair policy that will protect their rights and assist them in obtaining appropriate medical help. The MSEC policies are constructed to be administered in a uniform fashion, one which is also in concordance with each licensing board's regulations. The MSEC works directly the Nebraska's Licensing Assistance Program (LAP) and is a committee that functions in the interests of quality patient care and safety, and thus is part of the Mary Lanning Healthcare Organizational Excellence Program. All practitioners are required to sign a statement stating that they have read and understood the Policy Regarding Practitioner Health Issues as a condition for appointment or reappointment to the Medical or Allied Health Professional Staff.

Purpose

This policy establishes standardized guidelines for the identification, intervention, referral for treatment, rehabilitation and reinstatement of any practitioner who may be identified as an impaired health care provider. An impaired health care provider is one who is unable to deliver health care with skill, safety, and appropriate professional conduct to patients because of physical or mental illness, including but not limited to temporary and permanent loss of motor skills or cognitive abilities, behavioral impairment, and substance abuse, including abuse of prescription drugs, "recreational" drugs or alcohol. Mary Lanning Healthcare's Code of Conduct and the Mary Lanning Healthcare Medical Staff Code of Conduct Policy (Section 3.7) deal with inappropriate behavior; therefore, the MSEC will not address such problems. The MSEC is also not a forum for defending practitioners against accusations of criminal wrongdoing.

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

1. Maintaining a safe environment for patients, MLH employees, and other practitioners

2. Providing a mechanism for evaluating possible impairment of the health care professional

3. Providing a confidential, positive medical assistance program to the impaired professional

4. Providing ongoing education to the MLH community that addresses practitioner health and emphasizes prevention, diagnosis, and treatment of impairment of staff members

Structure of MSEC

The structure of the MSEC is described in the Mary Lanning Healthcare Rules and Regulations (Section 2).

Mechanism for Reporting and Reviewing Potential Health Issues

1. Practitioners who are suffering from a health issue that affects their ability to practice are encouraged to voluntarily bring the issue to any member of the MSEC so that appropriate steps can be taken to protect patients and to help the practitioner to practice safely and competently. With substance misuse/abuse, the Nebraska licensing Assistance Program can be directly consulted and may assist and monitor physicians/practitioners independently with an individualized program focused on rehabilitation.

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

3. If any individual has a reasonable concern that a member of the medical staff or another practitioner is unable to safely practice due to a health issue and an immediate response is necessary in order to protect the health and safety of patients or the orderly operation of the hospital, the individual shall immediately notify the relevant department chair and/or the CEO, or designee, who shall assess the practitioner to determine whether it appears that the practitioner can safely treat patients. If a determination is made that the practitioner cannot safely practice, the responsibility for care of the affected practitioner's hospitalized patients can be assigned to another practitioner with appropriate clinical privileges by the chair of the appropriate department. The wishes of the patient shall be considered in the selection of a covering practitioner. The Department Chair and the CEO, or designees, as well as the individual who notified those individuals, shall all file reports as described herein.

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

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

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

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

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

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

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

    a. Recommend that the practitioner voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation program or receive the necessary medical treatment to address and resolve the health problem;
    b. Recommend that appropriate conditions or limitations be placed on the practitioner's practice;
    c. Recommend that the practitioner voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to

ensure that the practitioner is able to practice safely and competently;

d. Recommend that some or all of the practitioner's privileges be suspended if the practitioner does not voluntarily agree to refrain from practicing in the hospital.

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

12. If the practitioner agrees to abide by the recommendation of the MSEC, a confidential report will be made to the CEO and the President of the Medical Staff. If the CEO and/or the President of the Medical Staff are concerned that the recommendation of the MSEC will not sufficiently protect patients, the matter will be referred back to the MSEC with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for an investigation pursuant to the Bylaws. (Medical Staff Bylaws Article VI, Section 6.5.2)

13. If the practitioner refuses to abide by the recommendation of the MSEC, the matter shall be referred to the Medical Executive Committee for an investigation to be conducted pursuant to the Bylaws. (Medical Staff Bylaws Article VI, Section 6.5.2)

Reinstatement

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

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

    a. The nature of the practitioner's condition;
    b. Whether the practitioner is participating in a rehabilitation program or treatment plan and a description of the program or plan;
    c. Whether the practitioner is in compliance with all of the terms of

the program or treatment plan;

d. To what extent the practitioner's conduct needs to be monitored;
e. Whether the practitioner is rehabilitated or has completed treatment;
f. Whether, if applicable, an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and
g. Whether the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

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

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

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

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

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

7. If a practitioner requested a leave of absence for health reasons without the involvement of the MSEC and is no requesting reinstatement of privileges, the practitioner, at a minimum, shall submit a report to the MSEC from his or

her attending physician/practitioner indicating that the practitioner is physical and/or mentally capable of resuming a hospital practice and performing the clinical privileges requested. The forms referenced above in paragraph 9 of the previous section should be utilized to permit exchange of information. The MSEC shall provide its recommendations regarding reinstatement to the Credentials and Medical Executive Committees.

Documentation Confidentiality

1. Consistent with quality-of-care concerns, the MSEC shall handle practitioner health issues in a confidential fashion. The MSEC shall keep the CEO and the President of the Medical Staff apprised of matters under review. The Credentials Committee may also be informed in situations where a practitioner's practice may continue to be monitored over a period of time.

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

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

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

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

6. If at any time it becomes apparent that the matter cannot be handled internally, or jeopardized the safety of the practitioner or others, the

CEO may contact law enforcement authorities or other governmental agencies.

7. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101, et seq.; Nebraska Health Care Quality Improvement Act, April 2011; and Bylaws Article XIV, Section 14.4.1; and any corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the hospital and its Board of Trustees when engaged in such professional review activities, and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

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

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

10. In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the hospital or its medical staff, including the investigation, hearing and appeal sections of those bylaws and policies, the provisions of this policy shall control.

Appendix A
Authorization and Release Disclosure of Information

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

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

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

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

_____ _____

Signature of Practitioner Date

Appendix B
Authorization for Disclosure of Information to MEC or Medical Staff Excellence Committee

I hereby authorized _____(facility performing health assessment and/or practitioner overseeing treatment or treatment program) to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice the art of medicine to Mary Lanning Healthcare (the "Hospital") and its Medical Executive Committee or Medical Staff Excellence Committee, including the information requested on the attached Heath Status Assessment form.

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

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

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

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

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

_____ _____

Signature of Practitioner Date

Appendix C

Release from Liability

Pursuant to the attached Authorization, I have authorized _____ (facility performing health assessment and/or practitioner overseeing treatment or treatment program) to provide Mary Lanning Hospital (the "Hospital") and its Medical Executive Committee and/or Medical Staff Excellence Committee with information relevant to an assessment of my health or to my treatment and/or rehabilitation.

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

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

_____ _____

Signature of Practitioner Date

Appendix D
Health Status Assessment

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

1. Does _____have any physical, psychiatric or emotional condition that could affect his/her ability to safely exercise the clinical privileges set forth on the attached list and/or to perform the duties of appointment, including responding to emergency call? ___Yes ___No

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

   _____

2. Is _____ taking any medication that may affect either clinical judgment or motor skills? ___Yes ___ No

   If yes, please specify medication(s) and any side effects: _____

   _____

3. Is _____ under any limitations concerning activities or workload? ___Yes ___No

   If yes, please specify: _____

   _____

4. Is _____ under the care of a physician or a practitioner? ___ Yes ___ No

   If yes, please identify: _____

   _____

5. In your opinion, is any accommodation necessary to permit _____ exercise privileges safely and/or to fulfill Medical Staff responsibilities appropriately? ___Yes ___No

If yes, please explain any such accommodation: _____

_____

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

6. Is _____currently participating in a treatment or rehabilitation program? ___Yes ___ No

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

   _____

7. Has _____ successfully completed a rehabilitation or treatment program? _____Yes ___No

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

   _____

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

   If yes, please describe: _____

   _____

_____ _____

Date Signature of Evaluator

Enclosure: Delineation of Privileges

3.2 Medical Staff Office
Operating Policies and Procedures
Application/Reappointment Fees

PURPOSE

The purpose of this policy is to establish a mechanism and process for collection and distribution of application/reappointment fees from medical staff members of Mary Lanning Healthcare. This fund will be utilized to provide a stipend to the physician(s) who are elected and assumes the duties and the responsibilities of President of the Medical Staff.

POLICY

All members of the Medical Staff of Mary Lanning Healthcare will be required to pay an application fee at the time of their initial appointment and reappointment to the staff. The fee for all MDs and DOs will be $200.00. The fee for all other members will be $100.00.

PROCESS OF COLLECTION OF FEES:

In conjunction with the time that the individual is sent their packet of information for initial or reappointment, a statement outlining the cost of the application for that individual will be sent to the applicant. Payment will be due upon the completion of the application by the applicant and the return of the application for processing. The applicant will submit payment to Mary Lanning Healthcare. If the payment has not been received by the time the application is ready for submission to the Credentials Committee, the application will not advance for approval.

In such cases where the provider's membership expires while waiting for payment, the member will be considered to have voluntarily relinquished their membership and privileges. If the member wishes to renew their membership after voluntarily relinquishing the membership and privileges, the member must submit a request for reinstatement to the Vice President for Medical Affairs. The reinstatement will be processed as an initial appointment with provider required payment of the application fee for an initial appointment and will be held to the Bylaws and Medical Staff policies related to an initial appointee.

Those MDs and DOs reapplying for membership who demonstrate meeting attendance at or above the following minimums shall receive a refund of 50% of the application fee when all of the following attendance criteria are met:

1. One General Medical Staff meeting annually;
2. One Departmental meeting annually;
3. 50% of all Committee meetings of the respective committee(s) to which the re-applicant has been assigned during the previous 2 years.

3.3 MLH Medical Staff
Code of Conduct Policy

PURPOSE

To encourage a fair and just culture, which in turn facilitates the highest standards of safety and quality, the Mary Lanning Hospital (MLH) Medical Staff has adopted this Code of Conduct as part of our Medical Staff Rules and Regulations, which shall be the primary means for review and disciplining members for inappropriate or disruptive behavior.

A high standard of professional behavior, ethics and integrity are expected of each individual member of the Medical Staff at MLH. This Code of Conduct is a statement of the ideals and guidelines for professional behavior of the Medical Staff in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, and others, aiming for the highest levels of patient care, trust, integrity and honesty.

POLICY STATEMENT

Medical Staff members have a responsibility for the welfare, well-being, and betterment of their patients, along with a responsibility to maintain their own professional and personal well-being. Each Medical Staff member is expected to treat all fellow medical staff members, hospital staff, hospital employees, house staff, students and patients with courtesy and respect and with regard for their safety and dignity.

When a member is found to have fallen short of these expectations, the Medical Staff supports tiered interventional strategies focused on restoring trust, placing accountability on, and rehabilitating the offending Medical Staff member. However, the safeguarding of patient care and safety is paramount, and the Medical Staff will enforce this policy with disciplinary measures whenever necessary, pursuant to Article VI, sections 4 and 5 of the MLH Medical Staff Bylaws. The evaluation, monitoring and regulation of professional behavior are essential elements of Professional Practice Evaluation.

DEFINITIONS

1. “Appropriate behavior” includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership, or activities of the organized Medical Staff, or to

engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.

2. “Inappropriate behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

3. “Disruptive behavior” means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

4. “Harassment” means conduct toward others based on but not limited to their race, religious creed, color, national origin, physical or mental disability, marital status, sex, age, sexual orientation, or veteran status; which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

5. “Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment. This Definition shall be applied and interpreted at least as expansively as this term is used under MLH Policies applicable to its employees.

6. Medical staff member means physicians and others granted membership on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

7. This policy applies to behavior directed toward any individual who is associated with MLH, including employees, colleagues, patients, families, visitors, vendors and other associates. The policy may also apply to behavior which occurs outside of MLH campus boundaries, if it is directed toward any of the above persons.

STANDARDS OF BEHAVIOR

A. Inappropriate Behavior

Inappropriate behavior by Medical Staff members is strongly discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive and subject to treatment as "disruptive behavior." Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Lack of cooperation without good cause;
- Refusal to return phone calls, pages, or other messages concerning patient care;
- Condescending language; and degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital; and
- Inappropriate comments or behaviors in meetings.

B. Disruptive Behavior

Disruptive behavior by Medical Staff members is prohibited whether it affects another Medical Staff member, nurse, hospital employee, patient, or member of the Board of Trustee. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language;
- Physical contact that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution;
- Sexual harassment;
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation; and
- Repetitive inappropriate comments or disruptions in meetings.

PROCEDURES

A. Delegation by President

At the discretion of the President (or Vice President if the President is the subject of the complaint), the duties here assigned to the President can be delegated to the Hospital's VPMA / Chief Medical Officer or to other elected representatives of the Medical Staff.

B. Initiation of Complaints

Medical Staff members have an obligation to address and/or report incidents of inappropriate and disruptive behavior. Complaints about a member of the Medical Staff regarding allegedly inappropriate or disruptive behavior are encouraged to be in writing, signed and directed to the President or, if the President is the subject of the complaint, to the Vice President, and include, to the extent feasible:

1. the date(s), time(s) and location of the inappropriate or disruptive behavior;

2. a factual description of the inappropriate or disruptive behavior;

3. the circumstances which precipitated the incident;

4. the name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;

5. the names of other witnesses to the incident;

6. the consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and

7. any action taken to intervene in, or remedy, the incident, including the names of those intervening.

Persons making a complaint should be aware that a written and signed complaint is quite helpful in enabling the Medical Staff to conduct a thorough and valid investigation, although anonymous complaints will also be accepted, investigated and addressed to the degree possible.

C. Handling of Complaints – President or Designee

1. The President or designee will review all complaints concerning Medical Staff members, first to identify any allegations of sexual harassment or other disruptive behavior, and second to identify any other complaint requirement prompt action in order to ensure patient care and safety or to address any issue that may impact Hospital employee safety.

2. All complaints, which if substantiated, would rise to the level of sexual harassment by a Medical Staff member shall be reported by the President or designee to the Board Chair, the Hospital President/CEO, the VPMA/Chief Medical Officer and the Vice President of Human Resources.

3. Investigations of complaints involving Harassment Claims against Medical Staff members shall be coordinated between the Medical Staff, the VPMA/Chief Medical Officer, the Hospital President/CEO and the Vice President of Human Resources. The Board Chair shall be kept informed of the progress and status of the investigation.

4. Generally, the President or designee will speak with the complainant and with the Medical Staff member who is the subject of the complaint.

5. The Medical Staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the Medical Staff member pursuant to Article VI, sections 4 and 5 of the MLH Medical Staff Bylaws.

6. Medical Staff members who are the subject of a complaint shall be provided a summary of the complaint and a copy of this Policy in a timely fashion, in no case more than thirty (30) days from receipt of the complaint by the President or designee.

7. The Medical Staff member may be asked to apologize to the complainant.

8. The Medical Staff member shall be offered an opportunity to provide a written response to the complaint, and any such response will be kept along with the original complaint in all relevant files.

9. The complainant will be provided an explanation of how complaints are handled, including possible limitations on the Medical Staff's ability to disclose the outcome of its review of the complaint.

10. After discussion with the Medical Staff member, the President or designee will make a determination of whether the complaint, on its face, could be considered inappropriate behavior or disruptive behavior.

11. Any complaint of disruptive behavior will be referred to the Medical Staff Excellence Committee for review and action.

12. Any complaint involving Harassment Claims will be referred to the Medical Staff Excellence Committee for review and action, with notice to the Board Chair, the VPMA/Chief Medical Officer, the Hospital President/CEO and the Vice President of Human Resources.

