# PART I PREAMBLE, DEFINITIONS, NAME, PURPOSE OF THE MEDICAL STAFF ORGANIZATION

**ARTICLE I**

# I.1 PREAMBLE

This document, developed and adopted by the medical staff and then approved by the governing body, together with the governing body bylaws, provide a framework of joint governance, including professional self-governance, and actions of responsible medical staff leaders, subject to the fiduciary authority of the governing body of Catawba Valley Medical Center.

**I.2 DEFINITIONS**

**Adverse Recommendation/Decision:** A recommendation by the Medical Executive Committee (MEC) that the governing body deny an applicant’s request for medical staff appointment, reappointment, or specific clinical privilege, or that the MEC recommends reduction or rescinding of privileges of a current staff member, or that the governing body denies, revokes, or restricts membership or clinical privileges. The **“first adverse decision”** refers either to a negative MEC recommendation, or to a negative board action following a positive MEC recommendation.

**Allied Health Practitioners:** Clinicians, including, but not limited to, nurse practitioners, nurse midwives, physician’s assistants, Certificate Registered Nurse Anesthetists, psychologists, etc. credentialed and privileged by the CVMC Medical Staff to provide patient care services within an approved scope of practice. See Article V for details.

**Appendix 1 (Hearing and Appeals), Appendix 2 (Immunity from Liability) and Appendix 3 (History and Physical Documentation Requirements):** Appendix 1, Appendix 2 and Appendix 3 are part of this bylaws document. \***Amended 01/26/10 Approved by BoT 2/22/10.**

**Assignment:** In the context of staff categories, means acceptance and accomplishment of a task assigned the staff member, such as by the MEC or Chief of Staff.

Board of Trustees: Refers to the governing body of Catawba Valley Medical Center.

**Bylaws:** Refers to these bylaws of the Hospital’s Medical Staff.

**Chief of Staff:** The chief office of the Medical Staff elected by Members of the Medical Staff at a meeting of the Medical Staff held pursuant to Article VII of these Bylaws and approved by the Board of Trustees.

**Clinical Departments and Sections:** Clinical department means a grouping of practitioners according to clinical activities and interests. Sections mean sub-divisions of a clinical department, established only when necessary.

**Clinical Privilege or Privileges:** Permission granted by the governing body, acting upon Medical Executive Committee recommendations, to render specific types of care to patients, including the defined scope thereof, in or under the auspices of Catawba Valley Medical Center.

**Completed Application: That** state of the application process where all forms, materials and validations/verifications have been received in the Medical Staff Office. (See also II.7).

**Effective:** Accomplishing a reasonably expected result.

**Efficient/Efficiency:** In the context of this document, unless usage suggests otherwise, means accomplishment of reasonably expected results of patient care, with appropriate attention to utilization of patient care resources.

**Governing Body:** Synonymous with Board, Board of Directors and Board of Trustees. Details regarding its authority for establishing a medical staff organization are provided in the organizational bylaws (board bylaws) of Catawba Valley Medical Center.

**Ex Officio:** By virtue of an office or position held, with voting rights unless otherwise specified.

**Gender:** Words of masculine gender include correlative words of the feminine and neuter genders unless usage indicates otherwise.

**Health Care Quality Improvement Act of 1986 (HCQIA):** It is the intent of the provisions of this document, and their implementations, to be in compliance with the Health Care Quality Improvement Act of 1986 (HCQIA).

**Hospital:** In the context of this document, unless usage suggests otherwise, means board plus executive/administrative staff plus medical staff.

**Input:** “Contribution to a common effort.” (Webster). A voice; an opinion clearly and objectively expressed, provided for the purpose of guiding decisions of authoritative bodies and individuals.

**Licensed Independent Practitioner:** Any individual permitted by law and by CVMC to provide care, treatment, and services without direction or supervision. Only Licensed Independent Practitioners are eligible for Medical Staff membership. See below.

**Medical Executive Committee (MEC):** The elected representatives of the medical staff, authorized to act on behalf of the medical staff except when otherwise specified.

**Medical Staff:** The Physicians (Medical Doctors and Doctors of Osteopathic Medicine), Dentists, Oral Surgeons and Podiatrists providing health care services in, or under the auspices of, Catawba Valley Medical Center subject to the provisions of these bylaws. Such references as “medical staff organization” and “medical staff member” refer to the organizational functions of the hospital performed by these practitioners.

**Medical Staff Appointment:** Includes appointments to the medical staff of Physicians (MD and DO), Dentists, Oral Surgeons and Podiatrists, assignment to a staff category, and assignment to a clinical department, or appointments as an Allied Health Practitioner and assignment to a clinical department. Medical staff appointment does not automatically confer specific clinical privileges.

**Medical Staff Organization:** The formal structure which accomplishes specific organizational functions, including but not limited to continuing education, clinical review, making “credentials” recommendations to the board, and providing coordinated input to the administration and the board on affairs related to patient care and/or to interests/concerns of practitioners.

**Practitioners:** Clinicians, including Physicians, Dentists, Oral Surgeons, Podiatrists, and Allied Health Practitioners, credentialed and privileged to provide services to patients in or under the auspices of Catawba Valley Medical Center subject to these bylaws.

**President/Chief Executive Officer:** The individual appointed by the governing body to act in its behalf in the overall management of Catawba Valley Medical Center.

**Related Documents: Medical** Staff Rules and Regulations and Policies and Procedures which are as binding as bylaws provisions.

**Under the Auspices of:** In the context of this document, means as part of services provided by and charged for by Catawba Valley Medical Center or related economic entities, as opposed to health care services provided by individual practitioners who use Catawba Valley Medical Center facilities and services for their patients.

I.3 NAME:

The name of this organization is the Medical Staff of Catawba Valley Medical Center.

**I.4 PURPOSE**

The purpose of the individual practitioner is to provide effective and efficient care, but the purposes of the medical staff **organization** shall be

1. to reflect, influence and maintain the professional nature of medical practice through such organizational activities as collegial discussion, continuing medical education, participation in providing educational opportunities to residents in training (as applicable), nursing, and the community, and

2. to perform certain functions delegated by the governing body, including but not necessarily limited to:

a. through a responsible committee, provide recommendations regarding applications for medical staff membership and clinical privileges;

b. establish (subject to board approval) rules, regulations, policies, and methods manuals at both general staff and clinical department levels, to govern professional prerogatives and obligations of medical staff members/appointees;

1. through staff leadership, with the assistance of qualified support personnel, to develop and use physician-specific performance data for quality improvement, credentialing, or other appropriate uses;

d. select leaders carefully, considering reputation for objectivity and fairness, and organizational skills including communication skills;

e. establish mechanisms whereby staff members/appointees have input into Hospital affairs;

f. encourage/facilitate continuing education opportunities for practitioners and state whether or not a certain level of participation in these activities is required;

g. through responsible staff leaders, pursue effective courses in accomplishing needed improvements in the performance or behavior of staff members (see Article IX); and

h. through responsible leaders, provide periodic reports to the governing body.

**PART II MATTERS OF MEMBERSHIP, APPOINTMENT AND CATEGORY, AND OF INDIVIDUAL-SPECIFIC CLINICAL PRIVILEGES**

**ARTICLE II MEDICAL STAFF MEMBERSHIP ELIGIBILITY AND PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

**II.1 Nature of Membership**

Membership on the Medical Staff or the right to exercise temporary privileges shall be extended only to professionally competent, fully licensed physicians, podiatrists and dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to the Medical Staff shall confer only such Clinical Privileges and prerogatives as have been granted in accordance with these Bylaws. No practitioner shall admit or provide services to patients in the Hospital unless he is a member of the staff or has been granted temporary privileges in accordance with the procedures set for in Article IV.

**II.2 Eligibility**

Only Physicians, Dentists, and Podiatrists shall be deemed to possess basic qualifications of Membership in the Medical Staff, except for the Honorary Staff category. Such Physicians, Dentists and Podiatrists must:

(a) document their current and unrestricted license to practice their profession in the State of North Carolina;

1. provide evidence of:
* training, experience, current clinical competence,
* good reputation, judgment and character, **\*Amended 01/25/11 Approved by BoT 02/22/11.**
* mental, physical, and emotional stability, and
* ability to work with and relate well to others,
* to the extent required by the provisions of these bylaws;

(c) hold a current and unrestricted DEA certificate, where applicable;

1. be eligible to participate in federal health care programs, including Medicare, Medicaid, veteran’s health benefits or any other federal health care program;
2. provide proof of and maintain in force professional liability insurance coverage in an amount to be determined by the Board, with MEC input;
3. live and practice within a reasonable distance from the hospital as determined by the Medical Executive Committee or as set forth in these Bylaws; and
4. provide evidence of active membership on another Joint Commission -accredited hospital medical staff if applying for courtesy privileges.

**II.3 Effect of Other Affiliations**

No practitioner shall be automatically entitled to Membership on the Medical Staff or to the exercise of particular clinical privileges merely because he holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, is a member of a medical school faculty, or because he had, or presently has, staff membership or privileges at another health care facility or in another practice setting. Nor shall any practitioner be automatically entitled to appointment, reappointment or particular privileges merely because he had, or presently has, staff membership or those particular privileges at this Hospital.

**II.4 Nondiscrimination**

No aspect of Medical Staff Membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

# II. 5 Ethics and Conduct

Professional conduct shall be governed by the Code of Ethics of the practitioner’s relevant professional organization and CVMC’s Code of Conduct.

In addition, every practitioner, at the time of appointment and reappointment, and at all times during the appointment period, must demonstrate to the satisfaction of the Medical Executive Committee and Board, a willingness and capability, based on current attitude and evidence of performance, to work with and relate to other staff members, members of other health disciplines, hospital management and employees, patients, and the community in general, in a cooperative, professional manner that is essential for maintaining hospital operations to best assure the provision of high quality and cost-effective patient care.

# II.6 Harassment Prohibited

Harassment by a Medical Staff Member against an individual (e.g. against another Medical Staff Member, Hospital employee, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, or sex shall not be tolerated.

“Harassment” is unwelcome verbal or physical conduct which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

All allegations of harassment shall be promptly investigated by the Chief of Staff, Medical Executive Committee or its designees, or, if warranted, by the President or his or her designees and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of Medical Staff Privileges or Membership.

#  II.7 Appointment and Re-appointment Procedures, General

# \*Amended 01/25/11 Approved by BoT 02/22/11.

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) shall exercise Clinical Privileges in the Hospital unless and until that person either (1) has applied for and received appointment to the Medical Staff or (2) has been granted Privileges as set forth in these Bylaws.