13. For an initial complaint of inappropriate behavior against a particular Medical Staff member, the President or designee shall have discretion to do any of the following:
    - Send the Medical Staff member a letter of guidance about the incident;
    - Send the Medical Staff member a letter of warning or reprimand;
    - If the incident itself and discussion with the Medical Staff member suggest that the Medical Staff member would benefit from health services, counsel the Medical Staff member accordingly and follow up to confirm action was taken;
    - If the incident suggests that the Medical Staff member would benefit from health services, but the Medical Staff member does not agree, refer the matter to the Medical Staff Excellence Committee for consideration of a Health Status Assessment;
    - If the incident is consistent with prior inappropriate behavior, refer the matter to the Medical Staff Excellence Committee for action.

14. The Medical Staff Excellence Committee shall document the disposition of each complaint, with a record to be kept in the Medical Staff office files.

15. Department Chairs will be kept informed regarding complaints directed toward their members. This should always occur at the time of final disposition for complaints of inappropriate behavior, but the Chairs will also be informed earlier in the process when indicated by the seriousness or repetitive nature of the incident or when the complaint is of disruptive behavior.

D. Handling of Complaints – Medical Staff Excellence Committee

1. In the event of referral of a complaint of sexual harassment or other disruptive behavior against a Medical Staff member or if the Medical Staff Member has demonstrated persistent, repeated inappropriate behavior, the Medical Staff Member shall be provided an opportunity to meet with the Medical Staff Excellence Committee, and any written response by the Medical Staff member will be provided to the Medical Staff Excellence Committee for review at or promptly after the meeting with the Medical Staff Excellence Committee.

2. Department Chairs will be notified and invited to provide input whenever a referral is received by the Medical Staff Excellence Committee. Department Chairs will be kept informed of any further actions taken by the Medical Staff Excellence Committee.

3. In the event of proposed resolution of a complaint against a Medical Staff member involving sexual harassment or harassment based on an individual's race, color, religion, sex, national origin, disability, age or genetic information that does not involve formal Medical Staff disciplinary procedures or formal Hospital employment disciplinary procedures, there shall first be communication and coordination between the President, the Hospital President/CEO, the Vice President of Human Resources and the Board Chair.

4. If the Medical Staff Excellence Committee determines that the Medical Staff member has engaged in sexual harassment or harassment based on an individual's race, color, religion, sex, national origin, disability, age or genetic information, a letter of admonition will be sent to the Medical Staff member, with a copy to the President, the Board Chair, the Hospital President/CEO, the VP/Chief Medical Officer and the Vice President of Human Resources.

5. A rehabilitation action plan developed by the President, designee and/or the Medical Staff Excellence Committee may be required of the Medical Staff member found to have engaged in disruptive behavior, with the advice and counsel of the Medical Executive Committee.

6. If, in spite of admonition and any other intervention, the sexual harassment or harassment based on an individual's race, color, religion, sex, national origin, disability, age or genetic information recurs, the President or designee shall notify the Board Chair, the Hospital

President/CEO, the VP/Chief Medical Officer and the Vice President of Human Resources, and refer the matter to the Medical Executive Committee with a request for investigation under Article IV, Section 4 of the Medical Staff Bylaws, and the Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws.

7. If, in spite of an admonition and any other intervention, the disruptive behavior on the part of the Medical Staff Member recurs, the President or designee shall refer the matter to the Medical Executive Committee with a request for investigation under Article IV, Section 4 of the Medical Staff Bylaws, and the Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws.

8. Notwithstanding the foregoing procedures, the President, the Medical Executive Committee, the Hospital President/CEO and/or the Board of Trustees may intervene at any time and insist upon a formal investigation of a complaint pursuant to Article VI, section 4 of the Medical Staff Bylaws. And if there is an imminent danger to the health of an individual or individuals, the Medical Staff member may be summarily suspended as provided in the Medical Staff Bylaws.

9. A confidential file summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology and written responses from the Medical Staff member, shall be retained in the Medical Staff office for so long as the Medical Staff member remains on the Medical Staff.

BEHAVIOR DIRECTED AGAINST A MEDICAL STAFF MEMBER:

Inappropriate or disruptive behavior which is directed against the organized Medical Staff or directed against a Medical Staff member by a Hospital employee, administrator, board member, contractor, or other member of the Hospital community shall be reported by the Medical Staff member to the Hospital pursuant to Hospital policy or Code of Conduct, or directly to the Hospital Board of Trustees, the state or federal government or relevant accrediting body, as appropriate.

ABUSE OF PROCESS:

Threats or actions directed against the complainant by the Medical Staff member who is the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by Medical Staff members against

complainants will give rise to corrective action pursuant to the Medical Staff bylaws.

Individuals who falsely submit a complaint or otherwise abuse this process shall be subject to corrective action under the Medical Staff Bylaws or hospital employment policies, whichever applies to the individual.

3.4 MLH Medical Staff
Clinical Privileges for New Procedures or Treatments

POLICY:

All requests for privileges to perform a new procedure/technique/treatment or utilize new technology not previously performed/utilized at Mary Lanning Hospital will be subject to a form review and approval process. The assessment shall address at a minimum: a) community need/ b) efficacy; c) hospital-specific capabilities (equipment, space, staff, training, and other resources); d) risks. Should the organization determine that providing the procedure/technology is in the best interest of patients and the Hospital, privileging criteria will be developed. Once criteria is developed and approved, qualified practitioners may then apply for the specific privilege. The request will be processed in accordance with existing privileging policies and procedures, subject to final approval by the Board of Trustees.

NOTE: Should the organization determine that the new procedure / technology is not in the best interest of the organization, the practitioner's request does not constitute a denial of privilege and is not reportable to the National Practitioner Data Bank. Similarly, should the organization develop criteria for said privilege and should the requesting practitioner not meet criteria, the requesting practitioner is considered ineligible to apply. This situation is not considered a denial of privileges, and therefore is not reportable to the National Practitioner Data Bank.

PROCEDURE:

1. Practitioner Request for New Procedure or Treatment: The interested practitioner shall make a written request for consideration of the new procedure/technique/treatment/technology to the Credentials Committee. The request shall be in writing, utilizing a prescribed form/format (available in Medical Staff Services Office) and include at a minimum the following:
    a. Description of procedure/technique/treatment/technology, including indications and contraindications
    b. Benefits to patients /organization
    c. Anticipated volume
    d. Requirements for space, equipment, staff, training, other resources
    e. A description of the background and training that should be required to a practitioner for privileges to perform the procedure or treatment, with reference to scientific literature and other sources as appropriate, including other specialties that might also request these privileges.

2. Review - Extension of Current Privilege: The Credentials Committee, in conjunction with the appropriate Department Chair, will determine whether or

not the procedure/technique/treatment/technology is an extension of an existing privilege, or is new to the Hospital. If it is determined that it is an extension of an existing procedure already being performed and no additional resources are required, the Credentials Committee will revise the description of the privilege delineation (if necessary) for incorporation into the existing Privilege Request Form. No further action is required by the Credentials Committee, and the practitioner need not apply for an additional privilege.

3. Review - New Procedure: The Credentials Committee, in conjunction with the appropriate Department Chair, will determine whether or not the procedure/technique/treatment/technology is an extension of an existing privilege, or is new to the Hospital. If it is determined that it is not an extension of an existing procedure already being performed, the Credentials Committee will notify Hospital Administration, and an ad-hoc committee meeting will be called. The ad-hoc committee will include the CEO (or designee), Credentials Committee Chair, appropriate Department Chair, and other administrators/medical staff members as may be required. The ad-hoc group will review the request and determine if adding the new procedure/technique/treatment/technology is in the best interest of patients and the Hospital, and if appropriate resources are available to support the new privilege.

    a. If the ad-hoc group determines that the additional resources required are unavailable or not in the best interest of the organization, the Credentials Committee will notify the requesting practitioner and not further action will be required.

    b. If the ad-hoc group determines that the additional resources required are available and in the best interest of patients and the organization the CEO (or designee) will be responsible for obtaining resources and the Credentials Committee will be responsible for developing privileging criteria.

4. Criteria Development: The Credentials Committee may solicit criteria research from the practitioner submitting the request. In addition, the Medical Staff Coordinator will obtain information that may be available from other hospitals or specialty boards. In instances where the procedure may be performed by multiple specialties and requires the development of interdepartmental criteria, the Credentials Committee may choose to appoint an ad-hoc committee with representatives from each of the affected specialties. At a minimum, privilege criteria will address the following components:

a. Education/Training: Any additional education, training, certification (including Board certification), or continuing education which may be required in order to adequately perform the new privilege. Requirements should be specific as to approved training facility/course, length of training program, hands-on or didactic, etc.
b. Experience: Previous experience requirements, including number of cases and outcomes, either in training or in practice.
c. Performance Review: Development of specific indicators for ongoing performance review.

5. Criteria Approval: Once the Credentials Committee has developed the privileging criteria, the criteria will be submitted to the appropriate Department Chair(s) for review and comment. The Credentials Committee's recommendation will be submitted to the medical Executive Committee for approval of criteria.

6. Application for Privilege: Once the privileging criteria have been approved by the Medical Executive Committee, qualified applicants may submit a request for the new privilege, through mechanisms defined in the Medical Staff Bylaws, Policies & Procedures.

3.5 MLH Medical Staff and Allied Health Professional Immunization Policy

PURPOSE

In November, 2011, the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Advisory Committee (HICPAC) published recommendations for the immunization of healthcare workers (HCW). The Centers for Disease Control (CDC) frequently updates their recommendations for HCWs. These guidelines are intended to optimize hospital infection prevention and control programs. Many HCWs are at risk for exposure to, and possible transmission of vaccine-preventable diseases. Maintenance of immunity is, therefore, an essential part of prevention and infection control programs for HCWs. Optimal use of immunizing agents safeguards the health of workers and protects patients from becoming infected through exposure to infected workers.

The Mary Lanning Healthcare Infection Prevention Committee recommends such a program regarding COVID-19, Hepatitis B, Rubeola, Rubella and Varicella. This policy shall establish the procedure for immunization of the Medical Staff and Advanced Practice Professionals:

PROCEDURE

A. New Applicants to the medical staff will, as part of the credentialing process, provide current documentation of their immunization status. Acceptable proof of immunity will be the following:

    1. COVID-19 Vaccine - All eligible staff shall have received the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine prior to providing any care, treatment, or other services by February 14, 2022. All eligible staff must have received the necessary shots to be fully vaccinated – either two doses of Pfizer or Moderna or one dose of Johnson & Johnson – by March 15, 2022.

        a. The regulation also provides for exemptions based on recognized medical conditions or religious beliefs, observances, or practices. If an eligible staff member requires an exemption (based on recognized medical conditions or religious beliefs, observances, or practices), he/she is to contact the Chief Medical Officer (CMO). The CMO will follow Hospital policy; recommended action /accommodations will be communicated back to requesting staff member.

    2. Hepatitis B - Documentation of vaccination (completed three-shot series), or sufficient serum titer for Hepatitis B surface antibody or serology indicating prior infection. Those who are not immune to Hepatitis B are encouraged (but not required) to get vaccinated. If vaccination is refused, the applicant should sign a declination form.

3. Rubeola and Varicella - Documentation of immunization with two doses of live measles vaccine and two doses of live Varicella vaccine; or protective serum titer or record of physician-diagnosed case is acceptable.

4. Rubella - Documentation of immunization (one dose of live vaccine) or a protective serum titer. Physician-diagnosed Rubella on clinical grounds is not considered reliable proof of immunity.

5. Influenza – Documentation of annual vaccination or provide copy of vaccination refusal (declination) form in accordance with Hospital Policy Influenza Vaccination Plan (EH-416).

B. Vaccination will not be required in situations in which it is contraindicated.

C. The burden for obtaining acceptable proof of immunization rests with the applicant or medical staff member.

D. New applications will not be considered complete without confirmation of immunization status.

E. Immunization Records of New Applicants will be provided to the Infection Prevention Office by the Medical Staff Services Office with proof of annual Influenza vaccination.

F. Medical staff members who do not comply with the policy will be referred to the MEC for consideration of administrative resignation from the Medical Staff.

G. Students/Residents – the Immunization Requirements included in this policy are applicable to all Students and Residents who provide care to Mary Lanning Healthcare patients. Proof of immunization records for each Student/Resident shall be maintained on file by the respective College and/or University but shall be provided upon request by Mary Lanning Healthcare Medical Staff Services Office and/or Mary Lanning Healthcare Infection Prevention Office.

3.6 MLH Medical Staff
Plan for Ongoing Professional Practice Evaluation

Content

I. Purpose

The purpose of this plan for On-going Professional Practice Evaluation (OPPE) is to outline the method by which the Medical Staff conducts on-going evaluation of the practice and competence of its members. Results of evaluation processes are used to improve the quality of clinical practice, to assist in maintenance of competence, and to improve the system of care management of privileged practitioners.

II. Policy

It is the policy of Mary Lanning Healthcare to assess Provider performance and to support patient safety and quality improvement initiatives. Mary Lanning Healthcare supports Medical Staff quality and performance improvement activities through on-going data collection for the purpose of assessing a Provider's clinical competence and professional behavior.

Specific goals include:

A. Monitor practice and performance to identify improvement opportunities for both individuals and systems of care

B. Monitor for significant trends in performance by analyzing aggregate data and case findings

C. Establish an on-going evaluation process that is clearly defined, objective, equitable, defensible, timely, and helpful

D. Identify and address opportunities for system improvements

All healthcare delivery systems are inherently going to produce errors. Simple human error does not necessarily indicate substandard care or involvement of a substandard caregiver. Yet, all participants in healthcare delivery are responsible for the continual

effort at quality improvement, reduction in error, and identification of system processes that contribute to error along with making improvement in these processes.

The On-going Professional Practice Evaluation Process:

A. Provides for the continuous evaluation of each Provider's professional practice through:
    1. The use of clearly defined indicators and criteria;
    2. A clearly defined process for collecting, investigating, and addressing clinical practice concerns, including the process utilized to identify trends that impact quality of care and patient safety;
    3. A process ensuring that reported concerns regarding a privileged Provider's professional practice are uniformly investigated and addressed as defined by medical Staff policies and applicable law; and
    4. A process that gives individual Providers access to their performance reports.

B. Defines the Medical Staff's leadership role in overseeing the quality of patient care, treatment and services provided by practitioners privileged through the Medical Staff process;

C. Monitors and improves Medical Staff quality of care processes and documents that the standard of quality medical care is being met;

D. Provides a mechanism to validate that the care provided to patients is based on applicable medical standards of care utilizing six areas of general competencies:
    1. Patient care
    2. Medical/Clinical Knowledge
    3. Practice Based Learning and Improvement
    4. Interpersonal and Communication Skills/Professionalism
    5. System Based Practice

E. Recommends the implementation of changes to improve performance when opportunities are identified.

Peer Review Committee(s) conduct On-going Professional Practice Evaluation. Information used in the ongoing evaluation process may be acquired through the following:

A. Periodic chart review;
B. Direct observation;
C. Monitoring of diagnostic and treatment techniques;
D. Monitoring of clinical practice patterns;
E. Simulation;

F. Proctoring;
G. Cases referred to Medical Staff Excellence Committee (MSEC)
H. Patient Experience survey results or Patient Complaints
I. External Peer Review; and
J. Reported concerns from any source.

Criteria/indicators are developed assessing the aforementioned six areas of general competence. These criteria/indicators are developed with medical staff participation and reviewed/approved on an ongoing basis by Peer Review Committee Chair(s) and the Medical Executive Committee.

Relevant performance data accumulated through on-going professional practice evaluation shall periodically be reviewed by applicable Department Chair/Peer Review Committee(s) within established timeframes not to exceed every eight (8) months. Data will be communicated to Medical Staff membership via individualized "Performance Profiles" and shall be considered in the process of re-appointment to the medical staff.