**II.8 Applicant’s Burden**

In all matters pertaining to the candidate’s application for initial appointment and privileges, and for reappointment, renewal, or updating of privileges, including obtaining validation of supporting information, the burden of proof is the applicant’s. The applicant’s failure to sustain this burden of proof shall be sufficient grounds to deem the application incomplete and thus halt its consideration.

# II.9 Appointment Authority

The Medical Executive Committee shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modification of the Medical Staff membership category or Privileges and shall adopt and transmit recommendations thereon to the Board of Trustees. Appointments and reappointments to the Medical Staff shall be made by the Board of Trustees. Denials or revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws.

# II.10 Duration of Appointment and Reappointment

Appointments and reappointments, unless otherwise stipulated, shall be for a period not to exceed two (2) years. **\*Amended 04/24/12 Approved by BoT 05/29/12.**

**II.11 Initial Application**

Each applicant shall provide at least the following information on a form provided by the hospital:

1. photo documentation in the form of a valid U.S. state-issued driver’s license or a valid passport
2. names of at least three (3) professional references, none of whom may be from his/her practice group, and at least one of whom must practice in the same or a similar clinical specialty attesting to the ability of the privileges requested
3. a signed application for membership with information regarding professional school diploma, post-graduate training, current licenses to practice, DEA registration, Board Certification (except for General Dentistry), age and any specific training relevant to the privileges requested **\*Amended 04/23/13 Approved by BoT 05/18/13.**

d. results of professional performance evaluation data from an organization/s where the applicant is currently privileged, as appropriate to the privileges requested

e. information as to whether the applicant’s professional license, DEA registration, or medical staff appointment or clinical privileges at any other hospital in any jurisdiction has ever been voluntarily or involuntarily denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or relinquished

f. confirmation of the applicant’s current physical and mental health status adequate to assure the applicant’s ability to perform the privileges requested. In instances where there is doubt about an applicant’s ability to perform the privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff. **\*Amended 4/27/10 Approved by BoT 5/24/10.**

g. evidence of current professional liability insurance coverage in an amount to be determined by the board, with MEC input, as well as whether such coverage has ever been voluntarily or involuntarily cancelled

h. information about involvement in malpractice judgments, suits, claims and settlements within the last five (5) years

i. information about any pending or current investigations and/or challenges involving Medicaid and/or Medicare sanctions or challenges to participation in other federal health care programs

j. information about any removal from a managed care organization’s panel for quality of care reasons or unprofessional conduct

k. a complete chronological listing of residencies, internship, employment, training, practice locations, and other activities since completion of formal professional education

l. documentation of the availability of back-up coverage provided by a practitioner/s with similar training and scope of practice signed by both the applicant and the practitioner/s agreeing to provide such coverage

m. any additional information required by the MEC, relevant clinical department chair, credentials committee, or the board, to adequately evaluate the applicant.

n. a statement of the scope of the clinical privileges sought. **\*Amended 01/25/11 Approved by BoT 02/22/11.**

Failure by the applicant to provide information sufficient to satisfy requirements for the privileges requested within sixty (60) calendar days of written request for the information shall result in the application being null and void, with no further processing being required, and no right to Hearing and Appeal.

Failure by the applicant to provide truthful, accurate and complete information shall in itself be grounds for denial or revocation of staff membership/appointment and clinical privileges.

**II.12. Applicant’s Agreement: Appointment, Initial Privileges, Reappointment,**

**Privileges Renewal or Privileges Increase Request**

Each applicant for medical staff appointment or reappointment shall acknowledge that he/she:

1. has received, has read, and agrees to comply with these bylaws (each applicant should receive a copy of the bylaws with his/her application form), Rules and Regulations, and any applicable Department or Section Rules and Regulations
2. will comply with all applicable policies and procedures of the Hospital and the Medical Staff
3. will provide for the continuous care of patients and provide suitable arrangements for delegating the responsibility for diagnosis or care of patients to a practitioner with the same or a similar scope of privileges
4. is currently competent and able to perform all privileges requested
5. is willing to appear for an interview as part of the application process

f. authorizes hospital representatives to obtain validation of information supplied in support of the application

g. releases from any liability, to the fullest extent provided by law, all individuals and organizations who, in good faith and without malice, provide information relevant to the application

1. consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant’s professional or ethical standing that the Hospital or Medical Staff may have

i. is responsible for truth, accuracy, and completeness of the information provided.

At all times current professional performance data will be collected and used to assess whether the member’s staff privileges should be renewed as initially approved.

**II.13 Application for Initial Privileges \*Added 7/28/09 Approved by BoT 8/24/09**

An application for initial privileges will only be accepted from physicians, oral surgeons, or podiatrists who are board certified or are qualified to take the certifying examination by a member board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association Bureau of Osteopathic Specialists (AOABS), a board deemed comparable to the ABMS by the North Carolina Medical Board, or the appropriate board for those clinicians other than physicians (podiatrists, oral surgeons). Applicants who cannot document board certification in their primary area of practice at the time of initial appointment must achieve certification in their primary area of practice within five years from time of completion of required specialty training as identified by the ABMS Member Board Requirements for General Certification. Failure to achieve board certification within five years from the time of the completion of required specialty training as identified by the ABMS Member Board Requirements for General Certification will result in termination of privileges. **\*Amended 04/23/13 Approved by BoT 05/28/13.**

This termination of privileges will be put into effect at the end of the current reappointment cycle. Provisional reappointment for one reappointment cycle may be approved, during which board certification must be achieved. Continued failure to achieve board certification by the conclusion of the two-year provisional reappointment will render the physician ineligible for reappointment. **\*Added 7/28/09 Approved by BoT 8/24/09**

An application for initial privileges will be accepted by general dentists. **\*Added 04/ 23/13 Approved by BoT 05/28 /13**

In cases where a practitioner is applying for initial privileges with no local back-up available (i.e., no practitioners with similar privileges willing to provide back-up or no other practitioners within the area with similar privileges), the Medical Executive Committee may determine, based on the scope of privileges requested and the type of practice/specialty planned, what constitutes a suitable arrangement for back-up coverage.

**II.14 Requests for New or Expanded Privileges Between Reappointments**

##### All requests for new or expanded privileges between reappointment dates are approved for a time-limited period, determined at the time of approval by the Board of Trustees. Requests for new or expanded privileges between reappointments that represent new services or new technology for the hospital will follow the process outlined in Medical Staff Services Policy MSS.1003.

All requests for new or expanded privileges received from members in good standing will be considered based on information from ongoing professional practice evaluation data. This information will be considered in addition to any privilege-specific requirements for training, education, or evidence of current competency previously approved by the Board of Trustees, upon recommendation of the Medical Executive Committee. Performance data collected during the time limited period for new or expanded privileges will be considered by the Department Chair and the Credentials Committee prior to recommending renewal of the privilege to the Medical Executive Committee.

**II.15 Route of the Completed Application Whether Initial or Renewal**

Applications shall not be considered until they have been declared complete by the Medical Staff Services Department, in accordance with Medical Staff Services Policy MSS.300.

A “completed application” includes all information the applicant has been called upon to provide and verification of that information.

When the application has been deemed complete, the applicant will be so notified, but advised that further information may be requested by the relevant clinical department chair or by the Credentials Committee when it considers the application.

The completed application is next forwarded to the relevant clinical department chair(s) to review information concerning education, training, and recent clinical experience, and provide a report on the applicant’s qualifications. This report shall be provided within ten (10) working days after the department chair(s) has (have) been notified by the medical staff office that the application is complete.

No application shall be considered by the Credentials Committee without a report on qualifications from the relevant clinical department chair(s) or, in the event this report is not available within the required time period, from an individual selected by the Chairman of the Credentials Committee and the CEO. For advance practice nurses, the Chief Nursing Officer is included in the review process prior to consideration by the Credentials Committee.

The Credentials Committee then acts upon the application as soon as is practical, but in no event later than within sixty (60) days of completion. The Credentials Committee recommendation is immediately forwarded to the Medical Executive Committee, which acts on the application as soon as is practical, but in no event later than sixty (60) days after receiving the recommendation of the Credentials Committee, and forwards its recommendation to the governing body.

The governing body acts as soon as is practical, but in no event later than sixty (60) days after receiving the MEC’s recommendation, unless the MEC has made an adverse recommendation and the applicant has exercised his right to a Hearing.

The decision to grant, limit, or deny an applicant’s request for privileges or renewal of privileges shall be communicated to the applicant in writing as soon as is practical, but in no event later than sixty (60) days after the governing body renders a decision regarding appointment or reappointment to the medical staff. If clinical privileges are granted to the applicant, the written notification to the applicant informing the applicant of the governing body’s decision shall include a description of the scope of the privileges granted. **\*Added 01/25/11 Approved by BoT 02/22/11.**

**II.16 Disagreement Between MEC and Board**

If the Board does not concur in the Medical Executive Committee’s recommendation regarding the clinical privileges of an individual, then there shall be a review of the recommendation by a joint committee of the Medical Executive Committee and the Board before a final decision is reached by the Board. The joint committee shall consist of representatives of the MEC (appointed by the Chief of Staff) and the Board (appointed by the Board Chair). **\*Amended 01/25/11 Approved by BoT 02/22/11.**

**II.17 Reappointment and Renewal of Privileges**

Appointment and clinical privileges are renewable every two (2) years. See Article III.3 for additional detail. **\*Amended 01/24/12 Approved by BoT 03/26/12.**

The governing body reviews and acts on MEC recommendations regarding reappointment and renewal of clinical privileges.

A. Prior to the expiration of the medical staff appointment, each medical staff member receives an application for renewal of his appointment and clinical privileges. The application provides an opportunity

1. to request continuation of present staff status

2. to request a change in medical staff category or clinical department assignment

1. to request either an addition to or a deletion of specific clinical privileges

4. to provide updated information regarding appointments, honors, articles published, and other activities

5. to request that medical staff membership and privileges be terminated.

B. The following information must be available at the time of reappointment:

1. The recommendation of the chair of the clinical department to which the individual is currently assigned. The recommendation is based on an evaluation of objective information reflecting current clinical knowledge, skills and performance of requested clinical privileges as compared to peers, the results of peer review or relevant performance improvement activities, relations with other physicians, with the hospital and its employees and patients, availability, mental and physical stability, and technical proficiency and efficiency

The results of any focused practice evaluations initiated since the last reappointment must also be considered at the time of reappointment. These may be the result of new privileges granted since the last reappointment or of focused practice evaluations initiated in response to safety or quality issues.