Various and departments have accountability for various aspects of the OPPE process as follows:

A. Identification of indicators to be used for comparative analysis of each Provider's performance is accomplished by Medical Staff Departments, The Medical Staff Excellence Committee, and the Medical Executive Committee.
B. Collection of and comparison of aggregate data for these indicators is accomplished by the Quality Improvement Department, Medical Staff Services, and the Medical Staff Excellence Committee.
C. Development of thresholds to identify variations in practice patterns is the responsibility of the Medical Staff Excellence Committee and the Medical Executive Committee.
D. Referral of those providers who exceed the identified threshold for focused review (FPPE-2) is the responsibility of the Medical Staff Excellence Committee and the Medical Executive Committee.
E. The dissemination of results of the OPPE process to providers is the responsibility of the Office of Medical Staff Services with assistance from the Quality Improvement Department and the Medical Staff Excellence Committee.

On-going Professional Practice Evaluation and any corrective action taken as a result of such evaluation are conducted pursuant to the Medical Staff Focus Professional Practice Evaluation process.

III. Definitions

Medical Staff Excellence Committee (MSEC): The MSEC is established in Medical Staff Rules and Regulations, Section 2.B.4. The Medical Staff Excellence Committee is charged with the responsibility of patient safety and the oversight of delivery of quality care to through the assurance of the clinical competence of privileged practitioners. The MSEC is a peer review committee.

On-going Professional Practice Evaluation (OPPE): A process whereby the organization evaluates a practitioner's professional performance to facilitate decisions about maintaining, revising or revoking existing privilege(s) prior to or at the time of re-appointment.

Peer Review: The objective measurement, assessment and evaluation by Peer Reviewers or Peer Review Committees, of the quality of care provided by individual Providers, as well as the identification of opportunities to improve care and report findings/recommendations to (other) Peer Review Committees and/or the Medical Executive Committee for appropriate action.

Peer Reviewer: A qualified practitioner who performs Peer Review and who possesses the appropriate clinical judgment based on training, education, and experience.

Provider: Any Practitioner who is credentialed and privileged through the Medical Staff process at Mary Lanning Healthcare.

IV. Scope, Responsibility and Accountability

The scope of the OPPE process shall encompass the practice of all privileged members of the medical staff and all non-member privileged practitioners.

Relevant information from the Provider performance profile/review process will be integrated into performance improvement activities and will be utilized to determine whether to continue, limit or revoke existing privileges. Depending upon the findings of the ongoing professional practice review, interventions may be implemented. The criteria utilized to determine the type of intervention includes a risk of severity and/or of occurrence. Interventions may include, but may not be limited to, proctoring, education, focused review and corrective action. (Ref. Medical Staff Policy 3.3 Code of Conduct; Medical Staff Policy 3.7 Focused Professional Practice Evaluation; and Medical Staff Bylaws, Article XIV)

The activities of the On-going Professional Practice Evaluation are considered privileged and confidential in accordance with state law.

If a Provider has minimal or no activity at Mary Lanning Healthcare, peer references and references from other facilities at which the provider may be actively engaged that attest to the Provider's competency at the time of reappointment may be accepted as OPPE.

The Medical Executive Committee is accountable for all OPPE activities. The responsibility for appropriate and timely completion of OPPE processes is delegated by the Medical Executive Committee to the Medical Staff Excellence Committee, the Credentials Committee, Medical Staff Department Chairs, staff of the Medical Staff Services Office and the Quality Improvement Department.

3.7 MLH Medical Staff
Plan for Focused Professional Practice Evaluation

CONTENTS

I. Purpose and Policy

The purpose of the Medical Staff Focused Professional Practice Evaluation Plan is to outline and define the processes and activities for focused evaluation of practitioner performance. Focused professional practice evaluation is the process designed to:

A. Evaluate the privilege-specific competence of practitioners with no documented evidence of competent performance at this organization, and

B. Be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

It is the policy of the Medical Staff of Mary Lanning Healthcare (MLH) to evaluate competence of practitioners who do not have documented evidence of competent performance of requested privileges at Mary Lanning Healthcare within the guidelines set forth in this Plan document.

Should a question arise regarding the ability of a currently privileged practitioner to provide safe, high quality patient care, it is the policy of the Medical Staff of Mary Lanning Healthcare to initiate focused evaluation within the guidelines set forth in this Plan document.

Focused professional practice evaluation will be for a time-limited period.

Authority for directing the activities and participation in focused evaluation is delegated by the Medical Executive Committee to the Medical Staff Excellence Committees (MSEC) and to the Credentialing Committee.

II. Scope, Responsibility and Accountability

A. Scope of Focused Professional Practice Evaluation includes:
   1. Physicians and Non-Member Practitioners (NMPP) who request and/or have been granted delineated clinical privileges by Mary Lanning Healthcare will be subject to the requirements outlined in the Plan for Focused Professional Practice Evaluation
   2. Other licensed practitioners with delineated clinical privileges will be evaluated as indicated under the guidelines set forth in this Plan document.
   3. Activities performed by independent licensed health care professionals under a contractual arrangement with Mary Lanning Healthcare that involve direct patient care contact and/or have an impact on the outcome of a patient care service will be subject to the requirements outlined.

B. Responsibility and accountability for the focused evaluation process:
   1. The Medical Executive Committee (MEC) is responsible for performance improvement activities of the medical staff, providing for a leadership role in hospital quality and performance improvement activities, and ensuring an implemented focused evaluation process.
   2. The President of the medical staff is responsible for ensuring that the MEC is current with all appropriate issues and upon receipt of data, for reports to the Governing Board.
   3. The Medical Staff Excellence Committee (MSEC) functions on behalf of the MEC to assure that performance improvement and focused evaluation activities and functions are carried out in a timely and responsible manner and in compliance with requirements as outlined in the Medical Staff Governing documents and the most current standards of Joint Commission.

III. Definitions

As used in this document, the following will apply:

Focused Evaluation / Evaluation of Practitioner Performance: may also be referenced as peer review

Plan document: references the Medical Staff of Mary Lanning Healthcare Plan for Focused Evaluation of Practitioner Performance

Practitioner: a physician, podiatrist, dentist, or other practitioner with delineated clinical privileges providing services at Mary Lanning Healthcare

Medical Staff Excellence Committees (MSEC): committee charged with responsibility for evaluation of individual performance and evaluation of the quality of care provided by the medical staff

Peer: within the context of focused professional practice evaluation a "peer" is defined as an individual practicing in the same profession. Training, experience and expertise required to provide meaningful evaluation will determine what practicing in the same profession means on a case-by-case basis. Quality of care concerns related to general medical care may be reviewed by another physician, i.e. MD to MD. Specialty specific clinical issues, such as evaluation of the technique for a specialized surgical procedure, may require an individual trained and considered competent in that surgical specialty.

Quality Profile: cumulative and aggregate data compiled for use by Department Chairs and or Service Chiefs to support evaluation of current competence

Trigger Criteria: those criteria which if not met initiate additional evaluation and may require action by the MSEC

IV. Circumstances Initiating Focused Evaluation

A. Focused Professional Practice Evaluation to evaluate the privilege-specific competence of practitioners with no documented evidence of competent performance at MLH

    1. FPPE shall begin with the first admission or performance of newly requested privilege(s).
    2. Current privileged practitioners requesting new and/or additional privileges will undergo an evaluation.

B. A possible or potential problem with individual practitioner performance/ability to provide high quality safe patient care may be identified and referred for focused evaluation through identification of a significant departure from established patterns of practice (to include a sentinel event as defined by TJC, a reviewable event as defined by

Mary Lanning Healthcare policy, or a potential risk management issue). Examples include, but are not limited to:

Surgical:

Wrong surgical procedure performed on a patient

- Intraoperative or immediate post-operative death (within 24 hr) in an ASA Class I patient
- CNS injury / changes in high cortical functions related to anesthesia induction
- Cancellation of surgery after induction of anesthesia
- Laceration, perforation, tear, puncture of an organ or body part occasioned during an invasive procedure and requiring surgical intervention for repair

Patient Protection

- Patient suicide or attempted suicide resulting in serious disability (defined as event that results from patient actions after admission - excludes deaths resulting from self- inflicted injuries that were the reason for admission)
- Delay in response / treatment
- Missed diagnosis or misdiagnosis

Obstetrics

- Maternal death or serious disability associated with labor and delivery of a low risk pregnancy
- Infant injury i.e. skull fracture, paralysis, Erb's palsy, etc.
- Perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams

1. A concern or issue related to performance or delivery of care identified by a Department Chair, member of Medical Executive Committee (MEC), President of the Medical Staff, the Chief Executive Officer (CEO), or the Chief Medical Officer (CMO). A member of the medical staff may identify a concern and request referral by a Department Chair, the CMO, or the President of the Medical Staff.
2. Failure to pass screening criteria established by the Medical Staff for activities to include, but not limited to:
    - assessment and treatment of patients
    - medication use
    - blood and blood component use
    - operative procedures
    - procedures which are high volume, high risk, and / or problem prone
    - medical record evaluation
3. Examples of triggers for a focused review under this category include, but are not limited to:
    - Identification that recent patient outcome data has shown a negative trend
    - Questions arise regarding the practitioner's competency
    - A low-no volume provider wishes to maintain clinical privileges but does

not have enough clinical activity to measure current competency to provide service or perform a procedure

C. Issues of professional conduct to include disruptive behavior and non-compliance with established standards, rules and regulations are not reviewed through the focused evaluation process. (See hospital and medical staff bylaws, rules and regulations, and policies related to conduct, disruptive behavior and compliance with rules and regulations

V. Focused Evaluation Process

A. Focused professional practice evaluations may be conducted through the use of one or more of the following evaluation methods:

- Direct Observation
- Medical Record Review
- Outcomes Review
- Peer Review
- Feedback with Peers and Hospital Staff who have direct knowledge of the practitioner's practice

B. The Credentials Committee will select the method of performing the focused professional practice evaluations at the time of the practitioner's initial appointment and when a new privilege is granted.

1. The evaluation process is to be based on at least five cases.
2. Department Chairs and Service Chiefs also have the option to require the proctoring of specific procedures as outlined on the clinical privilege forms. The level of proctoring and the method shall be noted on the clinical privilege form.
3. Upon the practitioner's initial appointment to the Medical Staff, Medical Staff Services will monitor the physician's activity level at MLH. Once five cases have been completed by the practitioner, Medical Staff Services will initiate the following processes based on the selected focused professional practice evaluation method (Table A).
4. Medical Staff Services will be responsible for maintaining all reports and forms associated with this process in the practitioner's credentialing file.
5. Medical Staff Services will be responsible for monitoring the activity levels for all new practitioners privileged to practice at MLH. The Chair or Service Chief will be notified if the practitioner has not been involved with five cases at the first anniversary date of the initial appointment. The plan to evaluate the practitioner's performance will be re-evaluated at this time.

C. Additional Privilege Requests

1. For existing privileged practitioners who request new or additional privileges, Medical Staff Services will obtain documentation of education and current clinical competency and review it to the established criteria for that privilege.
2. Upon approval of the new privilege by the Chair or Service Chief, he/she will also be asked to select a method of focused professional practice evaluation for this new privilege. As with initial appointments, the method of evaluation can include Direct Observation, Medical Record Review, Outcomes Review, Peer Review, feedback with Peers and Hospital Staff who have direct knowledge of the practitioner's practice. The evaluation of the new privilege involves at least five cases or five episodes of performing the new privilege.
3. Upon approval of the new privilege by the Board of Trustees, Medical Staff Services will monitor the practitioner's activity level at Mary Lanning Healthcare. When five cases have been completed by the practitioner, Medical Staff Services will initiate the following processes based on the selected focused professional practice evaluation method (Table B).
4. Medical Staff Services will be responsible for maintaining all reports and forms associated with this process in the practitioner's credentialing file.
5. Medical Staff Services will also be responsible for monitoring the activity levels of the new privilege granted to the practitioner. The Chair or Service Chief will be notified if the practitioner has not been involved with five cases involving the new privilege at the first anniversary date of the initial appointment. The plan to evaluate the practitioner's performance will be re-evaluated at this time.
6. The Credentials Committee reviews the request for additional privileges, supporting documentation and the recommended focused review from the Chair or Service Chief.
7. The Credentials Committee determines if the documentation of competency is sufficient and if the focused review is appropriate. The Credentials Committee has the option to accept the recommendation from the appropriate Chair or Division Chief, revise the recommendation, or request additional information. If the Committee revises the recommendation, it sends the revisions back to the Chair or Service Chief for review and acceptance before sending a final recommendation to the MEC.

D. Requests for focused evaluation when a question arises about a practitioner's ability to provide safe, high-quality care are forwarded to the Quality Department.

1. The Quality Department will be responsible for the collection of information required for focused evaluation.
2. Prior to submission for MSEC evaluation the Quality Department will:
   a. the Referral Case Evaluation form (Attachment G)
   b. the original medical record(s) and assign an initial grade (after review) based on patient outcome (Table B)
   c. Notify the appropriate Department Chair/Service Chief

d. Identify and obtain additional information or data required by MSEC and Department Chair; obtain summary of findings by Department Chair, *Service* Chief and/or other practitioners as appropriate

3. All referrals for focused evaluation will be forwarded to the MSEC committee with appropriate attached documentation including the medical record(s), a statement of the reason for referral, and, as appropriate, the response by the involved practitioner and/or the Department Chair or other practitioners involved in the evaluation.
   a. Practitioners will not appear before MSEC at initial evaluation, and may, once notified of the case *review,* submit written information for consideration as they determine is appropriate.
   b. The MSEC will evaluate documentation and determine if the information presented is adequate and appropriate.
   c. After initial MSEC evaluation, the involved practitioner(s) may be notified of the *review* and asked for involvement in the *review* as determined necessary by the MSEC. Involvement may include written documentation, an appearance before the committee or both. (See Attachment H)
4. Should the MSEC determine that there is a significant issue and an interview of the involved practitioner (or others as deemed necessary) would be beneficial, an invitation will be extended for the next meeting (regularly scheduled or special meeting).
   a. If the practitioner declines an invitation, the MSEC will come to a conclusion based upon the available documentation and information.
   b. If the involved practitioner is not interviewed and wishes to provide direct input, his request will be considered.
5. The MSEC will come to a conclusion based upon an assessment of the medical care, judgment, documentation and compliance with accepted medical standards (sources may include but are not limited to: regional standard of care, TJC, CMS, AMA, specialty board and college standards, policies and/or white papers).
   a. The conclusion of the committee will verify the Grade *level.* The assigned grade will determine action to be taken.
   b. Should additional information be required by the MSEC the Committee will identify the information required, the person who will be responsible to obtain the information, the person or persons who will be requested to provide information, and the time frame in which the information will be reported back to the Committee.
6. Conclusions related to focused evaluation activities of the MSEC will be forwarded to the MEC for action and follow-up.

E. At the conclusion of the focused professional practice evaluation, the referring Committee reports the results to MEC along with further recommendations to either conclude the evaluation successfully, recommend extension of the *review* or other actions deemed appropriate by the referring committee The MEC *reviews* the outcomes of the focused professional practice evaluation and determines if the evaluation was completed successfully or if further action is warranted, up to and including corrective action as

outlined in the Medical Staff Bylaws. Other options for action include the physician's participation in mandatory training that may be followed by further evaluation to validate an improved performance. An extension of the *review* will not be considered if the physician/practitioner undergoing the evaluation failed to comply with the initial recommendations.

1. Upon receipt of a focused professional practice evaluation, the MEC reviews recommendations and makes a final decision. The MEC has the option to accept the Committees recommendations, revise the recommendations, or request additional information.
2. Action by the MEC may include, but is not limited to:
    a. Additional investigation
    b. Continuing education/training
    c. Revision of medical staff policy and procedure
    d. Referral to hospital Excellence Committee with recommendation for system or process evaluation and revision via a Quality Team
    e. Those processes defined in the Medical Staff Bylaws /Corrective Action /Fair Hearing
3. In the event that a physician is due for reappointment while a focused professional practice evaluation is underway, an abbreviated reappointment will be recommended to allow the necessary time for the evaluation to be completed.
4. Any action taken will be within the requirements of the Medical Staff Bylaws and provisions for Fair Hearing.