1. Confirmation of the individual’s current physical and mental health status adequate to assure the individual’s ability to perform the privileges requested. **\* Amended 10/28/14; Approved by BoT 11/24/14.** In instances where there is doubt about an applicant’s ability to perform the privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff. **\*Amended 4/27/10 Approved by BoT 5/24/10.**

1. Information about the degree of participation in staff and department meetings, CME opportunities, and other staff activities. Practitioners must obtain CME in accordance with the appropriate licensing body. At reappointment, practitioners are required to provide CME reflective of the privileges being renewed or requested. **\*Amended 01/11/2017 Approved by BoT 01/30/2017**
2. With the exception of those physicians appointed prior to 1985 or within five years of the completion of residency/fellowship training (for which rules for “Application for Initial Privileges” applies) and general dentists, physician members of the medical staff are expected to maintain board certification within their principle area of practice. At the time of reappointment to the medical staff, any physician who fails to maintain board certification may be provisionally approved for one reappointment cycle, during which board certification must be achieved. Continued failure to achieve board certification by the conclusion of the two-year provisional appointment will render the physician ineligible for reappointment. **\*Amended 04/23/13 Approved by BoT 5/28/13**
3. Evidence of continued liability insurance coverage in amounts established by the MEC and governing body, and information about malpractice judgments, suits, claims and settlements since the time of last appointment.

6. Information about practice at other institutions with which the applicant for reappointment is affiliated, including the practitioner’s staff membership, clinical privileges, or any specific clinical privilege(s) that has/have been limited, revoked, restricted, suspended, not renewed or voluntarily relinquished.

7. The Chairman may request additional references and/or other information necessary to determine the ability to perform the privileges requested, particularly in the case of licensed independent practitioners with activity within the hospital insufficient to provide the Department Chairman with information necessary to determine current competence and ability to perform the requested privileges.

8. Courtesy staff members must have had at least two patient encounters (admissions, consults, or performance of procedures) or admission of patients through the CVMC hospitalist program during the previous reappointment period. Practitioners unable to comply with this criteria will not have their courtesy staff status renewed, but may reapply for staff membership and clinical privileges at such time as they wish to use the resources of the hospital. **\* Amended 04/22/14 Approved by BoT 04/28/14**

9. Such other information as the MEC and/or governing body may require.

**II.18 Between Routine Reappointment Dates**

A. Practitioners shall furnish to the hospital

1. information regarding professional license renewal status, whether license has been or is in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed or voluntarily or involuntarily relinquished.

2. information of professional liability insurance cancellation or lapses without renewal

3. information about voluntary or involuntary restrictions on, relinquishment of, or revocation of staff membership and/or privileges at any other institution in any jurisdiction within seven (7) days of action being taken. **Amended 04/23/13 Approved by BoT 05/28/13**

4. information regarding the practitioner’s DEA renewal status, whether licensure has been, or is in the process of being, voluntarily or involuntarily denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished.

5. information regarding any pending or current investigations and/or challenges involving Medicaid or Medicare sanctions or challenges to participate in any other federal health care program.

6. information regarding whether the practitioner’s physical or mental health status has changed significantly since the last appointment or reappointment.

7. information regarding any changes in arrangements for the provision of back-up coverage by a practitioner or group of practitioners with similar training and scope of practice made since reappointment to ensure appropriate continuity of patient care.

In cases where a change in practice affiliations results in the creation of a single or multiple practitioners with no suitable back-up available within a reasonable geographic proximity (i.e., no practitioners with similar privileges willing to provide back-up or no other practitioners within the area with similar privileges), the Medical Executive Committee may determine what constitutes a suitable arrangement for back-up coverage based on the practitioner’s current scope of privileges and type of practice/specialty provided.

B. In addition, practitioners shall furnish upon request of the MEC or governing body

1. information about malpractice judgments, claims, suits or settlements

2. any additional information reasonably required by the MEC or governing body to adequately evaluate the staff member

# II.19 Leave of Absence

A leave of absence and reinstatement is a matter of courtesy, not of right. A leave of absence must be requested for any absence from the medical staff and/or patient care responsibilities longer than thirty (30) days, even if such absence is related to the individual’s physical or mental health or to his or her ability to care for patients safely and competently. All requests for a leave of absence will be considered in accordance with the CVMC Medical Staff Leave of Absence Policy. **\*Amended 01/11/2017 Approved by BoT 01/30/2017**

**ARTICLE III CATEGORIES OF MEMBERSHIP**

**III.1 Assignment**

Each appointee is assigned to a staff category by the MEC, upon recommendation of the Credentials Committee.

Assignment to a Staff Category, the primary purpose of which is to define membership privileges and obligations of a staff member, shall be made at the time of initial appointment to the staff. Changes in category assignment shall be made, ordinarily, only at the time of reappointment to the staff.

# III.2 Basic Responsibilities of Medical Staff Membership

All staff members with clinical privileges must:

1. provide patients with the quality of care meeting the professional standards of the Medical Staff;
2. retain responsibility for providing timely and continuous care and supervision of each patient in the hospital for whom the practitioner is providing services, or for arranging a suitable alternative for such care and supervision;
3. abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and policies of the Medical Staff and Hospital;
4. abide by the rules and regulations of all clinical departments in which privileges are held, and to the authority of the MEC and governing body, through the chair of the department to which the individual is assigned with relevant input of other department chairs;
5. discharge in a responsible and cooperative manner reasonable requests to perform necessary medical staff organizational functions or to provide coverage when needed and/or required within the scope of the practitioner’s competence/expertise;
6. submit to drug or alcohol screens(s) upon request of the Chief of Staff, or his designee, when incidents, problems or questions of professional competence regarding patient care within the hospital might reasonably imply a problem due to substance abuse;
7. prepare and complete in a timely fashion medical and other required records for all patients whom the Member admits to or provides care to in the Hospital, as specified in rules governing patient records;
8. participate in peer review and other quality evaluation and monitoring activities and agree to reasonable requests for improvement , if properly presented by individuals in authority;
9. work cooperatively with other Medical Staff Members, the Hospital Administration, and other Hospital employees so as not to adversely affect patient care;

(j) refuse to engage in, or to otherwise request, improper inducements of patient referral;

1. participate in such emergency service coverage or consultation service panels as may be determined by the Medical Executive Committee, which may include, in the determination of the Medical Executive Committee, a time requirement for on-call response;
2. assist the Hospital in meeting its uncompensated and partially compensated care obligations including, but not limited to, providing appropriate and necessary emergency or required follow-up care within the scope of the practitioner’s privileges, regardless of such patient’s ability to pay.

**III.3 Category Descriptions**

The prerogatives and obligations of each medical staff category are summarized on the following table. It should be noted that the table defines Membership Privileges, not Clinical Privileges.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Privilege/Obligation** | Active | SeniorActive | Telemedicine | Locum Tenens | Courtesy | Consulting | Honorary | Emeritus | AlliedHealthProfs. |
| Vote | Y | Y | N | N | N | N | N | N | N |
| Eligible to hold office | Y | Y | N | N | N | N | N | N | N |
| Eligible to admit pts | Y(a) | Y(a) | N | Y | ≤12/yr.(b) | N(c) | N | N(d) | N |
| ED Consultative Service or Care to Established Patient | Y(h) | Y(h) | N | N | Y(h) | N | N | N | N |
| Eligible for clinical privileges | Y | Y | Y | Y | Y | Y | N | N(d) | Y |
| Accept Assigned Tasks | Y | N | N | N | N | N | N | N | N |
| Attend Meetings | Y | N | N | N | N | N | N | N | N |
| Expected to Change to Active | NA | NA | N | Y | N(b) | N(f) | N | N | N |
| Accept Unassigned ED Patients | Y(e) | N | Y(g) | Y | N | N | N | N | N |

**\*Amended 04/22/14 Approved by BoT 04/28/14**

Note: Appointments to all staff categories are provisional and dependent upon compliance with the requisite stipulations of that category.

(a) Clinical support services which do not ordinarily admit patients

(e.g., pathology, anesthesiology, emergency services, dermatology, endocrinology, etc.) may belong to this category.

1. Will not be allowed to undertake any additional encounters beyond twelve (12) patient encounters (admissions, consults, or performance of procedures) per rolling 12 month period without applying for and being approved for Active Staff status, with its attendant prerogatives and responsibilities. **\* Amended 04/24/12 Approved by BoT 05/29/12**

(c) Except in emergency situations.

(d) Unless specifically authorized by the board.

(e) Unassigned ED admissions may be referred to other active staff physicians with whom the hospital has an established contractual agreement to provide such services.

(f) If consulting practitioner serves for an active staff member for more than 120 days, he or she must seek active privileges. **\*Amended 04/26/11 Approved by BoT 05/25/11**

(g) Telemedicine Staff will evaluate patients in the ED who will then be referred to other active staff physicians for admission and/or follow-up care, when needed.

(h) Provide ED consultative services, admission, or other care for established patients when not on-call for the Emergency Department for unassigned patients or arrange a suitable alternative for such care.

Active: Licensed, independent practitioners who regularly admit, attend, or consult on hospital patients and/or provide clinical services at or for the hospital and who assume all the functions and responsibilities of membership on the Active Staff. Active staff members must have had at least two patient encounters (admissions, consults, or performance of procedures) or admission of patients through the CVMC hospitalist program during the previous reappointment period. Members of the active staff also provide Emergency Department coverage in their specialty or arrange for such coverage.

Senior Active: Practitioners over age 60 with at least 10 years cumulative service in other Active staff categories. Assignment to this category will only be designated after written request.

Courtesy: Occasionally admits and/or treats patients, up to a total of 12 patient encounters *(admissions, consults, or performance of diagnostic or therapeutic procedures, or some combination)* per rolling 12 month period. Will not be allowed to undertake any additional encounters beyond 12 encounters per rolling 12 month period without applying for and being approved for Active Staff Category. Must have had at least two patient encounters or admission of patients through the CVMC hospitalist program during the previous reappointment period. **Note:** Eligibility requirements state Courtesy members must provide evidence of active membership on another Joint Commission-accredited hospital medical staff. **\* Amended 04/22/14 Approved by BoT 04/28/14**

Consulting: May be either:

1. Practitioners of recognized ability connected with educational institutions, or outside the local medical community, whose expertise may not be available within the community, who are utilized from time to time by medical staff members for clinical consultation;
2. Practitioners from within the local community, whose specialty expertise is only occasionally needed for hospitalized patients. Members of Consulting Staff shall be limited to a total of up to 12 patient encounters *(consults or performance of diagnostic or therapeutic procedures, or some combination)* per rolling 12 month period. Greater than 12 encounters per rolling 12 month period willresult in automatic reassignment to the Active Staff Category. **Note**: Practitioners whose specialty expertise is commonly or regularly required for attending or consulting on hospital in-patients, outpatient surgery patients, or emergency department patients would NOT qualify for the Consulting Staff.; or
3. Practitioners with a professional affiliation with Active Staff members, whose services are only occasionally needed in the hospital to fill coverage gaps due to vacations or emergent situations for a maximum of 120 days per year; if a practitioner serves in this capacity for more than 120 days, he or she must seek active privileges. **\* Amended 04/26/11 Approved by BoT 05/25/11**

Telemedicine: Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. The Medical Staff will establish a defined Telemedicine service at the request of the medical executive committee based on an unmet need identified by the medical staff and confirmed by the medical executive committee. Telemedicine consults may be obtained for appropriate patients at the request of a member of the medical staff. **\*Added 04/24/12 Approved by BoT 05/29/12.**

Locum Tenens: Practitioners who are employed in a short term manner by the hospital or a member of the medical staff for the purpose of temporarily undertaking patient care responsibilities. Practitioners may serve in the locum tenens category for a maximum of 120 days per year; if a practitioner serves in this capacity for more than 120 days, he or she must seek active (or courtesy or consulting) privileges. **\*Added 01/25/11 Approved by BoT 02/22/11.**

Honorary: Persons of outstanding reputation who the medical staff wishes to honor. **\* Amended 04/26/11 Approved by BoT 05/25/11**

Emeritus: Practitioners retired from clinical practice deserving of special recognition by the Medical Staff with consideration of their leadership within the Medical Staff, service to the community at large, and number of years of service to Catawba Valley Medical Center. Because non-clinical privileges are involved, reappointment is not required.  **\* Amended 04/26/11 Approved by BoT 05/25/11**

**ARTICLE IV - INDIVIDUAL-SPECIFIC CLINICAL PRIVILEGES**

**IV.1 Clinical Privileges and Obligations: General**

A practitioner exercises only those clinical privileges which he or she applies for, the MEC acts upon, and the governing body grants.

For general clinical obligations, see III.2.

**IV.2 Initial Clinical Privileges**

Each applicant, as part of the initial application procedure, shall request those specific clinical privileges which he/she wishes to exercise. It is the applicant’s burden to provide objective evidence of qualifications in these clinical privileges.

**IV.3 Periodic Renewal of Clinical Privileges**

At the time of reappointment, requests for specific clinical privileges must be updated by the staff member and acted on by the MEC and board.

**IV.4 Evaluation of Qualifications**

Recommendations and subsequent board actions shall be based upon information about the applicant’s training, including sufficient specificity of training to perform well in the clinical area(s) requested, and on evidence of current competence.

**IV.5 Dentists and Podiatrists**

Regardless of staff category or department assignment of dentists and podiatrists, surgical procedures performed by them are under the overall supervision of the Chairman of the Department of Surgery. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. Dentists and podiatrists may write orders and prescribe medications within the limits of their license to practice, and within the scope of applicable rules and regulations.

Dentist and podiatrist members of the medical staff may initiate the admission of patient with the concurrence of a physician member of the Medical Staff. Patients admitted to the hospital for dental or podiatric care shall receive the same basic medical appraisal as patients admitted for other surgical services. An Active Staff physician must take the patient’s medical history, perform a physical examination and evaluate the overall medical risk. An Active Staff physician shall also be responsible for all preoperative and postoperative problems. The dentist or podiatrist shall be responsible for that part of the history and physical examination which is related to dentistry/podiatry and all other appropriate elements of the patient’s record. Oral and maxillofacial surgeons who admit patients without medical problems may complete an admission history and physical examination and assess the medical risk of the procedure if qualified to do so and granted privileges.

**IV.6 Provisional, Temporary, and Emergency Privileges**

**A. Provisional Period**

All initial appointments to the medical staff, appointments as an Allied Health Practitioner, initial clinical privileges, advancements in staff category, and new clinical privileges, are granted on a provisional basis until satisfactory completion of a Focused Professional Practice Evaluation. **\*Amended 04/24/12 Approved by BoT 05/29/12.**

The provisional designation is removed when the MEC and board receive, from the chairman of the clinical department to which the individual is assigned, satisfactory assurance that the practitioner is capable of and willing to fulfill the responsibilities of his or her appointment and chosen areas of clinical practice.

The provisional period may be extended, once, for good cause, at the discretion of the governing body, on recommendation of the MEC. If, at the end of the extension, performance is not satisfactory to the MEC and governing body, then appointment, privileges, or a specific privilege, which has been the subject of the extension, shall not be granted.

**B. Temporary Privileges**

**a. Treatment or Need Specific**

Temporary admitting and clinical privileges to care for a specific patient, or to fulfill an important treatment or service need, may be granted for a period not to exceed 120 days. Treatment or need specific temporary privileges may be requested by a practitioner who is not a member of the medical staff and may be recommended by the Chief of Staff, with input from a member of the Credentials Committee, and may be granted by the Chief Executive Officer upon verification of current licensure and competence.

**b. During Processing of an Application**

Temporary privileges for a period not to exceed 120 days may be granted to an applicant before action on the application is final, but only after the application has been declared complete by the Medical Staff Services Department, and reviewed and approved by the Department Chair, the Chief of Staff and the hospital President.

To be deemed complete, verification must be received of:

1. Current N.C. medical license
2. Relevant training or experience
3. Current competence
4. The ability to perform requested privileges
5. Evaluation of National Practitioner Data Bank information

In addition, the completed application must include no information involving voluntary or involuntary relinquishment of any license or registration; of any termination of medical staff membership; or of any loss, limitation, or reduction of clinical privileges. Any discrepancy between the information provided by the applicant and that provided through the verification process will be sufficient to determine the application incomplete.

Such temporary privileges must be requested by the applicant.

**c. Individuals in Training**

Individuals in training, such as medical students and residents, may participate in the care of patients only under the supervision of a licensed independent practitioner who is an active member of the medical staff with relevant clinical privileges, subject to a protocol designed by the hospital and training program. During the period of temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned.

Temporary privileges shall automatically terminate at the end of the designated period, unless earlier rescinded. Temporary privileges may be rescinded by the CEO or his/her designee upon the advice of the Chief of Staff and/or the Chairman of the Credentials Committee, with input of the relevant department chair, and is not subject to Hearing and Appeal.

**C. Disaster/Emergency Privileges**

**a. Patient Emergency**

In case of a patient-specific emergency, any staff member should assist in care of the patient regardless of staff status or delineated privileges.

For the purpose of this provision, “emergency” refers to a condition in which serious or permanent harm might result to a patient, or in which the life of the patient is in immediate danger, if there is any delay in administering treatment.

**b. Physicians Staffing the Emergency Services Department**

## Physicians staffing the Emergency Services area, regardless of their other relationships to the hospital and to each other, are members of the hospital medical staff and subject to delineation of privileges, participation in Performance Improvement activities, periodic renewal of appointment and privileges, and responsible for privileges and duties of their assigned medical staff categories.

1. **Credentialing During Disasters**

During a disaster in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, the Chief Executive Officer or Chief of Staff (or their designee) shall be responsible for activating the Disaster Credentialing Policy and for deciding when a disaster situation no longer exists.

Once a disaster situation has been declared, the CEO or Chief of Staff shall decide on a case-by-case basis whether to grant disaster privileges. Disaster privileges will only be granted after receipt of two forms of acceptable identification, one of which must be a valid government-issued photo identification issued by a state or federal agency (i.e., driver’s license or passport). Acceptable forms of ID include:

1. Current hospital photo ID card/badge
2. Current medical license
3. Primary source verification of the license
4. ID certifying that the practitioner is a member of the North Carolina state medical assistance team
5. ID that certifies the practitioner has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies
6. Identification by a current hospital or medical staff member with personal knowledge of the practitioner’s identity and ability to act as a licensed independent practitioner

Once the CEO, Chief of Staff, or designee inspects the above-listed IDs and determines the volunteer’s services are needed, the volunteer can begin to administer care immediately with disaster privileges. Practitioners exercising disaster privileges must practice under the direction of a current member of the CVMC Medical Staff.

Primary source verification of licensure will begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary event that primary source verification cannot be completed within 72 hours, documentation will be provided as follows:

1. Reason primary source verification could not be performed
2. Evidence of a continued inability to provide adequate care, treatment and services

3. Evidence of attempts to rectify the situation as soon as possible.

Disaster privileges granted in this manner are intended only for the duration of the disaster, and may not exceed 72 hours. If the organization determines that the disaster remains in effect after 72 hours, privileges will only be continued based on the professional practice of the volunteer licensed independent practitioner privileged in this manner. Any problems uncovered during the disaster credentialing process will result in the immediate termination of privileges.

A report will be provided to the Medical Executive Committee and the Board of Trustees after the disaster situation is over containing the number of non-staff physicians utilized, their actions, and the directing physicians.

# IV.7 Medico-Administrative Positions

Physicians with hospital contracts whose duties include both administrative and clinical activities must be members of the medical staff, and must obtain clinical privileges in the same manner as any other medical staff members.

When a contract exists, the contract of the physician who has both administrative and clinical duties shall clearly define the relationship between termination of the contract by the hospital and reduction of clinical privileges through the provisions of these bylaws.

# ARTICLE V: ALLIED HEALTH PRACTITIONERS

**V.1 Qualifications**

Only Allied Health Practitioners (AHPs) who (i) can document their background, character, education, training, ability, competence, and health (ii) are qualified to provide a needed service within the hospital, and (iii) document their ability to abide by the ethics of their respective profession and to work in the best interest of patient care, shall be eligible to provide specified services in the hospital. The appropriate department, with the approval of the Medical Executive Committee and the Board, will establish qualifications required of members of a specific category of AHP, provided that such qualifications are not arbitrary and are in conformance with applicable law. AHP’s entitled to apply for clinical privileges under these bylaws shall include physician’s assistants, nurse practitioners, midwives, certified registered nurse anesthetists, and psychologists (doctoral and masters). These will include employees of a member of the medical staff, persons supervised by a member of the medical staff or hospital employees whose positions require the qualifications of an Allied Health Practitioner outlined above.