VI. Timelines

A. It is expected that the majority of focused evaluations will be completed within 90 days of initiation. Information required for Committee evaluation will be identified and requested within one (1) week of the date of referral or initiation of case evaluation.
    1. A follow-up request signed by the chair of the MSEC will be initiated for any responses not received within two (2) weeks or ten (10) working days of the initial request.
    2. The follow-up request will state "the case will be forwarded for MSEC committee evaluation without your input" if response not received within five (5) working days.
    3. Once all requested information is received, the case will be placed on the agenda of the next regularly scheduled meeting of the MSEC. If information is not received per the request, the referral will be placed on the agenda of the meeting to follow and noted to be incomplete.

B. In rare circumstances, the evaluation may extend beyond the so-day time frame. If the case is complicated, issues are identified that were not initially known, or if external evaluation is required, additional time will be allowed to assure a thorough evaluation of the case(s). Should MSEC be unable to complete a case evaluation within 100 days of initiation, a report will be submitted by MSEC to the MEC regarding the status and timeliness of the process.

VII. External Evaluation

A. Based upon the information gathered and/or the Grade assigned, the MSEC may make a request that a case be referred for external peer evaluation. In the event that a case of a serious nature is identified (e.g. unexpected patient death, serious patient injury, wrong site surgery or wrong procedure done on a patient) and external peer evaluation is indicated according to guidelines identified in part B below, the Chair of the Medical Staff Excellence Committee may, upon request from either the CMO or the Vice President of Quality, act on behalf of the Committee in authorizing external peer evaluation of the identified case. (See Attachment H)

B. Instances in which external peer evaluation might be considered beneficial include:

1. Evaluation of care within a specialty in which there is not a sufficient number of eligible reviewers, and in the opinion of MSEC additional expertise is needed in order to come to a conclusion
2. Issues which appear to require an external opinion to ensure objectivity; or the opinion of an unbiased "expert" would be considered beneficial
3. Situations in which there is a serious conflict in conclusions or lack of consensus by internal reviewers
4. The medical staff needs an expert opinion or witness as part of establishing a benchmark for quality monitoring, or participating in a corrective action investigation, or for a fair hearing and appeals process
5. Situations in which no staff members without a conflict of interest can be identified
6. A request by a practitioner to use new technology or perform a procedure new to the hospital that is a radical departure from current medical practices and the medical staff does not have the necessary subject matter expertise to evaluate adequately the quality of care involved

C. Oversight of the external evaluation process will be the responsibility of the Quality Department.

1. At Mary Lanning Healthcare, external peer review is contracted through a professional peer review service provider.
2. Records to be reviewed will be identified by the Chair of the MSEC and may include, but not be limited to:
   a. An overall sample of similar cases treated by the practitioner
   b. Specific records representative of the issue, problem, question, or concern

VIII. Conflict of Interest

A. It is recognized that there is a potential conflict of interest within a department when information is requested and provided by practice partners or competitors. It is the responsibility of MSEC and MEC to provide an evaluation mechanism removed from that

conflict of interest.

B. Should anyone be involved in evaluation of, or discussion related to, quality of care or performance by an individual practitioner it is his/her responsibility to identify any issues of conflict.

C. No practitioner may be involved in the evaluation of his/her own care, or that of his/her practice partner(s).

D. A practitioner may be allowed to provide input during an evaluation of his care as outlined above.

E. Members of the MSEC and MEC will recuse themselves during any evaluation of care in which they were involved.

F. At the discretion of the chair of MSEC and MEC, a committee member may be recused during an evaluation or discussion related to care by a practice partner, relative, or other relationship determined to be a possible conflict.

IX. Recordkeeping

A. All files, information, documentation and discussions related to evaluation activity are privileged and confidential in accordance with applicable Nebraska statutes and the Healthcare Quality Improvement Act, 1986.

B. Documentation of focused evaluation activity is confidential and available only to authorized individuals who have a legitimate need to access such information; and only to the extent necessary to conduct their assigned responsibilities.

1. Access to documentation is limited to:
    a. Medical staff officers
    b. Members of the MEC, Credentials Committee, and MSEC
    c. Quality Department staff
    d. Medical Staff Services staff
    e. Medical Staff attorney and hospital attorney
    f. CEO and representatives of the governing body

C. No copies of evaluation documents will be created and distributed unless authorized by medical staff bylaws/policy, the specific request of the President of the Medical Staff or CMO, or the CEO.

D. All files, minutes, and other documentation related to focused evaluation activity will be maintained in a secure location, in locked files. Retention of focused evaluation files will be compliant with state and federal requirements and consistent with established policies. Information may be archived in a secure manner in accordance with applicable policy.

E. All MSEC members, other practitioners and staff involved in evaluation and evaluation of performance will hold information in strict confidence and make no voluntary disclosures of such information and will sign a confidentiality statement related to their understanding of this policy.

X. Plan Evaluation and Revision

The Plan for Focused Evaluation of Practitioner Performance is reviewed on an annual basis, and appropriate revision recommended by the MSEC to the MEC.

XI. Attachments

Table A	Focused Professional Practice Evaluation Methods
Table B	Focused Evaluation Grading System with Required Action
Attachment C	Direct Observation Worksheet
Attachment D	Medical Record Review by Peer
Attachment E	Chair Final Recommendation
Attachment F	Health Information Management Evaluation
Attachment G	Referral Case Evaluation Summary Form

TABLE A—Focused Professional Practice Evaluation Method	
FPPE Evaluation Method	**Process**
Direct Observation	• Medical Staff Services will identify when the practitioner has been involved with five cases by monitoring activity reports • The physician(s) identified as the Direct Observer will be asked to complete Attachment C. The case demographic information will be completed by Medical Staff Services prior to the physician completing the form. • If all five cases are rated as satisfactory, the Chair or Service Chief will be asked to complete Attachment E • If concerns are identified during the review process, the Chair or Service Chief will develop a plan to address the issue, and this information will be communicated to the Credentials Committee • Successful completion of the evaluation process will be communicated to the Credentials Committee and to the Medical Executive Committee
Medical Record Review by a Peer	• Medical Staff Services will identify when five cases have been completed by the practitioner • Copies of the medical record and Attachment D will be provided to the Chair or Service Chief for review and completion by a peer. • If all five cases are rated as satisfactory, the Chair or Service Chief will be asked to complete Attachment E • If concerns are identified during the review process, the Chair or Service Chief will develop a plan to address the issue and this information will be communicated to the Credentials Committee and to the Medical Executive Committee. • Successful completion of the evaluation process will be communicated to the Credentials and to the Medial Executive Committee
Outcomes Report	• Medical Staff Services will identify when five cases have been completed by the physician and generate a report with procedure, diagnosis and disposition codes • If no complications are noted from the coding information, a case summary will be prepared for each of the five cases and presented to the Chair or Service Chief for review. If there are no concerns with any of the cases, the Chair or Service Chief will be asked to complete Attachment E. • If concerns are identified during the review process, the Chair or Service Chief will develop a plan to address the issue and this information will be communicated to the Credentials Committee • Successful completion of the evaluation process will be communicated to the Credentials Committee and to the Medical Executive Committee
Focused Peer Review	• Cases placed in the peer review process may also be included in the five cases that are to be reviewed during the focused professional practice review process • If the cases entered into the peer review process are identified to be appropriate and a total of five cases have been reviewed and found to be satisfactory, the Chair or Service Chief can complete Attachment E • Successful completion of the evaluation process will be communicated to the Credentials Committee and to the Medical Executive Committee
Discussion with Peers and Hospital Staff who have direct knowledge of the Practitioner's Practice	• Documentation from two peers or hospital staff members with direct knowledge of the practitioner's practice may be used once the physician has completed five cases. • Attachment F may be completed by Health Information Management Evaluation/hospital staff • The peers or hospital staff members will be asked to complete a reference form and submit it to Medical Staff Services. • The forms will be presented to the Chair or Service Chief who may then complete Attachment E • Successful completion of the valuation process will be communicated to the Credentials Committee and to the Medical Executive Committee

TABLE B—FOCUSED EVALUATION GRADING SYSTEM WITH REQUIRED ACTION

GRADE	FINDING	REQUIRED ACTION	REPORT
0	No quality problem identified/meets standard of care	None	None
1	• No adverse patient outcome or actual detrimental effect • Often done by practitioners in field, but not in total compliance with indicator • Possible documentation or system failure	Letter to practitioner notifying him/her of evaluation, conclusions, and statement that information will be included in Reappointment Profile. (May be a standard form letter from Chair of MSEC, committee member on behalf of the committee or a Department Chair.	Notification to practitioner; copy of notification to Chair of Department, entry on Reappointment Profile, entry of category (not practitioner specific) on summary report
2	• Potential for adverse patient outcome, minor temporary detrimental effect occurred/minimal adverse effect and/or • Practice differs from usual approach, but special mitigating circumstances present	Letter to practitioners from MSEC Chair on behalf of committee, to include conclusion(s), and statement that information will be included in Reappointment Profile. May include statement of concern or expectations as identified by committee	Notification to practitioner; copy of notification to Chair of Department, entry on Reappointment Profile, entry of category (not practitioner specific) on summary report
3	• Adverse patient outcome and/or detrimental effect that required additional medical or surgical treatment/moderate adverse effect and/or • A significantly unusual approach, different from most practitioners	Letter to practitioner from MSEC with conclusions of evaluation, including a specific statement outlining concern(s), expectations, and a statement that information will be included in Reappointment Profile. May include a request for response or outline specific corrective action	Notification to practitioner; copy of notification to Chair of Department, entry on Reappointment Profile, entry of category (not practitioner specific) on summary report
4	• Adverse patient outcome that required significant medical or surgical attention or treatment/significant adverse effect and/or • A very unusual approach that is never or rarely used by other practitioners in the field	Report from MSEC to MEC outlining evaluation process, findings, conclusions and identified concerns. The MEC will identify the plan for corrective action to include follow-up and may request that the MSEC notify the practitioner on their behalf. MEC will identify accountability for implementation of corrective action plan	Follow-up/tracking documentation initiated; notification to practitioner; data entry in Reappointment Profile with follow-up tracking as indicated; specified in MEC quality report
5	• Adverse patient outcome resulting in death, permanent loss or disability, or situation in which there was an imminent danger to body or mind and/or • Inappropriate and contraindicated approach	Report from MSEC to MEC outlining evaluation process, findings, conclusions and the identified concerns. The MEC will identify the plan for corrective action to include follow-up. The MEC will be responsible for notification and all corrective action, and will assure implementation of corrective action plan.	Follow-up/tracking documentation initiated; notification to practitioner; data entry in Reappointment Profile with follow-up tracking as indicated; included in MEC quality report

Attachment C - Procedural Review/Proctoring
Focused Professional Practice Evaluation Worksheet

Date: _____ Physician's Name: _____

Medical Record #: _____

Location: (circle one) Hospital Outpatient Building Clinic

Procedure Area: (circle one) OR Angio IR/Cath Other: _____

Diagnosis: _____

PROCEDURE REVIEW

Procedure: _____

_____

H&P completed and on medical record prior to procedure?	YES	NO
Consent complete and on medical record prior to procedure?	YES	NO
Interactions/communication with patient/family appropriate?	YES	NO
Lead/Participated in Time Out process?	YES	NO
Procedure Note completed immediately following procedure?	YES	NO
Was the outcome of the case acceptable/anticipated?	YES	NO

Note any complications from procedure: _____

_____

Note any concerns with technique/skill: _____

_____

Note suggestions for further training/proctoring: _____

_____

PATIENT MANAGEMENT

Patient admitted to the appropriate level of care?	YES	NO	N/A
History & Physical, Progress Notes, Discharge Summary documented in a timely manner?	YES	NO	N/A
Initial orders appropriate for diagnosis/work-up?	YES	NO	N/A
Medication utilization appropriate?	YES	NO	N/A
Appropriate use of ancillary services (Lab, Blood Bank, Radiology, etc)?	YES	NO	N/A
Appropriate consultations ordered in a timely manner?	YES	NO	N/A
Physician responded in a timely manner (calls, pages)?	YES	NO	N/A
Communication to patient/family timely and complete?	YES	NO	N/A
Medical Record Documentation Complete/Legible?	YES	NO	N/A
Any performance/behavior concerns noted by Staff/patient/patient's family/physicians?	YES	NO	N/A

Note any concern regarding management of case: _____

_____

CASE RATING

_____ Anticipated Outcome/No Management Issues

_____ Unanticipated Outcome/No Management Issues

_____ Unanticipated Outcome/Management Issues

Comments: _____

_____

_____

_____ _____

Evaluator's Signature Date

Attachment D - Medical Record Review
Focused Professional Practice Evaluation Worksheet

Date: _____

Physician's Name: _____

Evaluator's Name: _____

Medical Record #: _____

Location: (circle one) Hospital I Hospital II Outpatient Building

Date of Admission: _____ Date of Discharge: _____

PATIENT MANAGEMENT

Patient admitted to the appropriate level of care?	YES	NO	N/A
History & Physical, Progress Notes, Discharge Summary documented in a timely manner?	YES	NO	N/A
Initial orders appropriate for diagnosis/work-up?	YES	NO	N/A
Medication utilization appropriate?	YES	NO	N/A
Appropriate consultations ordered in a timely manner?	YES	NO	N/A
Appropriate use of ancillary services (Lab, Blood Bank, Radiology, etc)?	YES	NO	N/A
Physician responded in a timely manner (calls, pages)?	YES	NO	N/A
Communication to patient/family timely and	YES	NO	N/A
Medical Record Documentation Legible?	YES	NO	N/A
Any performance/behavior concerns noted by staff/ physicians?	YES	NO	N/A

Note any concern regarding management of the case:

_____

_____

PROCEDURE REVIEW

Procedure:

_____

_____

Type of Sedation: (Circle one) Minimal Moderate Deep

H&P completed and on medical record prior to procedure?	YES	NO
Consent complete and on medical record prior to	YES	NO
Interactions/communication with patient/family appropriate?	YES	NO

Procedure Note completed immediately following procedure? YES NO

Note any complications from the procedure:

_____

_____

Note any concerns with technique/skill:

_____

_____

Note suggestions for further training/proctoring:

_____

_____

CASE RATING

_____ Anticipated Outcome/No Management Issues _____

_____ Unanticipated Outcome/No Management Issues _____

Unanticipated Outcome/Management Issues _____

Comments:

_____

_____

_____ _____

Evaluator's Signature Date

Attachment E -

Chair/Section Chief Final Recommendation Form

Practitioner: _____

Department/Section: _____

Name of Proctor(s): _____

Focused Professional Practice Evaluation Review Method: (select all that apply)

____ Direct Observation

____ Medical Record Review

____ Outcomes Report

____ Peer Review Findings

____ Hospital/Peer Feedback

o I have reviewed the attached focused professional practice evaluations reports and based on the information reviewed, I recommend continuing this practitioner's privileges with no restrictions

o I have reviewed the attached focused professional practice evaluations reports and based on the information reviewed, I recommend continuing this practitioner's privileges with the following modifications:

_____

_____

o I have reviewed the attached focused professional practice evaluation reports and based on the information reviewed, I recommend continuing the review process as described below:

_____

_____

_____ _____

Signature (Chair/Section Chief) Date

Attachment F
Health Information Management Evaluation Worksheet

Date: _____ Physician's Name: _____

Health Information Management Evaluation

Have any concerns been noted with the following (circle the appropriate evaluation):

Timeliness of the History and Physical:	YES	NO	N/A	No Data	
Completeness of the History and Physical:	YES	NO	N/A	No Data	
Timeliness of the Operative Note:	YES	NO	N/A	No Data	
Completeness of the Operative Note:	YES	NO	N/A	No Data	
List the number of Medical Record Suspensions In the last year.	0	1	2	3	3+

Other Comments/Considerations:

_____

_____

_____

_____ _____

HIM Director/Representative's Signature Date

Department Director/Unit Evaluation

Based on your knowledge, interaction, and feedback from the staff, please circle the appropriate rating:

Interpersonal Communication Skills	Satisfactory	Unsatisfactory
Professionalism	Satisfactory	Unsatisfactory