**V.2 Procedure for Specification of Services**

Allied health practitioner’s application for specified services shall be submitted on the approved form and shall be processed in the same manner as provided in Article II as any other application for clinical privileges. The application shall outline the applicant’s character, health, background, education, training and experience and shall include an accurate description of the clinical privileges the applicant will perform in the hospital. Except where independent delineated clinical privileges have been granted, the AHP shall practice under the supervision of a medical staff member or, when appropriate, in cooperation with the responsible physician(s). The supervising medical staff member(s) and any medical staff member acting as a back-up for the supervising medical staff member in his absence shall certify that they will be fully responsible for all acts of the AHP, except where independent clinical privileges have been granted. If an AHP applicant is employed or retained by an organized group of physicians, the application must be submitted by the group and must be signed by all members thereof. Certain AHP’s granted specific delineated independent clinical privileges within the scope of the licensure, applicable law and prevailing standards of care will not be subject to the supervising medical staff member requirement, PROVIDED, that a member of the medical staff is responsible for the general medical care of the patient. When such independent clinical privileges are granted, the patient must, at all times, have a member of the medical staff who is responsible for the general medical care of the patient.

A patient may be seen by an Allied Health Practitioner with independent clinical privileges only upon written order of the attending medical staff member. The patient’s attending medical staff member will be the responsible medical staff member.

Only qualified members of the medical staff may admit patients to the hospital.

The application and supporting materials shall be sufficient to document the AHP’s ability to function as follows:

1. exercise judgment within the AHP’s area(s) of competence, provided that the responsible medical staff member has the ultimate responsibility, including supervision as required for patient care;
2. directly participate in the evaluation and management of patients under the supervision or direction of a member of the medical staff, except where independent delineated privileges have been granted as above, in which case the AHP must cooperate with the responsible medical staff member; and
3. within the limits established by the medical staff consistent with state statutes, write orders and record reports and progress notes in patients’ medical records.

An AHP shall be individually assigned to the clinical department appropriate to his professional training and specific privileges, except when state or federal regulations or these bylaws require assignment of an AHP to individual members of the medical staff and shall be subject, in general, to the same terms and conditions as specified in Articles II and III for medical staff appointments, except that an AHP shall not be considered a member of the medical staff for any purpose under these bylaws. An AHP shall carry out his professional activities, subject to department policies and procedures, and in conformance with the applicable provisions of the medical staff and hospital bylaws and rules and regulations.

All AHP’s, including those granted independent clinical privileges, must participate in quality assessment and performance improvement activities as established by the medical staff.

# V.3 Reappointment Process

Each Department Chairman shall complete his/her review of all pertinent information available regarding each AHP scheduled for reappraisal. Each appropriate Department shall establish guidelines for the periodic reappraisal of professional performance and competence in connection with reappointment. Information required to be submitted by each AHP applying for reappointment and to be reviewed by each person or body reviewing AHP’s for reappointment shall include all information bearing upon the AHP’s suitability for reappointment, including but not limited to:

1. All continuing training, education (relevant to specialty) and experience the AHP has received since his previous appointment or reappointment.
2. Mental and physical health information as specified on the reapplication form.
3. All sanctions of any kind imposed or pending against the AHP by any other health care institution, professional health care organization, professional health care regulatory board or body or licensing authority.
4. Verification of professional liability insurance (including cancellations, non-renewals and limits, claims, suits, and settlements). A copy of the AHP’s current professional liability insurance policy or proof of renewal must be submitted.
5. The recommendations of other health care organizations where the AHP provided clinical services during the preceding appointment period.
6. Membership, awards or other recognition conferred or granted by any professional health care society, institution or organization during the preceding period.
7. Description of requested duties or delineated clinical privileges.
8. A written statement from the supervising physician of the allied health practitioner outlining monitoring/supervision activities as well as overall performance. Verification of the allied health practitioner’s continued employment shall be submitted by the medical staff member(s), if applicable.
9. Such other specifics about the AHP’s professional ethics, qualifications and ability relevant to his qualifications to be reappointed or that may bear on his ability to provide quality patient care in the hospital

Reappointments of an AHP shall be processed in the same manner as reappointments to the Medical Staff pursuant to the procedures outlined in Article II.

**V.4 Prerogatives**

The prerogatives of an AHP shall be to:

1. Provide patient care services in accordance with approved privilege delineation, either under the supervision of the responsible medical staff member or, if approved, independently in cooperation with attending medical staff member upon his written order.
2. Write orders only as directed to do so by the responsible physician and only to the extent established by the Medical Staff, but not beyond the scope of the AHP’s license, certificate or other legal credential. Countersignatures are not required by the responsible physician with the following exception. The requirements for history and physical counter signatures are outlined in Appendix 3 of these Bylaws and other counter signatures are outlined in the Rules & Regulations Part 1, Section III, “The Patient’s Medical Record.” **\* Amended 10/28/14; Approved by BoT 11/24/14.**
3. At the discretion of the Department Chairman, serve on staff, Department and/or Section and hospital committees.
4. At the discretion of and at the specific request of the Department Chairman, attend part or all of a specific meeting of the staff and/or Department and/or Section to which he is assigned. AHPs shall not, however, have the right to attend regular meetings of the staff, Department or Section.
5. Attend hospital education programs when appropriate and when invited by the Chief of Staff or Department Chairman.
6. Exercise such other prerogatives as shall, by resolution or written policy duly adopted by the staff or by any of its Departments or committees which is approved by the Medical Executive Committee and the Board, be accorded to AHP’s as a group or to any specific category of AHP’s.

**V.5 Responsibilities**

Each AHP shall:

1. Meet the same basic responsibilities as required by Article II for Medical Staff members.
2. Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for alternative coverage in compliance with these Bylaws.
3. Participate in performance improvement activities as required by the medical staff.
4. Provide identification specifying the individual’s approved credentials to avoid any misidentification of the practitioner as a licensed physician or other licensed independent practitioner.
5. If supervision is required, function in reasonable proximity to the supervising medical staff member unless the supervising medical staff member clearly specifies to the Medical Executive Committee those circumstances which justify performance of duties away from the supervising medical staff member, and written policies are established to protect the patient. If independent privileges are granted, AHPs must work within the requirements outlined in the medical staff bylaws, policies, or accompanying documents.
6. A member of the Medical Staff who employs an AHP shall, when unavailable, name a member of the Medical Staff who will be available and who has agreed to provide supervision for the activities of the AHP in his or her absence. Failure to do so will be reported to the Medical Executive Committee.
7. In unusual or extreme situations when the responsible physician is unavailable, any other physician on the Medical Staff may be consulted for interim assistance. In extreme situations, such as a code blue, AHP’s shall be expected to perform appropriate treatment within the area of their competence.

**V.6 Termination or Suspension of Privileges and Limitations on AHP’s**

The Medical Executive Committee shall recommend to the Board action regarding Allied Health Practitioner’s privileges when it finds (i) that the activities or professional conduct of an AHP is below the standards established by the Medical Staff or is disruptive to the operation of the hospital; (ii) that AHP has represented himself or permitted another to represent him as a licensed physician or other practitioner; (iii) that the AHP has in fact performed services other than those approved by the application and delineation at the direction and under the supervision of the responsible member of the Medical Staff (except where independent clinical privileges have been granted) or has performed tasks for which he is not privileged or qualified by training; (iv) that an AHP is impaired by intoxicants or drugs when performing his duties in the hospital; (v) that an AHP has been convicted in any court of any felony or other criminal offense involving moral turpitude; (vi) that the AHP’s professional liability insurance has been canceled or materially changed; (vii) that the AHP ceases to be registered and approved by the applicable certifying or regulatory board or agency; or (viii) that the AHP fails to participate in the performance improvement program established by the medical staff. The Chief of Staff, the Chairman of a Department, the Chief Executive Officer, the Medical Executive Committee or the Board shall have the authority to suspend summarily all or any portion of the clinical privileges of an AHP when an AHP’s conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of any immediate injury or damage to the health or safety of any patient, employee, or other person present in the hospital. A summary suspension shall be effective immediately upon imposition, and the Chief Executive Officer shall promptly give notice of the suspension and a written statement disclosing the reasons of the suspension to the AHP and to the responsible physician.

Except as required by law, nothing contained in these Bylaws shall be interpreted to entitle an Allied Health Practitioner to the hearing and appeal rights in these Bylaws. However, an AHP who is the subject of an adverse action may challenge any such action by filing a written grievance within fifteen (15) days of the adverse recommendation or action with the Chairman of the Department to which the AHP has been assigned. Upon receipt of the grievance, the Chairman shall initiate an investigation and afford the AHP an opportunity for an interview within fifteen (15) days of receipt of the grievance. The Chairman, in his discretion, may appoint a committee composed of members of the medical staff familiar with the AHP’s current competence and ability to perform patient care duties within the approved scope of practice to conduct the interview. The Chairman and the Chief Executive Officer, or their designees, shall participate in any such interview as shall the supervising physician.

The AHP filing the grievance may provide rebuttals for any evidence presented and submit an oral and a written statement at the close of the interview. Within twenty (20) days after conclusion of the interview, a recommendation and the reasons for the recommendation shall be provided to the Chief Executive Officer. The Chief Executive Officer will forward a copy of the recommendation to the person who requested the hearing and to the Medical Executive Committee which may modify its original recommendation or action, considering the findings of the interview. The MEC will notify the AHP of its decision and forward its recommendation to the Board of Trustees for final action.

Upon receipt of the Board’s decision regarding an adverse action, the Allied Health Practitioner may request an appeal of the decision within ten (10) days of receipt. Upon receipt of the request, the Chairman shall appoint a committee composed of at least two members of the medical staff familiar with the AHP’s current competence and ability to perform patient care duties within the approved scope of practice. The Committee will review the results of the initial investigation and afford the AHP an interview within thirty (30) days of the receipt of the request. Within twenty (20) days after conclusion of the interview, a recommendation and the reasons for the recommendation shall be provided to the Chief Executive Officer. The Chief Executive Officer will forward a copy of the recommendation to the person who requested the appeal and to the Medical Executive Committee which may modify its original action, considering the findings of the appeal. The MEC will notify the AHP of its decision and forward its recommendation to the Board of Trustees for final action. The decision of the Board following the appeal is effective immediately and is not subject to further review. There is no exception to the rule that the AHP is entitled to only one interview and one appeal of any single matter.