Please explain any "Unsatisfactory" rating:

_____

_____

_____

Other Comments/Considerations:

_____

_____

_____ _____

HIM Director/Representative Date

ATTACHMENT G – REFERRAL CASE EVALUATION SUMMARY FORM

IDENTIFIER: MRN: PT ID:	**ADMISSION DATE:** **DISCHARGE DATE:**	**PATIENT AGE:**
DATE TO COMMITTEE:	**PRACTITIONER:**	**PATIENT SEX:**
IDENTIFIED THROUGH:		
SUMMARY: GRADE:		
CONCERNS:		
RESEARCH / FOLLOW-UP:		

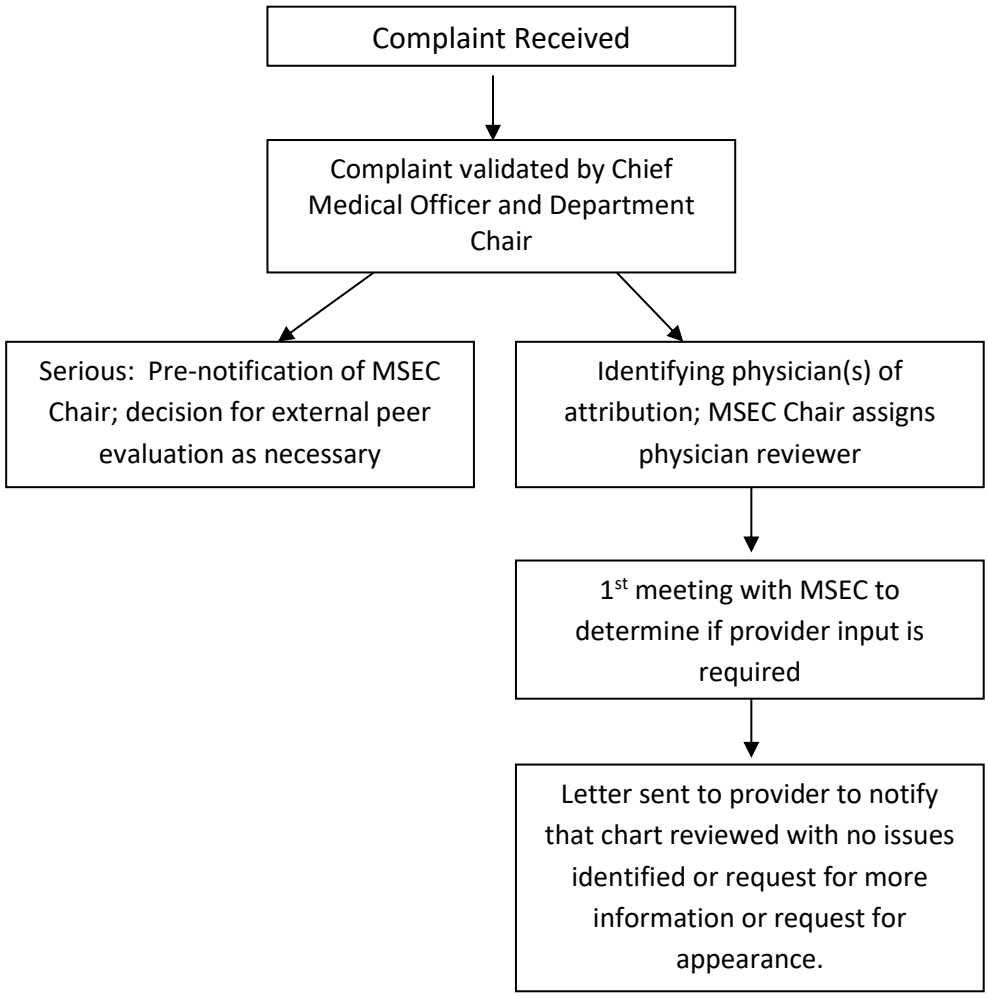
QUESTIONS ADDRESSED BY COMMITTEE: 1)			
FINDINGS:			
CONCLUSIONS:	□	No Quality Issue identified; Explanation for conclusion:	
	□	Quality Issue Identified	Grade by committee:
RECOMENDATIONS:			

Attachment H

Mary Lanning Healthcare

Medical Staff Excellence Committee

Peer Review Process



3.8 MLH Medical Staff
Policy on Confidentiality of Medical Staff Records

PURPOSE

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

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

This policy shall also apply to any and all discussions and/or deliberations regarding credentialing, performance improvement, and peer review matters that take place in the course of medical staff committee and department meetings, though such discussions are discouraged outside of identified peer review committees.

LOCATION AND SECURITY

All medical staff records shall be maintained in the Medical Staff Services Office under the care and custody of the Medical Staff Services Coordinator and the CMO. The Medical Staff Services Office shall be kept locked except when the Coordinator or the CMO (or an authorized representative) is able to monitor access to medical staff records in accordance with this policy. Access to medical staff records shall be allowed only in accordance with this policy and after obtaining a signed confidentiality statement.

FILES OF MEDICAL STAFF RECORDS

The credentials, performance improvement, and peer review file of each practitioner appointed to the medical staff of MLH shall include, but not be limited to, the following:

A. Applications for appointment, reappointment, and requested changes in staff status or clinical privileges with all attachments.
B. All information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, or changes in staff status or clinical privileges.
C. Results of queries to the National Practitioner Data Bank

D. Any periodic review and appraisal forms completed by the appropriate department chair, including those completed at the time of appointment or reappointment
E. Any performance improvement trend sheets data, and reports concerning the individual's practice at the hospital, including quality profiles
F. Any routine correspondence between MLH and the practitioner
G. Information concerning the practitioner's meeting attendance record and compliance with other citizenship requirements
H. Notations of telephone conversations concerning the practitioner's qualifications, including date of conversation, identification of parties to the conversation and information received and/or discussed
I. Any and all confidential correspondence from third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents provided by persons having knowledge or information concerning a practitioner's training, clinical practice, professional competence, or conduct at any other health care facility or medical school
J. Any evaluations or reports from proctors or monitors and any written explanation submitted by the practitioner
K. Any and all incident reports concerning the practitioner which are placed into the file for trending purposes, along with any written explanation submitted by the practitioner
L. Any confidential correspondence and/or memos to file, prepared pursuant to collegial intervention efforts with the practitioner
M. Confidential reports and/or minutes (redacted) of peer review committees pertaining to the practitioner
N. Any and all correspondence specifically relating to subparagraph (8) through (13), including written explanations or rebuttals submitted by the practitioner
O. Any correspondence setting forth formal Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements, or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the practitioner submits. The practitioner shall in all cases be permitted to submit a written rebuttal or explanation which shall also be maintained in the practitioner's file

RECORDS OF MEDICAL STAFF COMMITTEES AND DEPARTMENTS

Minutes and related documents and reports of medical staff committees and departments shall be maintained in an orderly and easily accessible fashion in the Medical Staff Office under the custody of the Medical Staff Services Coordinator.

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

A. Date and time of body that is meeting
B. List of those in attendance, those absent, and any guests or visitors
C. Notation as to presence or absence of a quorum
D. Notation that minutes of the previous meeting were read and approved
E. Identification of any individual who abstained from participation in any action taken or recommendations made
F. Recommendations or resolutions made or action taken

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

Minutes and reports of committees or departments shall be maintained in an especially confidential manner when they pertain to credentialing, performance improvement, or peer review matters. These documents shall be marked "CONFIDENTIAL PURSUANT TO PEER REVIEW STATUTES OF THE STATE OF NEBRASKA, AND THE NEBRASKA HEALTH CARE QUALITY IMPROVEMENT ACT OF APRIL 2011".

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

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

ACCESS TO MEDICAL STAFF RECORDS

Any individual permitted access to any medical staff records under this Section shall be afforded a reasonable opportunity to inspect the records requested and to make notes regarding them, in the presence of the CMO or an authorized representative. In no case shall an individual remove the records (or portions thereof) from the Medical Staff Services Office or make copies of them, without the express permission of the CMO or the CEO.

ACCESS BY INDIVIDUALS PERFORMING OFFICIAL MEDICAL STAFF FUNCTIONS The following individuals shall be permitted access to medical staff records to the

extent described:

A. The CMO and Medical Staff Services Coordinator personnel shall have access to all medical' staff records as needed to fulfil their respective responsibilities.
B. Medical staff officers shall have access to all medical staff records to the extent necessary for the performance of their duties.
C. Members of medical staff committees shall have access to the minutes and reports of the committees on which they serve and, when necessary to fulfill their responsibilities, to the credentials, performance improvement, and peer review files of individual practitioners.
D. Department chairs shall have access to all medical staff records relating to the activities of individuals seeking or exercising privileges in the respective departments. Department chiefs shall also have access to the credentials, performance improvement, and peer review files of individual practitioners whose qualifications or performance is being reviewed.
E. Department members shall have access to the minutes (and related documents or reports) of meetings of the department to which they are assigned.
F. Consultants engaged by MLH to assist a medical staff committee or department shall have access to the credentials, performance improvement, and peer review files of the practitioner being reviewed and to any other relevant medical staff records which are necessary to enable such consultants to perform their functions.
G. The CEO (or designee) shall have access to those medical staff records necessary for the performance of official functions.

ACCESS BY MEMBERS OF THE MEDICAL STAFF

A. CREDENTIALS, PERFORMANCE IMPROVEMENT AND PEER REVIEW FILES
    1. A practitioner shall not have access to the credentials, performance improvement, or peer review files of other practitioners, except as described in Section D.
    2. A practitioner shall routinely be permitted access to those items in his or her personal file that are identified in Section B, paragraphs 1-7 of this policy.
    3. Access by a practitioner to additional information in his or her file shall be governed by the following:
        a. With respect to items regarding matters internal to the hospital, set forth in Section B, paragraphs 10-15 of this policy, the practitioner shall have the opportunity to review these documents in the presence of the VPMA/CMO, an appropriate medical staff leader (e.g. CMO, or Credentials Committee Chair),

and/or the CEO.) At this meeting, the practitioner shall be shown the document (but not be provided the identities of hospital employees involved, unless, in the discretion of those involved in the meeting, revealing their identities would be conducive to quality and performance improvement and would not result in adverse consequences to the hospital employee(s) or willingness of other employees to document incidents). The practitioner shall be given the right to submit a written explanation for inclusion in the file.

b. With respect to items relating to matters external to the hospital (including Section B, paragraphs 8 and 9), practitioners shall not be told the identity of any individual outside the hospital who provided information, unless the individual providing such information or evaluation consents to the disclosure or this information is the basis for an adverse professional review action that entitles the practitioner to a hearing pursuant to the Medical Staff Bylaws, Credentials Procedures, or Medical Staff Rules and Regulations. However, the substance of the information contained in this documentation may be discussed with the practitioner and he/she shall be given the right to submit a written explanation for inclusion in the file.

B. MEDICAL STAFF COMMITTEE AND DEPARTMENT FILES

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

established by granting access.

C. ACCESS BY INDIVIDUALS OR ORGANIZATIONS OUTSIDE THE HOSPITAL OR MEDICAL STAFF

1. Requests from other hospitals
2. If a practitioner has not been the subject of any recommendation or action relative to maintenance of privileges, then the CMO (or authorized representative), CEO (or designee), President of the Medical Staff (or designee) or Chair of the Credentials Committee may release information contained in that practitioner's credentials, performance improvement, and peer review file in response to a request from another hospital, medical staff, or managed care organization. Such request must be in writing and shall include the practitioner's authorization for the release of the requested information. Disclosure shall be limited to the information requested and shall be accompanied by a statement that the information is being provided with the expectation that the requesting entity will continue to maintain appropriate confidentiality.
3. If a practitioner has been the subject of any recommendation or actions relative to maintenance of privileges, then no information shall be released upon request of another institution until the practitioner has provided Mary Lanning with a specific, signed release deemed satisfactory by the hospital. All responses to such requests shall be reviewed and approved by the CMO, CEO (or designee), and/or President of the Medical Staff, who may consult with hospital's legal counsel.

REQUESTS FROM HOSPITAL SURVEYOR

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

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

REQUESTS FROM STATE PROFESSIONAL BOARDS

State law permits the State Medical Board, the State Board of Dental Examiners, and other state professional licensing boards to subpoena medical staff records concerning individual practitioners on the medical staff of the hospital. MLH legal counsel (or

designee) must review the subpoena and approve release of the requested records before access is granted. Disclosure shall be limited to the information requested.

SUBPOENAS

All subpoenas pertaining to medical staff records shall be referred to MLH legal counsel (or designee) who may first consult with the CMO, Medical Staff President, and/or CEO regarding the appropriate response.

OTHER REQUESTS

All other requests for medical staff records (or portions thereof) by persons or organizations outside the hospital shall be reviewed by hospital legal counsel and the CMO or the CEO (or designee). The release of any information may be conditioned upon approval by the Medical Executive Committee and/or the MLH Board of Trustees.

CORRECTIONS OR DELETIONS OF MEDICAL STAFF RECORDS

A. Credentials, performance improvement and peer review files of practitioners
   The CMO (or authorized representative) shall correct or delete materials contained in a practitioner's credentials, performance improvement, and peer review file only after the practitioner has submitted a written request demonstrating good cause for the correction or deletion and that request has been approved by the Medical Executive Committee and the CEO (or designee).
B. Medical Staff Committee and Department Records
   Any corrections, deletions, or omissions noted prior to the approval and adoption of medical staff committee or department minutes shall be made in the minutes prior to signature by the authorized Medical Staff officer. Subsequent to formal adoption of the minutes, corrections or deletions may be made only by means of an addendum to the minutes.
C. Sanctions
   1. All suspected breaches of confidentiality or other violations of this policy by a member of the medical staff shall be reported to the Medical Executive Committee. The Medical Executive Committee, or an ad hoc committee appointed by the Medical Executive Committee, shall conduct a prompt investigation and determine if there has, in fact, been a violation of any of the provisions of this policy. If it is determined that a violation has occurred, the committee shall, depending on the nature and severity of the violation:
      a. Issue a letter of guidance, warning or reprimand;
      b. Remove the individual from the committee assignment and/or Medical Staff Office; and/or
      c. Recommend more severe disciplinary action in accordance with

the Medical Staff Bylaws, which may include a recommendation to revoke the medical staff appointment and clinical privileges of the individual found to have violated the policy.

2. Any practitioner found to have violated this policy also risks loss of available legal protections (including loss of indemnification for any litigation costs and expenses).
3. All suspected violations of this policy by an employee of the hospital shall be referred to the Chief Executive Officer (or designee) for review and appropriate action pursuant to the personnel policies of the hospital.

Appendix A - Confidentiality Statement

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

1) Information pertaining to other practitioners obtained or generated through the peer review, corrective action, credentialing, appointment/reappointment process;
2) Information pertaining to the financial or proprietary interests of Mary Lanning; and
3) Information pertaining to the Mary Lanning Healthcare's strategic plan and/or marketing efforts.

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

_____ _____

Signature Date

_____

Printed Name

Appendix B - Confidentiality Statement and Notification Statement for Surveyors

(To be signed by surveyors to whom medical staff records will be disclosed)

I have requested that I be allowed to inspect MLH Medical Staff credentialing, peer review, or performance improvement records at Mary Lanning Healthcare (MLH), Hastings, NE.

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

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

2) To notify Mary Lanning Healthcare prior to the further disclosure of that information outside of the survey process, whether pursuant to a subpoena or otherwise, and to cooperate with any efforts of the hospital to contest that disclosure.

_____ _____

Signature Date

_____

Print Name and Title

Appendix C - Confidentiality Statement and Staff Record Review

While reviewing my own medical staff record, I recognize:

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

2) Information pertaining to the financial or proprietary interests of MLH; and

3) Information pertaining to the Mary Lanning Healthcare strategic plan and/or marketing efforts.