When changes in employment status by an AHP require a change in the AHP’s supervising physician, the AHP shall only remain eligible for clinical privileges at CVMC if the back-up supervising physician of record is a member of the medical staff in good standing and willing to accept the supervising responsibility. Additionally, the loss of privileges by the AHP’s supervising physician of record, whether voluntary or for cause, shall result in an automatic loss of privileges at CVMC by the AHP unless the back-up supervising physician of record is a member of the medical staff in good standing and willing to accept the supervising responsibility. Documentation clarifying supervisory responsibilities and other requirements for maintaining clinical privileges (i.e., scope of practice change, malpractice coverage, etc.) must be received by the Medical Staff Office to maintain privileges without interruption. Neither of these circumstances shall entitle the AHP to the fair hearing and appeal procedure outlined above, nor does it preclude the AHP from reapplying for clinical privileges. No AHP shall have membership on the Medical Staff of the hospital. Any and all services provided by AHP’s within the hospital shall be subject to the review functions performed by the Medical Staff committees.

**PART III MATTERS OF ORGANIZATION, OFFICERS AND MEETINGS**

**ARTICLE VI OFFICERS AND MEETINGS**

**VI.1 List of Officers, Terms, and Succession**

Officers are:

Term

Chief 1 year

Vice Chief/Chief-Elect 1 year

Immediate Past Chief 1 year

Secretary 1 year

Officers may succeed themselves only once in the same office.

Officers begin to serve on the first day of the new staff year.

**VI.2 Eligibility Requirements**

Only Active staff members are eligible to be elected officers, and failure to meet the requirements of Active staff membership during the term of office results in automatic removal from office.

Officers shall not hold two offices simultaneously, or be both an officer and department chairperson simultaneously.

Officers shall not simultaneously hold office on any other medical staff.

**VI.3 Selection of Officer Candidates**

In selecting its officers, the medical staff considers the responsibilities involved and candidates’ interest, availability, organizational skills (including communication skills, written and oral), and reputation for objectivity and fairness, all of which are required to best provide medical staff participation in hospital affairs.

**VI.4 Nomination, Election, Vacancies**

1. **Nominations** A slate of officer candidates will be selected by a nominating committee composed of three (3) members of the Active staff appointed by the Chief of Staff. Additional nominations will be sought from the General Medical Staff by electronic means or written correspondence. Both the slate chosen by the nominating committee and any individuals nominated separately shall be presented for a vote. Where officers are chosen by electronic vote, the Nominating Committee shall announce its selection at least two (2) weeks in advance of the voting period, so that additional nominations can be made, and any such nominees who desire to be considered may be included in the ballot. **\* Amended 2/10/15; Approved by BoT 2/26/15**
2. **Election** Officers shall be elected prior to the Annual meeting of the medical staff through electronic means, or as provided in VI.9, by a majority of staff members eligible to vote. **\* Amended 2/10/14; Approved by BoT 11/24/14**

**C. Vacancies** Vacancies are filled by special election as soon as responsibly possible after the vacancy occurs, except that vacancy in the office of Chief of Staff is filled by the Chief-Elect.

**VI.5 Removal of Officers**

Failure of an officer to maintain Active staff status results in automatic removal from office.

In addition, the medical staff may, by a 2/3 vote of at least a quorum, remove any medical staff officer for failure to fulfill his/her responsibilities, malfeasance in office, physical or mental infirmity to a degree that renders him/her incapable of fulfilling the duties of the office, or conduct detrimental to the interests of the medical staff and/or hospital. **\* Amended 10/28/14; Approved by BoT 11/24/14**

**VI.6 Duties of Officers**

**A. Chief of Staff**

The Chief of Staff shall:

a. act in coordination and cooperation with the CEO in all matters of mutual concern within the health care organization

b. call, preside at, and be responsible for the agenda of all general staff meetings of the medical staff

c. serve on the Medical Executive Committee and serve as its chairperson

d. serve in an advisory capacity to all other medical staff committees

e. be responsible for the enforcement of medical staff and related rules

f. appoint committee members to all standing, special, and multidisciplinary committees except as otherwise provided

g. present the views, policies, and needs of the medical staff to the governing body and CEO

h. interpret the policies of the governing body to the medical staff, and report to the board on performance and maintenance of quality and efficient care

i. oversee the activities of department chairpersons.

**B. Vice Chief/Chief Elect**

In the absence of the Chief of Staff, the Vice Chief/Chief Elect assumes the duties and authority of the Chief. In addition, the Vice Chief/Chief Elect shall

a. serve on the Medical Executive Committee

b. automatically succeed the Chief of Staff when the latter fails to serve for any reason

c. succeed the Chief of Staff at the end of the Chief of Staff’s term

d. chair the Performance Awareness Committee and Quality Coordinating Council

**C. Secretary**

The Secretary shall

a. serve on the Medical Executive Committee, Performance Awareness Committee and the Quality Coordinating Council.

b. provide for accurate and complete minutes of all medical staff meetings

c. call medical staff meetings on order of the Chief of Staff

d. provide for a record of attendance at meetings

e. attend to all correspondence on behalf of the staff

f. make minutes and correspondence available to the governing body

**D. Immediate Past Chief of Staff**

The Immediate Past Chief of Staff shall

a. serve on the Medical Executive Committee and the Performance Awareness Committee

b. chair the Bylaws Committee

c. perform such other reasonable duties as shall be assigned to him by the Chief of Staff or MEC

**VI.7 Meetings of the General Medical Staff, of Clinical Departments and Sections, and of Committees**

**A. General Medical Staff**

The general medical staff meets quarterly with an annual meeting held on the fourth Tuesday of October plus on special call. Attendance at general medical staff meetings is not required. \*Amend**ed 2/10/15 Approved by BoT 2/26/15.**

The meeting established by these Bylaws for the fourth Tuesday in October is designated the Annual meeting, at which newly elected officers are announced and emeritus members are inducted. \***Amended 2/10/15 Approved by BoT 2/26/15.**

Special meetings of the general medical staff may be called at any time by the Medical Executive Committee, Chief of Staff, or by the governing body, and are held at the time and place designated in the meeting notice. Only the Medical Executive Committee, the Chief of Staff or the Board of Trustees may request action on an item by electronic vote. \***Amended 2/10/15 Approved by BoT 2/26/15.**

**B. Clinical Departments and Sections**

Clinical departments meet at least quarterly.

Clinical sections meet as often as is necessary to transact their business and to provide educational opportunities to clinical section members. \***Amended 2/10/15 Approved by BoT 2/26/15.**

**C. Committees**

The Medical Executive Committee and the Performance Awareness Committee meet at least ten (10) times per year; other medical staff committees meet only as often as necessary to perform their assigned functions.

**VI.8 Notice of Meetings**

Notice of all meetings of the general medical staff, of departments, and of committees shall be provided in a timely manner.

**VI.9 Quorum**

Once a quorum has been established, actions taken are binding. Unannounced new business requiring action may be introduced at a meetig only if a quorum is present**.**

**\* Amended 10/28/14; Approved by BoT 11/24/14.** Motions presented for approval by a Committee of the Medical Staff may be approved by electronic votig without the need for a meeting.

**\* Amended 2/10/15; Approved by BoT 2/26/15.**

1. General Medical Staff Meetings: A quorum for a meeting of the general medical staff shall be 25% of the persons eligible to vote. **\* Amended 2/10/15; Approved by BoT 2/26/15.**
2. Electronic Voting: A quorum for an electronic vote shall be established once 25% of eligible voters have responded by voting on each question presented for vote, including a vote of “present,” or “abstain.” The period during which members may vote electronically for any question(s) shall be pre-designated and no less than two weeks in length. **\* Amended 2/10/15; Approved by BoT 2/26/15.**
3. Committee Meetings: A quorum for a meeting of a committee shall be 50% of the persons eligible to vote. \***Amended 01/26/10 Approved by BoT 2/22/10.**
4. For department or section meetings, a quorum is 25% of staff members assigned to that department and eligible to vote.

**VI.10 Attendance Requirements**

Members of the staff assigned to categories with voting privileges (with the exception of Senior Active and Emeritus), are required to attend at least fifty percent of the regular meetings of the clinical department/section to which they are assigned and fifty percent of meetings of committees of which they are a member within their two year reappointment cycle. There is no required attendance at the annual general medical staff meeting. \***Amended 07/22/14 Approved by BoT 07/28/14.**

**VI.11 Minutes**

Minutes of meetings include a record of attendance and actions taken. A permanent file of minutes of general staff meetings, committee meetings, meetings of clinical departments and of sections shall be maintained.

**VI.12 Majority Vote**

Except as otherwise specified, actions are by majority vote of staff members eligible to vote and present.

**VI.13 Rules of Order**

Where they do not conflict with these bylaws, the latest edition of Robert’s Rules of Order shall be followed.

**ARTICLE VII CLINICAL DEPARTMENTS AND SECTIONS**

**VII.1 Assignment to Department**

Each staff appointee is assigned membership in one clinical department, by the MEC upon recommendation of the Credentials Committee, and considering the wishes of the appointee.

Departmental assignment does not automatically restrict clinical privileges. The staff member may be granted clinical privileges in one or more of the other departments/section.

The exercise of clinical privileges within each department/section is subject to relevant rules and regulations, and to the authority of the chair of the department to which the individual is assigned, with relevant input of other department chairs, depending upon the nature of the individual’s hospital practice.

Disagreement between department chairs or section chiefs shall be resolved by the MEC, to the satisfaction of the governing body.

**VII.2 List of Departments and Sections**

For purposes of accomplishing bylaws-described medical staff functions, Departments are:

1. Emergency Medicine 6. Pediatrics

2. Family Medicine 7. Psychiatry

3. Medicine 8. Radiology

4. Obstetrics/Gynecology 9. Surgery

5. Pathology

See each clinical department’s Rules and Regulations for a listing of sections, if any.

**VII.3 Additional Departments or Sections**

For the purpose of accomplishing medical staff organizational functions in the most effective and efficient manner, additional departments, or clinical sections within departments, may be established by the MEC.

**VII.4 Department Chairpersons and Section Chiefs**

**A. Qualifications**

In the selection of Department Chairs, Vice Chairs and Section Chiefs and Vice Chiefs, attention shall be paid to the responsibilities involved and candidates’ interest, availability, organizational skills (including communication skills, written and oral), familiarity with hospital policies and procedures, and a reputation for objectivity and fairness, all of which are required to best provide medical staff participation in Hospital affairs. **\*Amended 4/27/10 Approved by BoT 5/24/10.**

Department Chairs and Section Chiefs shall be members of the Active staff category, in good standing, have an active hospital practice, (regularly admits, attends, or consults on hospital patients and/or provides clinical services at the hospital), and be certified by an appropriate specialty board, or have affirmatively established comparable competence, through the credentialing process.