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

_____ _____

Signature Date

_____

Print Name

3.9 MLH Medical Staff
TB Testing Policy

POLICY

Annual Tuberculosis (TB) testing is no longer required for practitioners at Mary Lanning Healthcare, in accord with recommendations of the Nebraska Tuberculosis Program, which exempts healthcare settings that are considered low risk from annual testing per Centers for Disease Control Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis. Risk assessments will be reviewed annually by Mary Lanning Infection Prevention and the frequency of testing will be adjusted as needed.

New medical staff and allied health practitioner staff members with privileges will receive a baseline TB screening test at the time of on-boarding. Applicants who have been continuously engaged in practice in a low-risk area, as defined by the Centers for Disease Control Guidelines, with proof of previous negative TB testing, will be exempt.

Testing will be performed after known exposure to Mycobacterium Tuberculosis per protocol of MLH Infectious Disease.

PROCEDURE

1. MLH Infection Control will be the provider of TB testing.

   If an applicant to the Medical Staff or allied health professional staff has had a Mantoux test within the past 12 months, documentation must be forwarded indicating when, where and by whom the test was administered, and the results. If not, individuals will be tested once credentialing/privileging is complete.

2. Medical Staff or allied health professional staff members who have had a positive PPD skin test will be provided with an annual questionnaire to identify any symptoms of active disease.

3.10 MLH Medical Staff
MLH Corporate Compliance Policy

PURPOSE

The purpose of this policy is to outline the educational requirements of the Mary Lanning Healthcare's Corporate Compliance Program in order to ensure that all Medical Staff and privileged non-member practitioners are familiar with, understand, and are updated on the Mary Lanning Healthcare Corporate Compliance Program, Code of Conduct and other related policies and procedures.

A. Initial Appointment/Current Staff Membership
All current, independent privileged practitioners (medical staff and allied health professionals) and those applying for initial appointment to the Medical Staff or as an allied health practitioner will be provided a copy of the Mary Lanning Healthcare Compliance Code of Conduct and Ethical Behavior Policy (ADM 710.00) and each will be asked to sign an acknowledgement form (Attachment A).

B. Reappointment
All medical staff members and privileged non-member practitioners will be asked to provide evidence of two hours of compliance education for the two-year reappointment cycle. Evidence will be in the form of a signed acknowledgement form in which the applicant attests to the fact that he/she has completed compliance education for the time period (Attachment B).

The two hour education requirement may be fulfilled by attending in-house educational programs (CMEs) attending out-of-hospital educations programs, or by reviewing select video/audio and/or written educational materials.

C. Records Maintenance
All documentation related to training of the medical staff and non-member privileged practitioners shall be maintained in the Medical Staff Office.

Attachment A

MLH Medical Staff Acknowledgement Form

Corporate Compliance Program

By signing below, I certify that I have received the Mary Lanning Healthcare Compliance Code of Conduct and Ethical Behavior policy, and information regarding the Corporate Compliance Program. I have read and understand that the Code has been adopted by the Administration and approved by the Board of Trustees and that it applies to employees, contractors, members of the medical staff and non-member privileged practitioners. I also understand that I may call the Corporate Compliance Officer to report concerns or violations of the Compliance Code of Conduct and Ethical Behavior policy.

_____ _____

Signature Date

Attachment B
Medical Staff Compliance CME Acknowledgement Form

I acknowledge the mandatory CME requirement of 2 hours of organizational integrity (compliance) education for each two-year reappointment cycle.

These credits may be attained by attending in-house educational programs, attending outside educational programs, or by reviewing selected video, audio, and/or educational materials.

Please sign below attesting to attendance at a CME program and/or review of appropriate video/audio or educational materials.

I understand that Mary Lanning Healthcare has a Corporate Compliance Program and a Corporate Compliance Officer (402-460-5505).

Signature _____ Date _____

3.11 Failure to Comply with Corporate Compliance Policy

POLICY

All members of the medical staff must comply with the Mary Lanning Healthcare Corporate Compliance education policy (Med Staff Policy 3.10). Upon initial appointment the Corporate Compliance policy requires an initial signature confirming delivery of the Compliance Code of Conduct and Ethical Behavior Policy and return of the Corporate Compliance Acknowledgement Form to the Medical Staff Office. At the time of reappointment (every 2 years) a signed compliance acknowledgment form is to be returned to the Medical Staff Office.

PROCEDURE

New Applicants

1) Upon initial application to the Medical Staff, the applicant will receive the Compliance Code of Conduct and Ethical Behavior Policy and acknowledgment form. The applicant will have 30 days to review the booklet and return the acknowledgment form to the Medical Staff Office. The acknowledgement form will remain a permanent part of the applicant's file.

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

Medical Staff Members Reappointment

1) The Compliance Code of Conduct and Ethical Behavior Policy will be distributed to all members of the medical staff upon MEC adoption of this policy. An acknowledgement form, along with a letter of explanation of Corporate Compliance and the necessity of education about it. Members will be instructed to sign the acknowledgement form and return it in the self-addressed stamped envelope to the Corporate Compliance Officer.

2) All reappointments will require attestation of Corporate Compliance CME and completion by signing the Corporate Compliance Education Acknowledgement Form. The Medical Staff Office will send notice of any deficiency in the reappointment application to members of the Medical Staff and to non-member privileged practitioners prior to reappointment. If such documentation is not received prior to reappointment, then any reappointment granted will be conditional upon receipt of the required documentation within 90 days from the time of reappointment. After 60 days, the Medical Staff member or non-member privileged practitioner will receive a certified letter warning that he/she has 30 days to attest Corporate Compliance education. If attestation of Corporate Compliance education is still delinquent at 90 days, the Medical Staff member or non-member privileged practitioner will undergo automatic administrative resignation.

3.12 Leave of Absence

POLICY

This policy is established to provide a mechanism for accommodation and management of the voluntary leave of absence of a privileged practitioner.

Any practitioner, whether suffering from incapacity or for other reasons, may request a voluntary leave of absence from membership and/or privileged status, during which he/she shall have no admitting or other clinical privileges and during which he/she shall not be required to attend meetings or pay dues/fees. Reinstatement of membership and/or privileges shall be at the discretion of the Medical Executive Committee and subject to such conditions as it may impose, including the requirement of reapplication. The practitioner on leave of absence must request reinstatement before the Medical Executive Committee will consider the matter.

PROCESS

A practitioner may obtain a voluntary leave of absence from medical staff membership and/or clinical privileges by submitting a written request to the Medical Executive Committee stating the reason for the leave and the time period of the leave, which may not exceed one (1) year, with exception for military leave with medical activity. If the leave is granted, all rights and privileges of the practitioner shall be suspended from the beginning of the leave period until reinstatement.

Reinstatement: At least sixty (60) days prior to the one-year anniversary of leave, or at any earlier time, the practitioner may request reinstatement of membership/privileges by submitting a written notice to that effect to the Chief Medical Officer (or designee) for transmittal to the Medical Executive Committee. The practitioner shall submit a written summary of his/her relevant activities during the leave. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the practitioner's membership/privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of membership/privileges pursuant to this section shall not be considered an adverse action and shall not be reported to the Licensing Board or to the National Practitioner's Data Bank. A request from a practitioner so terminated shall be submitted and processed in the manner specified for application for initial appointments.

If a practitioner requests leave of absence for the purpose of obtaining further medical training, the MEC will satisfy itself as to the continuing competency of the practitioner. Any new privileges requested in conjunction with the training will be acted upon and monitored in similar fashion as if the practitioner were a new applicant.

Reinstatement will ordinarily be automatic if the *leave* is an armed services commitment with proof of medical activity. However, if such a leave occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

If the practitioner requests a leave for medical reasons or reasons other than further training or armed services commitment, the MEC may, prior to reinstatement, require proof of competency and ability to perform privileges requested.

3.13 Medical Staff Leadership Stipends

Section 1. Medical Staff Leadership Stipends

Stipends will be provided annually for the following leadership positions of the Mary Lanning Healthcare Medical Staff:

- President
- President-Elect
- Chair, Credentials Committee
- Chair, Department of Medicine
- Chair, Department of Family Practice
- Chair, Department of Women and Children
- Chair, Department of Surgery

Section 2. Rationale

It is of considerable value to Mary Lanning Healthcare to have a well-organized, well governed, competent medical staff. Well trained and knowledgeable Medical Staff leadership is vital to the existence of a good medical staff. Leadership at the Medical Staff level must be executed by an informed, engaged, and energetic physician leadership team.

The time commitment for medical staff leaders has increased in recent years as the responsibilities of medical staff leaders have increased. With the development of the medical staff as an independent, self-governing body, individuals assuming leadership positions (President and Vice President) can expect to devote significant time to duties of the offices. This time is certain to impact the physician's productivity in his/her medical practice.

Primary responsibilities of the President and President-Elect are detailed in the organization's Bylaws.

Primary responsibilities of the Credentials Committee are detailed in Medical Staff Rules and Regulations, Section 2, Part B, Medical Staff Committees. The position of Chair of the Credentials Committee is recognized as a vital leadership role that merits a stipend. This is the most important committee chair after MEC and MSEC. The Credentials Committee Chair is expected to obtain formal education in the medical staff credentials process and have a thorough understanding of pertinent Joint Commission Standards, Medical Staff Bylaws, and Rules and Regulations.

All individuals holding a Medical Staff leadership position for which a stipend is provided by Mary Lanning Healthcare agree by signature to stipulations of this policy set forth in stipend agreements defined by Mary Lanning Healthcare.

Stipend Plan

President's Stipend

The President will spend at least 10 (ten) hours per month tending to duties of the office. The President's stipend shall be calculated using 10 hours per month, at a rate of $110.00 per hour, or $13,200.00/yr.

This stipend shall be payable $1,848 by the Medical Staff and the balance ($11,352) by Mary Lanning Healthcare.

Formal education expenses relative to Medical Staff Leadership shall be reimbursed by Mary Lanning Healthcare not to exceed $3,000.00 per year.

Vice President's Stipend

The Vice President will spend at least 5 (five) hours per month tending to duties of the office. The Vice President's stipend shall be calculated using 5 hours per month, at a rate of $110.00 per hour or $6,600.00 per year.

This stipend shall be payable $924 by the Medical Staff and the balance ($5,676) by Mary Lanning Healthcare

Formal education expenses relative to Medical Staff Leadership shall be reimbursed by Mary Lanning Healthcare not to exceed $3,000.00 per year.

Credentials Committee Chair Stipend

The Credentials Committee Chair will spend at least 5 (five) hours per month tending to duties of the office. Using calculations similar to those described, the annual stipend for this Chair shall be $8,000.00.

This stipend shall be payable $2,000 by the Medical Staff and the balance ($6,000) by Mary Lanning Healthcare.

Formal education expenses relative to Medical Staff Leadership/Credentials process shall be reimbursed by Mary Lanning Healthcare not to exceed $1,000.00 per year.

Department Chair Stipend

Chairs of the Departments of Surgery, Women & Children, Medicine, and Family Practice will spend at least 5 (five) hours per month tending to the duties of the Department. Using calculations similar to those described, the annual stipend for this Chair shall be $6,600.00.

This stipend shall be payable $924 by the Medical Staff and the balance ($5,676) by Mary Lanning Healthcare.

Formal education relative to Medical Staff Leadership/Credentials process shall be provided by Mary Lanning Healthcare.

Updated and approved by MEC 04/19/2022

3.14 Senior Active Staff Responsibilities

An appropriately privileged Senior Active Staff member may:

- Admit patients without limitation, except as otherwise provided in these Bylaws or in Medical Staff Rules and Regulations;
- Chair committees of the Medical Staff;
- Chair his/her department;
- Serve in a Medical Staff leadership position if qualified;
- Vote on all matters presented at regular and special meetings of the Medical Staff and of the department(s) to which he/she may belong;
- Exercise all clinical privileges as are granted to him/her.

A Senior Active Staff member who has not accepted a leadership position or is not a chair of a committee or a Medical Staff department is not required to serve on any committee of the Medical Staff.

A Senior Active Staff member must, in addition to meeting the basic obligations set forth in these Bylaws and in Rules and Regulations:

- Participate in continuous quality improvement and continuing medical education activities required by the Medical Staff;
- Discharge the recognized functions of staff membership by attending patients as required, giving consultation to other staff members consistent with delineated privileges, and fulfilling such other staff functions as may reasonably be required of staff members
- Provide on-call coverage for all patients admitted to the hospital and be available for coverage for all patients presenting to the Emergency Department who identify the physician as a personal primary care provider. In the event of inability to provide this coverage, it is the responsibility of the Senior Active Staff member to establish coverage arrangements with another appropriately privileged (Senior) Active Staff member.

3.15 Medical Staff Office
Residents and Healthcare Students Policy

Prior to any resident or student observing, shadowing or partaking in any practice experience, notification shall be given to the Medical Staff Services Office to allow for proper credentialing and an orientation to take place. The resident or student's name, preceptor, and dates of preceptorship shall be provided to the Medical Staff Services Office.

Arrangements for housing and meal charges will be made on an individual basis, as needed through Medical Staff Services.

Notification of the preceptorship to the clinical services will be generated through the Medical Staff Services Office.

Residents:

A resident is a MD. or D.O. in a residency training program, approved by the Accreditation Council for Graduate Medical Education, that has an education affiliation agreement with Mary Lanning Healthcare or participates in the Rural Training Tract program through the University of Nebraska Medical Center.

Residents shall not hold medical staff appointment and shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff.

Activities performed by residents shall be under the supervision of a Medical Staff member. Clinical activities shall be limited to those of the clinical privileges granted to the supervising Medical Staff member and agreed upon by the hospital, preceptor program and the sponsoring Medical Staff member, and are limited to the scope of their specialty as permitted by the State of Nebraska and the Hospital. For those residents in the Rural Training Tract program, the supervising physician must be physically present when providing any activity beyond a core Family Practice privilege.

Residents must possess a State of Nebraska Medical or Training license and will be verified prior to any practical experience. Curriculum Vitae may be requested as needed.

Proof of malpractice insurance shall be verified prior to any practical experience.

Residents may attend patients in all hospital services. They may write and sign orders and document in the medical record.

Residents shall identify themselves as a resident and shall wear a name badge identifying them as such.

Residents may not serve on Medical Staff Committees.

Healthcare Students:

A healthcare student is one who is enrolled in an MD. or D.O. program or a physician assistant, advanced practice registered nurse, certified nurse midwife, certified registered nurse anesthetist and nursing students outside of the MLH/Creighton School of nursing, in an approved training program that has an education affiliation agreement with Mary Lanning Healthcare or with a MLH Medical Staff member.
Healthcare students shall not hold medical staff appointment and shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff.

Healthcare students shall not be granted specific clinical privileges. Activities performed by students shall be under the supervision of a medical staff member as permitted by Mary Lanning Medical Staff Bylaws, Rules, and Regulations, and individual departmental policies. Clinical activities shall be limited to the scope of their profession.

The supervising practitioner is directly responsible for the actions of the student.

Healthcare students may perform history & physical examinations, as scope of practice allows by the State of Nebraska and Hospital policy, at the supervising practitioner's discretion. Orders may not be carried out until approved by the sponsoring practitioner.

Healthcare students are not allowed to examine or treat Emergency Department patients without the physical presence of the supervising physician.

Healthcare students shall identify themselves to patients as a medical student under the supervision of the attending practitioner.

Healthcare students shall wear a name badge identifying them as such.

3.16 MLH Medical Staff
Medical Staff Education regarding Restraint and Seclusion of Patients

I. Purpose

This policy is to establish in Medical Staff governing documents the acknowledgement of Mary Lanning Healthcare's position that patients have the right to be free from restraints of any form that are not medically necessary. Further, restraints and seclusion, when employed in the care of the patient, will be used as necessary with the goal of preserving the patient's safety and dignity.

II. Policy

In accord with hospital policy, it is the policy of the medical staff of Mary Lanning Healthcare to regularly educate physicians in the use of restraint and seclusion of patients. (c.f. MLH Policy ADM234.00).

All educated physicians shall acknowledge by signature attesting to completion of the educational process. (Attachment A)

Education regarding restraint and seclusion of patients shall be a requirement of medical staff membership for identified physicians and shall recur in conjunction with the reappointment cycle.

III. Identified Physicians

Physicians in the following disciplines shall be excluded from the requirement for restraint/seclusion education:

Anesthesiology
Pathology
Radiology
Endocrinology
Cardiology
Obstetrics/Gynecology
Ophthalmology
Otolaryngology
Neurological Surgery
Hematology/Oncology
Oral/Maxillofacial Surgery
Infectious Disease
Nephrology
Urology
Wound Care/Cosmetic Surgery
Plastic Surgery
Thoracic Surgery
Vascular Surgery
Radiation Oncology
General Surgery
Pediatrics

IV. Attachment A

ATTACHMENT A

Date

Dear Mary Lanning Healthcare Provider:

The Joint Commission required all Physicians/Licensed Practitioners who are authorized to order restraints to have a working knowledge of the Administrative Restraint and Seclusion Policy (ADM234.00). New physicians, as well as physicians re-appointed to the Mary Lanning Healthcare Medical Staff are required to document knowledge of the current Restraint and Seclusion Policy.

Please review the attached Restraint and Seclusion Policy, sign below indicating receipt and review thereof, and return to the Medical Staff Services office. Please keep a copy of the policy for your records and only return this document.

Thank you,

_____ _____

Signature and Credentials Date

TELEMEDICINE APPLICATION (DELEGATED CREDENTIALING) (MSSD 3.17)

NAME:_____ **DEGREE:**_____

SPECIALTY:_____ □ ***(is specialty covered by exclusive contract? If so, is practitioner party to the contract? If not, practitioner is not eligible to apply)***

_____ **Office Phone:**_____
Preferred Mailing Address

Office Fax:_____

_____
City **State** **Zip**

Email:_____**(required)** **Cell #:**_____
(required)

Social Security No.:_____ **Date of Birth:**_____

State License No.:_____ **Expiration:**_____

DEA No.:_____ **Expiration:**_____

Primary Contact:_____
Name Title/Company/Group

_____
Phone Fax Email

□ Active □ Courtesy □ Non-Member Privileged Practitioner
And (if applicable)
□ Employment with MLH (location/service)_____

□ Contracted service with MLH (location/service)_____

□ Locum Tenens coverage for _____ Dates_____

1. **If joining a group practice, name of practice:**_____

   a. **Your anticipated start date?** _____(Credentialing typically takes 60-90 days)

2. **Do you have a current Nebraska Medical License?**
   □ **YES** □ **NO (explain:**_____

3. **Are you eligible to participate in Medicare/Medicaid or other federal programs?**
   □ **YES** □ **NO (explain:**_____

4. **Are you currently Board Certified?** Board certification required for all physicians
   □ **YES** **Specialty**_____ **Expiration Date**_____
   □ **NO** To be eligible to apply for privileges, physician must have completed training within the past 5 years and in process of obtaining board certification. **Date Completed Training:** _____

FOR OFFICE USE ONLY	**Pre-app taken by**_____ **Date**_____ **Source (person you talked to):** _____ **Date application mailed out:** _____

3.18 Medical Staff Office
Medical Student Roles and Supervision

SCOPE
This policy applies to all facilities of Mary Lanning Healthcare (MLH) that host clinical rotations as defined by the individual Education Agreements. This policy does not include fellows, who are required to be credentialed and privileged in accordance with MLH Medical Staff Bylaws.

PURPOSE
To provide guidelines for the supervision of students participating in official clinical rotations with members of the medical staff who hold approved clinical privileges at Mary Lanning Healthcare. ("the Facility").

DEFINITIONS:

The word 'should' implies that limited, reasonable exceptions can be made. The word 'must' implies that deviation is not permitted.

Levels of Supervision for Medical Students:

a. Direct Supervision: the supervising physician or his/her designee is physically present with the student and patient.
b. Indirect Supervision with Direct Supervision Immediately Available: the supervising physician or his/her designee is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.

POLICY STATEMENT:

Students will have appropriate clinical supervision while participating in rotations.

Supervision of Medical Students:

Qualified physicians, residents, or advanced practice providers of the Facility shall engage in the teaching and clinical supervision of medical students. Supervising physicians and preceptors must all be members in good standing of the Facility's medical staff authorized to supervise and/or provide resources for medical students. The supervising physician must be a privileged member of the medical staff of MLH and be aware of the medical student learning objectives. Credentialed and qualified Advanced Practice Providers (Physician Assistant - PA, Nurse Practitioner - NP, Certified Registered Nurse Anesthetist - CRNA, and Certified Nurse Midwives - CNM) may supervise students as a delegated responsibility from the supervising physician preceptor. This does not waive the supervising physician's responsibility for the student.

Medical students, defined as students actively enrolled in a College of Medicine as candidates for an MD or DO degree and participating in

approved clinical rotations, will be directly responsible to and supervised by designated clinical supervisor(s) during each assignment.

All students shall report to, and be responsible for, their College of Designation via their faculty members. During the student's rotation, the Physician Preceptor shall be responsible for the patient care provided by the student. Any direct contact between a student and a patient of the Facility shall be under the supervision of the Physician Preceptor.

Medical students will have the status of learners at the Facility. They are not to replace Facility staff and are not to render independent patient care and/or service except as such are identified for educational value as a part of the faculty-planned educational program and unless such patient care and/or service are under the supervision of the Physician Preceptor.

Student Roles

Medical Students Years One (1) and Two (2):

- Must be under the supervision (direct or indirect supervision with direct supervision immediately available as defined by this policy) of a physician who is a member of the Facility's Medical Staff at all times.
- May participate in physical exam, critical data analysis and disposition, history taking and have access to medical records.
- May assist in procedures when the attending physician agrees that the student has achieved the required level of competence and permission is granted by the patient.
- May not document in the patient medical record
- May not write or give verbal orders.

Medical Students Years Three (3) and Four (4):

- May participate in care and management of the patient, including invasive and noninvasive procedures, under the supervision of the supervising physician or another qualified medical care professional to whom that supervision has been assigned at all times with patient permission.
- May assist in procedures when the attending physician agrees that the student has achieved the required level of competence and permission is granted by the patient.
- May document in the medical record with the permission of the supervising physician
- Third year (MS3) students may not call consults to other physicians but may, under the direction of their supervising physician, call non-physician consults and schedule appointments.
- Fourth year (MS4) students may, under supervision, call consults to other physicians.
- May not write orders or give verbal orders

Advanced Practice, Nursing and Pharmacy:

It is important to our students' education that they receive exposure to and opportunities to work with advanced practice, nursing and pharmacy professionals. Allied health includes, but is not limited to, audiology, clinical laboratory science, medical coding, clinical psychology, EMT/ paramedic, physical therapy, occupational therapy, optometry, sonography, speech-language pathology, respiratory therapy, and social work. When a medical student is participating in a non-hospital affiliated practice in which allied health professionals, nurses, or pharmacists are present, it is the responsibility of the supervising physician to assure that these providers are appropriately credentialed and capable of medical student supervision within their scope of practice. When a medical student is participating in an affiliate hospital-based experience, it is assumed that all such providers employed are appropriately credentialed by the affiliate hospital and capable of medical student supervision within their scope of practice.

RELATED POLICIES:

- Medical Staff Clinical Rotations and Observations

3.19 Medical Staff Office
Resident Roles and Supervision

SCOPE
This policy applies to all facilities of Mary Lanning Healthcare (MLH) that host clinical rotations as defined by the individual Education Agreements. This policy does not include fellows, who are required to be credentialed and privileged in accordance with MLH Medical Staff Bylaws.

PURPOSE
To provide guidelines for the supervision of Residents participating in official clinical rotations with members of the medical staff who hold approved clinical privileges at Mary Lanning Healthcare. ("the Facility").

DEFINITIONS
The word 'should' implies that limited, reasonable exceptions can be made. The word 'must' implies that deviation is not permitted.

Levels of Supervision for Residents:

1. Supervising Physician: A credentialed physician.
2. Levels of Supervision: Four levels of supervision are defined.
    a. Direct: The supervising physician is physically present with the resident and the patient.
    b. Indirect: There are two types of indirect supervision:
        - Indirect supervision with direct supervision immediately available: The supervising physician is present in the hospital (or other site of patient care) and is immediately available to provide Direct Supervision. The supervisor must not be engaged in other activities (such as a patient care procedure) which would delay his/her response to a resident requiring Direct Supervision.
        - Indirect supervision with direct supervision available: The supervising physician is not required to be present in the hospital or site of patient care, or may be in-house but engaged in other patient care activities, but is immediately available through telephone or other electronic modalities, and can be summoned to provide Direct Supervision.
    c. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

POLICY STATEMENT:
Supervision by physicians/medical staff

1. At all times and at all training sites, patient care performed by residents will be under the supervision of a qualified supervising physician with appropriate privileges and credentialed to provide the required level of care.
2. The Supervising Physician is responsible for ensuring patient safety and quality of care.

3. Programs must define the level of supervision required for each clinical experience for each level of training using supervision definitions provided in this policy.
4. Resident supervision must be monitored by each program and by the institution.
5. Emergencies: An "emergency" is defined as a situation where immediate care is necessary to preserve the life or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by medical center personnel, is permitted to do everything possible to save the life of the patient.

Communication

1. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising physician, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. Residents must notify the supervising physician of significant changes in the patient's condition.

Progressive Responsibility of Residents

1. Supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
2. Residents are expected to provide competent and compassionate patient care, and to work effectively as a member of the health care team. The highest level of professional demeanor and conduct, both in direct patient care and in communication with family members, other health care professionals, and support staff, is expected at all times.
3. Residents are directly responsible to the MLH Medical Staff Attending (Preceptor) to whom they have been assigned for all matters related to the professional care of patients. The Preceptor is responsible for review of, and co-signature per Medical Staff Bylaws, of all care provided by the Resident. Under the supervision of attending physician, general responsibilities of the Resident may include:
    a. Initial and ongoing assessment of patient's medical, physical, and psychosocial status
    b. Performing history and physical
    c. Developing assessment and treatment plan
    d. Performing rounds
    e. Recording progress notes
    f. Ordering tests, examinations, medications, and therapies
    g. Interpreting results of tests
    h. Arranging for discharge and after care
    i. Writing or dictating admission notes, progress notes, procedure notes, and discharge summaries
    j. Providing patient education and counseling health status, test results, disease processes, and discharge planning
    k. Performing procedures
    l. Assisting in surgery

4. Residents must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
5. Residents must be competent in communicating with team members in the hand-over process.

Graduated Levels of Responsibility

During training Residents will receive progressively increasing levels of responsibility in caring for patients under faculty supervision. Providing safe and effective patient care is of utmost importance.

The Preceptor is responsible for evaluating the progress of each Resident in acquiring the skills necessary for the Resident to progress to the next level of training.

- Factors considered in this evaluation include the Resident's clinical experience, judgment, professionalism, cognitive knowledge, and technical skills.
- At each level of training, there is a set of competencies that the Resident is expected to master.

Examples of expected competencies and responsibilities for each level of training:

- Post Graduate Year 1 (PGY-1)
    - Supervision will be provided by Preceptor or indirectly with direct supervision immediately available. If indirect supervision is provided, supervision must be consistent with MLH Medical Staff Bylaws and with the specific criteria established by policy which delineate the criteria the PGY-1 Resident must meet in order to be eligible for indirect supervision.
    - Residents will be able to perform a history and physical, start intravenous lines, draw blood, order medications and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and medical staff, obtain informed consent, place urinary catheters and nasogastric tubes, assist in the operating room and perform other invasive procedures such as arterial line or central line insertion under direct supervision.
    - The Resident is expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus of care.
    - The Resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the Preceptor.
    - Residents are expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost-effective care.

- Post Graduate Year 2 (PGY-2)
    - PGY-2 Residents are expected to perform independently the duties learned in the first year.
    - The PGY-2 Resident may perform some procedures with indirect supervision (such as insertion of central lines, arterial lines) once competency has been documented according to established criteria.
    - Specific procedures allowed with indirect supervision at the PGY-2 level will vary with training program and must be guided according to published criteria established by the teaching faculty and in accordance with the Preceptor.
    - The PGY-2 Resident must be able to demonstrate continued sophistication in the acquisition of knowledge and skills in the selected specialty and further ability to function independently in evaluating patient problems and developing a plan for patient care.
    - The Resident at the second-year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the Preceptor.
    - The Resident should be able to explain more complex diagnostic and therapeutic procedures to the patient and family.
    - The Resident should be adept at the interpersonal skills needed to handle difficult situations.
    - The PGY-2 should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.

- Post Graduate Year 3 (PGY-3)
    - PGY-3 Residents should be capable of managing patients with virtually any routine or complicated condition with indirect or direct supervision, as determined by the Preceptor.
    - PGY-3 Residents may perform additional diagnostic and therapeutic procedures with indirect supervision once competency has been documented according to established criteria and approved by the Preceptor.
    - Specific procedures allowed with indirect supervision at the PGY-3 level will vary with training program and must be guided according to published criteria established by the teaching faculty and approved by Preceptor.
    - The PGY-3 Resident can perform progressively more complex procedures under the direct supervision of the Preceptor.
    - At the completion of the third year, the Resident should be ready to assume independent practice responsibilities in those specialties requiring three years of training, under indirect or direct supervision, as determined by the Preceptor.

- Post Graduate Year 4 (PGY-4)
    - PGY-4 Residents will assume an increased level of responsibility and can perform the full range of complex procedures expected of the chosen specialty under the direct or indirect supervision, as determined by the Preceptor.
    - The Resident should have mastery of the information contained in standard tests and be facile in using the literature to solve specific problems.
    - The PGY-4 Resident should begin to have an understanding of the role of practitioner in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians.

- Post Graduate Year 5 or Higher (PGY-5)
    - The PGY-5 Resident can perform most complex and high-risk procedures expected of a physician with the supervision of the Preceptor.
    - The Preceptor should be comfortable allowing the PGY-5 resident to manage all common problems expected to be encountered during independent practice.
    - During the final year of training the Resident should have the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice.
    - The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine.

Responsibilities of the Teaching Facility

Graduate Medical Education Committee (GMEC): The GMEC will provide oversight of the appropriateness of supervision through regular review of hospital data, program data, and ACGME data (faculty and resident surveys) by the Clinical Learning Environment Operations Committee annually.

3.20 Medical Staff Office
Clinical Rotations and Observations

SCOPE
This policy applies to all facilities of Mary Lanning Healthcare (MLH) that host clinical rotations or observations as defined by the individual Education Agreements. This policy does not include fellows, who are required to be credentialed and privileged in accordance with MLH Medical Staff Bylaws.

PURPOSE
To outline academic faculty, students, residents, and MLH requirements for clinical student experiences, including hands-on, observation or shadowing experiences. (For the purposes of this policy, "hospital" may be cross-referenced with the term "facility".)

STATEMENT OF POLICY REGARDING ROTATIONS

1. It is the position of MLH to participate in various student and residency rotation programs in order to foster clinical knowledge and support our healthcare disciplines. The following types of students currently enrolled in a graduate or post-graduate program are permitted:
    a. Medical Students
    b. Residents
    c. Advance Practice Nurses
    d. Physician Assistants
2. A written contractual agreement must be executed by both MLH and the participating academic institution, to include a current copy of professional liability and workers' compensation coverage, prior to students/residents applying for a learning experience at MLH.
3. The academic institution and/or student/resident applying for a clinical rotation will provide documentation, in the form of Appendix A-Student/Resident Orientation Form, at least fifteen (15) business days prior to the scheduled start date, which includes, but are not limited to:
    a. Legible government-issued identification such as a driver's license or passport. (For hospitals that issue a temporary ID badge for their rotations, students will be requested to present an actual physical copy for verification.)
    b. Current Basic Life Support (BLS) certification or other certification as required for role.
    c. Occupational Health and Safety Administration (OSHA) training for infection control, fire safety, and environment of care or successful completion of the OSHA quiz (attached in Appendix A), if attestation letter does not verify OSHA training.
    d. Tuberculosis (TB) testing, influenza vaccination (or valid signed medical exemption), and other immunizations as may be required by the MLH's Infection Prevention department. Influenza vaccinations or valid medical exemptions are

required for any student rotation scheduled from September 1st through March 31st of the following year in accordance to the MLH Influenza Policy. Students and residents will be required to pursue vaccination at their own costs outside of MLH organization.

e. Letter of good standing from the academic institution to include an attestation or actual copies of any criminal background check conducted by the academic institution prior to the request for rotation. The letter of good standing can be accepted in lieu of an actual training program director signature on the Rotation Application.
f. For residents, current Nebraska training license number and DEA license number on Orientation Form or actual copy of license
g. Notation on Orientation Form of assigned Medical Staff Preceptor with appropriate privileges at MLH where the rotation is taking place. It is the clinical student/resident/academic institution's responsibility to have made appropriate arrangements for supervision/sponsorship with a Medical Staff Preceptor.
h. MLH staff will submit EPIC computer access paperwork for students/residents; rotations of 10 days or less will be READ ONLY access.