*Note: The following provisions (B, C, D and E) apply unless contractual arrangements determine the chairmanship of the department.*

**B. Selection**

Each department and each permanent Clinical Section selects its Chair and Vice-Chair. These selections will be made by the departments/sections prior to the close of the appropriate calendar year and reported to the Medical Executive Committee. **\*Amended 4/27/10 Approved by BoT 5/24/10.**

**C. Term and Succession**

Department chairs and vice-chairs and section chiefs and vice-chiefs shall serve one-year terms unless a department specifies in its departmental Rules and Regulations that officers are elected for two-year terms; however, they may succeed themselves without limitation. **\*Amended 4/27/10 Approved by BoT 5/24/10.**

**D. Vacancy**

Should a vacancy in the position of department chair occur, a new chair is selected, by the procedure described above, as soon as is reasonably possible.

Should a vacancy in the position of Section Chief occur, the relevant clinical department chairman appoints a new chief of that section as soon as reasonably possible.

**E. Removal**

Removal of a department chair, vice-chair, section chief or vice-chief may be initiated by a 2/3 vote of staff members a) assigned to the department or section, b) eligible to vote and c) present, at a regular or special meeting of the department or section. Removal is not final until acted upon by the Medical Executive Committee. . **\*Amended 01/25/11 Approved by BoT 02/22/11.**

**F. Responsibilities**

Responsibilities of the department chair or section chief (relative responsibilities shall be clarified in the Rules and Regulations of each clinical department) include, but are not necessarily limited to

1. Directing clinically related activities of the department
2. Administratively related activities of the department, unless otherwise provided by the hospital
3. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
4. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
5. Recommending clinical privileges for each member of the department
6. 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
7. The integration of the department of service into the primary functions of the organization
8. The coordination and integration of interdepartmental and intradepartmental services
9. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
10. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
11. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
12. The continuous assessment and improvement of the quality of care, treatment and service
13. The maintenance of quality control programs, as appropriate
14. The orientation and continuing education of all persons in the department or service
15. Recommending space and other resources needed by the department or service

**ARTICLE VIII COMMITTEES AND FUNCTIONS**

**VIII.1 Types of Committees**

There shall be a Medical Executive Committee, a Credentials Committee, a Performance Awareness Committee, and a Quality Coordinating Council, and such other permanent and temporary committees of the staff as may from time to time be necessary.

Permanent committees may be established by the Medical Executive Committee upon approval of the governing body, but temporary (ad hoc) committees might be established by the MEC, or by a department or section.

**VIII.2. Medical Executive Committee**

**A. Composition**

The Medical Executive Committee consists of:

Voting Members

* Officers
* Chairs of each clinical department
* Chair of the Credentials Committee or another member of the Committee designated by the Chair

Non-Voting Members

- Chief Executive Officer (Administrator) or designee

- Medical Director, if applicable

- Chief Operating Officer & CNO

- Vice Presidents acting as Administrative Liaisons to Medical Staff Departments and/or Committees

\***Revised 10/22/13 Approved by BoT 11/25/13.**

**B. Duties**

The duties of the Medical Executive Committee (MEC) are:

a. to represent and act on behalf of the staff, subject to such limitations as may be imposed by these bylaws

b. to coordinate the activities of and policies adopted by the staff, departments, and committees

c. to receive and act upon reports and recommendations from the departments, committees and officers of the staff concerning peer review, quality improvement, utilization review or corporate compliance activities and other responsibilities

d. to recommend to the governing body all matters relating to medical staff membership appointments, re-appointments, staff category and departmental assignments, and clinical privileges **\*Amended 4/27/10 Approved by BoT 5/24/10**

e. to pursue corrective action to necessary conclusions in accordance with Article IX

f. to make recommendations on medico-administrative and hospital management affairs, including patient care needs such as space, staff and equipment

g. to obtain medical staff cooperation with retaining accreditation status of the hospital

h. to participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs

i. to resolve interdepartmental and intradepartmental disputes, when necessary and possible

In executing these duties, the Executive Committee forwards all reviews and recommendations to the Governing Board for approval. **\*Added 4/27/10 Approved by BoT 5/24/10.**

**C. Meetings**

The Medical Executive Committee meets at least ten (10) times per year and maintains a permanent record of its proceedings and actions.

**D. Removal of Officers or MEC Members \*Added 01/25/11 Approved by BoT 02/22/11.**

1. The MEC may remove members from the committee if confirmed and documented patterns of clinical judgment or skills are identified that may adversely affect patient care, if confirmed and documented patterns of behavior or conduct are identified that may adversely affect the medical staff, hospital or employees, or if the member is placed on probationary status (as provided for in these bylaws) for any reason.
2. MEC members are automatically removed from the committee if they are removed from their office by the medical staff (in the case of medical staff officers), by their departments (in the case of department chairs), by the Chief of Staff (in the case of the Credentials Committee chair), or if their status as active members of the medical staff is relinquished, suspended, or revoked. **\*Added 01/25/11 Approved by BoT 02/22/11.**

**VIII.3 Credentials Committee**

**A. Composition**

The Credentials Committee shall consist of:

No more than eight (8) members in good standing of the Active medical staff, who shall have been members in good standing of the Active staff for three (3) years or more prior to appointment by the Chief of Staff. Members will be assigned staggered terms ranging from two to four years. Each member may serve no more than two consecutive four-year terms. Members serving two consecutive four-year terms must have at least a one-year break before reappointment to the Credentials Committee. **\*Amended 01/25/11 Approved by BoT 02/22/11.**

The Credentials Committee shall elect its own chairperson annually. **\*Amended 01/25/11 Approved by BoT 02/22/11.**

**B. Duties**

The duties of the Credentials Committee shall be

a. to insist on validation of information provided in support of applications

b. to conduct a thorough, objective, and fair review of applications for medical staff membership and clinical privileges, both initial appointment and reappointment

c. to seek such additional information as is deemed necessary to make confident recommendations about applicants to the MEC and governing body

d. to forward a recommendation on each completed application for staff membership and/or clinical privileges, whether initial, renewal, or requested change (see II.14)

1. to assist department chairs and section chiefs, as applicable, in resolving problems with medical staff members pursuant to the provisions in Article IX.

**C. Meetings**

The Credentials Committee shall meet as often as necessary to accomplish the duties defined above.

**VIII.4 Credentialing Criteria Committee**

# Composition

The Credentialing Criteria Committee shall be appointed by the Chief of Staff and will consist of Chairman and two (2) additional members from two different Departments and additional members as needed.

### Duties

(1) Prior to this Committee being called to consider any matters, the following protocol shall be followed: Department Chair, Section Chief (if applicable) and the Credentials Committee Chair are to be contacted and will make the decision as to whether or not new criteria are necessary to be developed for a new service or procedure. If any one of these three individuals is of the opinion that the Credentialing Criteria Committee should meet to evaluate the procedure/treatment, a meeting will be held. In instances where services and/or procedures cross specialty lines, representatives of the appropriate specialty(ies) will be involved in the decision-making process.

If it becomes necessary for this Committee to consider the matter and the decision is that the service or procedure necessitates new guidelines, the guidelines will be developed under the auspices of the Committee and submitted through appropriate channels for approval and implementation (Department/Medical Executive Committee/Governing Body).

1. To establish minimal credentialing criteria for procedures and services provided in the hospital against which applications for privileges to perform those procedures and services can be assessed for appointment and reappointment.

(3) Report to the Medical Executive Committee recommendations on (1) and (2) above.

### Meetings

This Credentialing Criteria Committee meets only as needed.

# VIII.5 Performance Awareness Committee

**A. Composition**

The Performance Awareness Committee shall consist of:

Members shall include the Vice Chief, who shall serve as Chair, the Secretary of the Medical Staff, and the Immediate Past Chief. The Chief of Staff shall serve as a voting, ex-officio member and shall attend meetings of the PAC. Additional members shall be appointed as needed by the Chief of Staff, with the approval of the MEC and governing body.

**B. Duties**

The Performance Awareness Committee shall:

1. provide oversight for the performance of the medical staff practice evaluation/peer review function and make recommendations to the MEC regarding appropriate corrective action in matters pertaining to medical staff membership or privileges
2. determine that a sentinel event has occurred in accordance with hospital policy
3. receive reports of the activities of each clinical department, on no less than a quarterly basis

d. assist department chairs, section chiefs, and designees with accomplishing effective development and use of performance awareness information

e. provide a regular report to the MEC, no less than quarterly.

f. evaluate other matters of physician performance as referred to the Committee and recommend or implement actions in accordance with these bylaws and accompanying medical staff documents.

**C. Meetings**

The Performance Awareness Committee meets at least ten times per year and maintains a confidential record of its proceedings in accordance with N.C. General Statue 131E-95.

**VIII.6 Quality Coordinating Council**

**A. Composition**

The Quality Coordinating Council is a hospital-wide council consisting of representatives of the executive/management staff, medical staff, and nursing service.

Medical staff members of this hospital-wide council are the Vice Chief/Chief-elect who shall serve as Chairman, and the Secretary of the Staff.

**B. Duties**

The QCC provides a forum and coordinating mechanism for relating medical staff functions to hospital departments, including Nursing, and the executive/management staff of the Hospital.

**C. Meetings**

The QCC meets at least every other month, keeps a record of its proceedings, and provides regular reports (no less than quarterly) to the MEC and the governing body.

**VIII.7 Tissue and Transfusion Committee**

1. **Composition**

The Tissue and Transfusion Committee shall consist of:

The Committee Chair, who shall be appointed by the Chief of Staff, the Vice Chairs of the Departments of Medicine, OB-GYN, and Pathology, or their designees, the Section Chiefs of Orthopaedics and General Surgery, or their designees, and a representative of Hematology/Oncology to be appointed by the Chief of Staff unless this specialty is represented by the Vice Chair of the Department of Medicine. **\*Amended 04/24/12 Approved by BoT 05/29/12.**

1. **Duties**

The Tissue and Transfusion Committee shall:

1. maintain the Exempt Tissue List and make recommendations to the MEC regarding revision;
2. evaluate and monitor physician performance regarding the utilization of blood, preparation and availability of blood and blood products by the blood bank, and the following of established procedures in administering blood;
3. evaluate and monitor physician performance regarding the appropriateness of clinical pathology discrepancies;
4. at the discretion of the Committee, refer cases to the appropriate medical staff department or section for further review. Recommendations may also be made by the Committee and forwarded to the Section, Department, or MEC, as appropriate, regarding corrective action.
5. Provide a regular report to the MEC, no less than quarterly.