4. Students and residents will be required to submit a new Orientation Form for each rotation that exceeds a rolling year from the initial approval. If the precepting physician is different for each rotation, the student shall be responsible for ensuring that the precepting physician's information has been updated on the form or via a separate acceptable form.
5. Failure of the student/resident or academic institution to request a rotation within the expressed timeframe or to complete their rotation form prior to the start date shall result in a delay of approval and a delay in the start of the requested rotation.
6. Upon completion of the Orientation form and approval of the rotation by the Chief Medical Officer (CMO) or designee, notification shall be given to the approved student or resident. The individual student or resident shall be required to complete an orientation. The student/resident shall be notified via email prior with the date/time of the Orientation, which is typically held the morning of the first day of rotation. The Orientation is conducted by the Medical Staff Office Coordinator. Students shall be responsible for understanding and completing requirements of all orientations necessary. Failure to complete this orientation shall result in a delay in the start of the rotation, restricted access to secured patient areas or a termination of the rotation.
7. All students, residents and Medical Staff Preceptors must be familiar with and adhere to the MLH policies and procedures as well as the policies set forth by the academic institution pertaining to rotations.
8. Students and residents must conduct themselves in a professional manner. All students and residents will comply with MLH's personal appearance and grooming policy. In addition, students and residents must

adhere to any surgical attire policy required. The student or resident may be required to wear a specified uniform per their academic institution's policy, which includes some visible indication of their student or resident status.

9. Students and residents will maintain the dignity and confidentiality of patients, associates, physicians, and visitors per MLH confidentiality and HIPAA standards. They are advised to obtain permission from patients and families as to their participation/observation in supervised care. Medical Staff Preceptors are encouraged to document such consent or refusal in the medical record whenever possible.
10. Clinical student/resident supervision is the responsibility of the academic institution and the identified Medical Staff Preceptor.
11. If during the course of the approved rotation, the Medical Staff Preceptor has their Medical Staff Membership and Clinical Privileges automatically relinquished, suspended, terminated or resigned, the student and/or academic institution shall be responsible for obtaining another preceptor and/or sponsor with appropriate privileges at the facility where the rotation is taking place.
12. Students and residents are expected to function within their academic institution's course guidelines and within the direction and supervision of the Medical Staff Preceptor. The Medical Staff Preceptor (a fully credentialed member of MLH medical staff) is ultimately responsible for the care of the patient. During the time students are on site, the Preceptor is responsible for all direct care of their patients, including documentation in the Electronic Health Record (EHR), oversight of all care provided by a student/resident, and other duties designated by medical staff privileges.
13. Students and residents will provide supervised care/services in accordance with the appropriate level of education outlined by the academic institution and pursuant to Nebraska statutes. Additional limitations may be enforced by academic institution, MLH as well as the Nebraska Department of Health & Human Services.
    a. Students are not allowed to request consults nor respond to nursing questions/call. Preceptors are required to make physician-to-physician requests for consultation and respond to nursing questions/calls.
    b. Students and residents may not first assist at surgery when a qualified first assistant is required. They may scrub and assist in those cases where a qualified first assistant is not required.
    c. Based on licensure status, students may NOT perform the following procedures:
        - Arterial blood gas (ABG) puncture unless they are a respiratory therapy (RT) student and are appropriately supervised by a competent MLH RT
        - Give or accept verbal or telephone orders or enter orders in the CIS
        - Initiate invasive monitoring
        - Invasive procedures in the Neonatal Intensive Care Unit

- Chemotherapy
- Narcotic counts (except pharmacy students)
- Hold narcotic, epidural, patient controlled analgesia (PCA) keys in their possession
- Have access to the Pyxis machine.
- Pick up narcotics from the pharmacy
- Obtain, hang or co-sign for the administration of blood products

d. Residents cannot delegate any duties of a fully licensed physician in accordance with Nebraska Statute 38-2025 and cannot supervise physician assistants at any time while approved for rotation.

14. The Preceptor will supervise administration of any IV medications (not previously expressed as prohibited in section #14) by a resident. Students and residents will not administer medications or treatments (such as insulin, fractional doses) prescribed by standing orders without consultation with the Registered Nurse and Preceptor overseeing the care of the patient.
15. It is the responsibility of the Preceptor to communicate to the academic institution and to the hospital on any immediate concerns pertaining to the safety, quality of patient care, treatment and services provided by clinical students and residents.
16. The Preceptor will be responsible for determining each student's or resident's progressive involvement and autonomy in specific care activities by assessing and confirming the safety, quality of care, treatment and services provided to patients prior to allowing the student to advance in the level of care provided.
17. Students and residents will not be paid by for the time spent while on rotation, and they are not considered employees of the hospital; therefore, they are not considered eligible for any benefits hospital may afford to its employees.
18. Reporting educational activities to the Medical Executive Committee and the Governing Board: Annually, the Medical Staff Services Office will report to the Medical Executive Committee on the following components: All reporting information will be forwarded to the Board of Trustees, via the minutes of the Medical Executive Committee.
    a. The number of students and residents who have completed rotations;
    b. The educational institutions with which students and residents were affiliated;
    c. The Preceptors who supervised students and residents during the reporting period;
    d. Any issues/concerns arising from care or services provided by the hospital, Medical Staff Preceptor, and patients.

PROCEDURE

Orientation of Students and Residents

1. Orientation will be conducted by the Medical Staff Office on the first day of student/resident rotation. At that time, they will be required to present a legible copy of government-issued identification document (driver's license or passport) for verification of identity and issuance of a temporary badge, where facility requires. A Student/Resident ID badge will be provided, identifying the individual as a student/resident at all times, while on campus.
2. Training for IT access may be scheduled prior to the student/resident's clinical rotation. This will be coordinated by the IT Department.
3. Students and residents with assigned stationary rotations in the operating room, emergency department, and labor & delivery units may be required to obtain department specific orientation.
4. Orientation elements should include, but are not limited to, the following topics:
    a. Fire extinguishers, fire pull stations, evacuation routes, emergency exits, oxygen shut off valves, eye wash stations, personal protective equipment, sharps containers, material safety datasheets, and other pertinent policies and procedures as it pertains to department roles and responsibilities
    b. Occupational Safety & Occurrence Reporting resources
    c. Cultural Competency, where facility requires
    d. Infection control standards: Hand Hygiene, Isolation, and Transmission Based Precautions
    e. Environmental Safety
    f. Medication administration to include IV therapy for licensed training residents
    g. Patient Rights and Responsibilities (as related to the students/residents educational participation)
    h. Emergency response codes and related action steps
5. Students/Residents must be trained on the EHR- EPIC and the appropriate affiliated electronic modules- prior to being granted access to these communication mechanisms if the rotation is ten (10) days or more in length. If previously EPIC trained through any UNMC facility, there is no need to repeat training if login access has been Active within past 90 days, and you have been trained in the Specialty Module to which you are clinically rotating.

STATEMENT OF POLICY REGARDING OBSERVATIONS/SHADOWING OPPORTUNITIES

1. Interested parties shall be required to contact the Human Resources Office in order to participate.
2. MLH hospitals reserve the right to request current influenza vaccination or a valid medical exemption should the observation or shadowing request take place during September 1st through March 31st in accordance to MLH's Influenza Policy. If the observer has had recent exposure to TB, s/he may also be required to provide an updated TB/PPD test or formal documentation indicating no evidence of active disease, if previously tested

positive.

3. All observers must conduct themselves in a professional manner and adhere to any dress or surgical attire policy facility requires.
4. Students and faculty will maintain the dignity and confidentiality of patients, associates, physicians, and visitors per MLH confidentiality and HIPAA standards. They are advised to obtain permission from patients and families as to their observation in supervised care. Medical Staff Preceptors are encouraged to document such consent or refusal in the medical record whenever possible.
5. There is no access to the electronic health record (EHR) for observations/shadowing opportunities.

DEFINITIONS

Clinical Student: Any medical, dental, podiatric, advanced practice nursing or physician assistant student that is interested in a hands-on educational experience, who is not eligible for training licensure within the State of Nebraska, or other State's as identified in the Education Agreement(s).

Clinical Resident: An individual, who has completed medical, dental or podiatric school training and is enrolled in a graduate hands-on training program and who has been granted a resident training license by the State of Nebraska, or other State's as identified in the Education Agreement(s).

Medical Staff Preceptor: An identified MLH medical staff physician, dentist or podiatrist privileged at the facility where the rotation is taking place, who assumes ultimate responsibility for the educational experience, conduct, and supervised care of patients provided by all students or residents assigned to or agreed upon by the academic institution. The Medical Staff Preceptor may not necessarily conduct the day-to-day educational experience throughout the term of the rotation; therefore, s/he may sponsor multiple students and residents at any given time.

Allied Professional Practice (APP) Preceptor: An identified Allied Professional Practice Provider (APRN, PA, CRNA, CNM) privileged at the facility and who collaborates in the care of the patients assigned to them with a Sponsoring Physician, and who conducts the day-to-day educational experience of students assigned to them by the academic institution. No APP Preceptor may supervise more than two (2) students at any one time.

Rotation: A clinical rotation is a hands-on educational experience that is supervised by a physician, dentist or podiatrist care and services to patients.

Observations/Shadowing: Observation or shadowing is defined as a short-term non-contact, observational only experience supervised by an identified Medical Staff Member. In this case, a contractual affiliation agreement with the academic institution is not required.

POLICY VIOLATION

Any student or resident who fails to abide by this policy may have their approved rotation

suspended, delayed, restricted or revoked by the CMO or designee. Students and residents are not eligible for clinical privileges or medical staff membership and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under the hospital's respective Medical Staff Bylaws if there is a violation of this policy that results in the suspension, restriction or termination of the rotation.

Repeated violations of this policy by any school or graduate training program shall result in a discontinuation accepting future requests for student or residency rotations.

REFERENCES AND SOURCES OF EVIDENCE

- The American College of Graduate Medical Education (ACGME) Common Program Requirements, July 2017
- The Joint Commission. (2019) *Comprehensive Accreditation Manual for Hospitals*

3.21 Medical Staff Office
Medical Records Completion and Enforcement Policy

Documentation	Trigger	Required components	Delinquent	Authentication Requirements
History and Physical	Time of admission	A complete history includes, at a minimum: • Primary Surgeon • Assistants • Procedure Performed • Pre-operative diagnosis • Post-operative diagnosis • Detail account of Intraoperative findings • Detail of surgical techniques • Specimen removed • Complications • Condition of patient at conclusion of procedure • Estimated blood loss • Implants A complete history includes, at a minimum: •Clinically appropriate evaluation of the chief complaint •History of present illness A complete physical examination includes, at a minimum: •Clinically appropriate evaluation of the vital signs including Lungs, Heart, and Involved specific organ system or body part •Assessment and plan of treatment	24 Hours	MD, DO, APP w/co-signature, Resident/Student w/co-signature

Updated History and Physical (Complete H & P must be documented within 30 days of admission to qualify as an "update"	Time of admission	Document that patient examined, H & P reviewed, and changes (if any) are noted	24 Hours	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Emergency Department Note	Encounter time	Documentation of organ systems exam including: •Cardiovascular •Pulmonary •Organ system pertinent to encounter •Vital signs •Assessment Plan	24 Hours	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Consultation Note	Time of closed loop communication requesting consultation	Recommend Provider to Provider communication for Consult Request. Consultant to communicate opinions and recommendations	7 Days	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Pre-Operative Documentation	Prior to patient signing consent (except in an emergency)	Current H & P (from inpatient or updated at the time of admission). Documentation of consent discussion	Prior to patient signing consent (except in an emergency)	H & P - MD, DO, APP w/co-signature, Resident/Student w/co-signature in accordance with MLH ADM Consent Policy

Brief operative note	Completion of Surgical Procedure	• Pre-operative / Pre-Procedure Diagnosis • Post op diagnosis • Procedure Performed • Primary Surgeon • Assistant • Anesthesia • Description of procedure/findings • Estimated blood loss • Specimen removed • Complications • Implants	Must be completed prior to the patient moving to the next level of care unless Operative Note is completed immediately	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Operative note	Completion of Surgical Procedure	• Pre-operative / Pre-Procedure Diagnosis • Post op diagnosis • Procedure Performed • Primary Surgeon • Assistant • Anesthesia • Description of procedure/findings • Estimated blood loss • Specimen removed • Complications • Implants	Must be completed prior to the patient moving to the next level of care. If brief Operative Note is completed, Operative Note must be completed within 12 hours	MD, DO, APP w/co-signature, Resident/Student w/co-signature

Procedure Note	Upon completion of the procedure	• Primary Surgeon • Assistants • Procedure Performed • Pre-operative diagnosis • Post-operative diagnosis • Detail account of Intraoperative findings • Detail of surgical techniques • Specimen removed • Complications • Condition of patient at conclusion of procedure • Estimated blood loss • Implants	Must be completed prior to the patient moving to the next level of care. If brief Operative Note is completed, Operative Note must be completed within 12 hours	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Anesthesia and sedation note	Surgery completion	Complete the standard documentation per Anesthesia Protocol	48 Hrs	MD, DO, CRNA
Obstetrical Record	Time of admission	Complete pre-natal record if available or H & P	24 Hours	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Inpatient Progress Note	Daily	Primary team to complete daily progress notes including chronological report of patient's course in the hospital and shall reflect any change in the condition and the results of treatment	7 Days	MD, DO, APP w/co-signature, Resident/Student w/co-signature

Discharge Summary	Time of Discharge	• Final diagnosis, including hospital problem list • Procedures performed • Procedure Performed • Significant findings • Narrative summary of clinical course during hospitalization • Patient's condition and disposition at discharge	14 Days	MD, DO
Discharge Documentation	Time of Discharge	In accordance with provider discharge instructions and final medication reconciliation - in accordance with Medical Staff Rules and Regulation	Within 48 hours of Discharge	MD, DO
Code Status Order	Time of Admission	Per Administrative Policy ADM204.00	24 Hours	MD, DO, APP w/co-signature
Verbal Order Authentication	Entry Time	• Shall be transcribed into patient's EHR • Include date, time of order • Name and signature of person transcribing order • Name of the Physician or designee submitting order • Documentation that order has been read back to the provider	At time of provider's next visit, or within 7 days	MD, DO, APP w/co-signature, Resident/Student w/co-signature
Co-Signature	Time of Discharge	All documents and orders requiring co-signature per Medical Staff Rules and Regulations Policy 3.21	30 Days	MD, DO

Rules and Regulations	Approval by Medical Executive Committee	Approval by Board of Trustees
Original Adoption	05-20-2013	05-23-2013
Revision	02-18-2014	
Revision	09-15-2014	
Revision	01-19-2015	
Revision	04-30-2015	
Revision	08-18-2015	
Revision	06-20-2017	
Revision	09-19-2017	
Revision	09-16-2019	
Revision	09-15-2020	
Revision	03-16-2021	
Revision	01-18-2022	
Revision	02-15-2022	