# Meetings

##### The Tissue and Transfusion Committee meets at least quarterly and maintains a confidential record of its proceedings in accordance with N.C.G.S. 131E-95.

# VIII.8 Bylaws Committee

# Composition

##### The Bylaws Committee shall consist of:

The Immediate Past Chief of Staff, who shall serve as the Chair, and the Chairs of the Departments of Medicine and Surgery. Additional members, as needed, shall be appointed by the Chief of Staff.

### Duties

The Bylaws Committee shall, at least annually, review and evaluate the need for revisions to the Medical Staff Bylaws and Rules and Regulations.

### Meetings

The Bylaws Committee shall meet at least one time per year or as needed to fulfill its duties.

**VIII.9 Additional Medical Staff Functions**

The accomplishment of the following functions may or may not require the existence of separate, established committees. The functions consist of **\*Amended 01/25/11 Approved by BoT 02/22/11.**:

1. Surgical Case Review
2. Medical Records Review
3. Medical Care Evaluation Review
4. Drug Utilization Review
5. Radiation Safety Review

**\*Amended 01/25/11 Approved by BoT 02/22/11.**

Evidence that these functions are being effectively accomplished at the departmental level is included in departmental reports to the MEC, and to the governing body or the Quality Coordinating Council.

**A. Medical Record Review**

Through a responsible group, individual, or committee

a. medical records are periodically reviewed to determine that they are timely, legible, complete, accurate, and adequate to serve as a source of needed information

b. rules and regulations related to medical records, including forms, timeliness of completion, and availability to attending physicians, are periodically reviewed and updated.

c. confidentiality policies of the hospital are reviewed at least annually and updated as necessary

d. the format of the patient record is periodically reviewed, and recommendations regarding format improvements may be made.

**B. Utilization Management**

Through a responsible group, individual, or committee

a. the appropriateness of admissions to the hospital and of ancillary diagnostic services, use of discharge planning, length of stay, discharge practices, consultations, and other factors related to appropriate utilization of hospital and physician services are reviewed; in this function, the medical staff acknowledges its obligation to evidence its concern with cost of care, and effective hospital payment

b. the utilization management activities described above are guided by a written plan, and include review of patients regardless of source of payment. The utilization review plan is reviewed annually and revised as necessary.

c. for certain specific purposes, medical audits may be performed. Such purposes include, but are not necessarily limited to, determining that surgical procedures are indicated, to resolve issues related to suspected marginal practice, to measure practitioner performance against reasonable objectives of patient care results and cost effectiveness of care, to determine effective use of consultations and/or to document effective communications with fellow practitioners, hospital employees and patients

**C. Continuing and Post-Graduate Medical Education**

Responsible individuals, groups, and/or committees are encouraged to organize and supervise locally presented CME opportunities and, if applicable, post-graduate training programs.

A portion of the local educational opportunities relate to findings from the medical staff’s data-based performance awareness (Quality Improvement) activities.

**D. Pharmacy and Therapeutics (Medication Use Subcommittee)**

Through a responsible group, individual or committee

a. utilization and administration of drugs is monitored. The information is evaluated and acted on by relevant department chairmen.

b. assistance is provided in formulating policies regarding selection, distribution, and safety procedures for administering drugs in the hospital.

**E. Surgical Case and Invasive Procedures Review**

Through a responsible individual, group, or committee

a. monitoring, evaluation, and action include all aspects of surgical cases,

including but not limited to indications, complications, and mortality.

**F. Infection Control**

Through a responsible individual, group, or committee, medical staff participation in hospital-wide efforts to control infections includes, but is not necessarily limited to, participating in

a. identification and analysis of the causes for nosocomial infections

b. development and implementation of effective preventive and corrective measures designed to minimize infection hazards

c. response to recommendations and reports related to infection control received from the Nursing Service and/or other hospital departments.

**VIII.10 Representation on Hospital Committees**

Medical Staff members are provided, as requested, to hospital committees dealing with matters that affect the medical staff (examples: Building and Grounds, Strategic Planning, Environment of Care, etc). Such committees operate in accordance with hospital bylaws and any applicable policies and procedures. The Chief of Staff shall make such appointments on an annual or as-needed basis.

**PART IV ACTIONS AFFECTING STAFF APPOINTEES/MEMBERS OTHER THAN ROUTINE REAPPOINTMENT/PRIVILEGES RENEWAL**

**ARTICLE IX QUESTIONS OF MARGINAL PRACTICE AND/OR BEHAVIOR, DISREGARD FOR RULES, PHYSICAL OR MENTAL IMPAIRMENT, UNETHICAL CONDUCT**

Like the other provisions of these bylaws, it is the intent of this Article IX, and its implementation to be in compliance with the Health Care Quality Improvement Act of 1986.

**IX.1 Problem Identification**

Confirmed and documented patterns or incidents that adversely affect, or could adversely affect patients, the medical staff, the hospital or its employees, are addressed by clinical department chairs, section chiefs, Performance Awareness Committee, and/or the MEC and governing body in a timely manner.

Problem identification relating to a practitioner’s clinical judgment or skills, compliance with hospital and/or medical staff rules, physical or mental status, efficient practice, ethical behavior or conduct, may be by information developed routinely in the course of performance evaluation activities, or by an incident report or by complaint from a medical staff member, patient, or hospital employee.

# Physical or Mental Impairment

While the first responsibility of the organization is to protect patients from harm, it is the intent of the medical staff to provide a process for identifying and managing matters of individual physician health that is separate from the medical staff disciplinary function. Issues related to physical or mental impairment should be addressed to the Chief of Staff in accordance with established medical staff policy. It is the responsibility of the Chief of Staff or his designee, along with consultation from the President or his designee, to determine the appropriate initial response when physical or mental impairment is suspected.

**Marginal Practice and/or Behavior, Disregard for Rules, Unethical Conduct**

If determined necessary by the MEC for fact-finding purposes, or if requested by the affected practitioner, by any member of the medical staff, or by the CEO on behalf of the governing body, in a written request to the MEC including grounds for the request, a formal study (review, investigation) shall be conducted. In that event, this procedure shall be used:

a. the Chief of Staff, considering MEC recommendations, shall appoint a formal ad hoc study group (investigative committee) and shall designate its chairperson.

b. the initial meeting of this study group shall be held within seven (7) calendar days of the decision to initiate this procedure, except that the initial meeting shall be within three (3) calendar days if the practitioner has been summarily suspended

c. the affected practitioner shall be informed by the chairperson of his/her department of the existence of the study group, and may be invited to attend its initial meeting

d. legal counsel should be asked to advise proper procedure, and to evaluate the appropriateness of any resulting recommendation

e. following its initial meeting, depending upon the scenario, either a) the study group is ready (has enough information) to report its finding(s) and recommendation(s) to the MEC, or b) obtains further information from whatever sources, prior to framing its conclusion(s) and recommendation(s)

f. the report of the study group shall be considered at a special meeting of the MEC, called solely for this purpose, within fourteen (14) calendar days of completion of the study group’s report

g. the MEC shall either a) accept the study group’s finding(s) and recommendation(s), or b) accept the finding(s) but make a different recommendation(s) regarding selection of a remedy, or c) ask for additional information before deciding on a recommendation

In either event, the MEC shall act on the study group’s report no later than fourteen (14) business days after receiving it.

If this procedure is used, it is not a Hearing, and should not be referred to as a Hearing (see Appendix 1).

**IX.2 Choosing a Remedy**

Resolution may be by one, or a combination of, several remedies, which shall be chosen after considering the urgency, recurrence, frequency and/or severity of the specific pattern or incident, as well as whether or not an uncooperative attitude is encountered.

A requirement for monitoring or supervision of a practitioner, or a requirement for consultation may be imposed at any time, shall not be considered a disciplinary action, and shall not entitle a member to a Hearing or Appellate Review (see Appendix 1, which is a part of this medical staff bylaws document).

 **IX.3 Medical Staff’s Obligation**

The Medical Executive Committee, through responsible individuals

a. develops and evaluates objective information to determine whether there are reasonable grounds to conclude that a problem exists

1. brings the full authority of responsible officers, department chairs, and committees to bear to resolve the issue in a timely manner

c. includes information about resolving the problem in the MEC’s reports to the governing body.

**IX.4 Governing Body’s Obligation**

The governing body

a. reviews the medical staff’s conclusion about the presence or absence of a problem and, as necessary, the objective information upon which that conclusion is based

b. through the CEO, assures availability of necessary resources, such as information systems and support personnel, legal counsel, consultants, etc., as necessary

c. assures the MEC and affected individual of its support for reasonable, good faith efforts to resolve the issues

d. reviews, questions, and approves, modifies, or refers back to the MEC, the resolution of the issue proposed/implemented by medical staff leaders

e. acts on MEC recommendations in a timely manner

f. takes direct action in the event that the problem cannot be resolved by medical staff leaders to the governing body’s satisfaction, whatever the reason.

**IX.5 Probationary Status**

Probation, when imposed, is for a specified time period, and may apply to membership, clinical privileges, or one or more specific clinical privileges. Probationary status is removed as soon as the MEC and governing body are satisfied that the problem necessitating the imposition of probationary status is resolved.

**IX.6 Restriction of Clinical Privileges, Reduction in Staff Category, Removal of Medical Staff Appointment and/or Privileges**

The governing body may, ordinarily upon the recommendation of the MEC, amend an individual’s privileges for the purpose of restricting the potential of harm to patients, other medical staff members, the hospital or its employees.

The remedy of complete expulsion from the medical staff membership and removal of all clinical privileges may be taken by the governing body.

**IX.7 Summary Suspension**

In the event that an individual practitioner’s action may pose a danger to patients, other medical staff members, or the hospital or its personnel, then either the Chief of Staff, the chairman of the clinical department of which the practitioner is a member, the CEO, or the governing body Chairperson, shall each have the authority by independent action to summarily suspend all or any portion of the clinical privileges of the medical staff member in question. Such suspension does not imply final finding of fact or responsibility for the situation that caused the suspension.

Such summary suspension is immediately effective, is immediately reported to all the individuals named above, and remains in effect until a remedy is effected following the provision of this Article IX of the medical staff bylaws.

Immediately, upon the imposition of a summary suspension, the appropriate department chair or the Chief of Staff assigns to another medical staff member the responsibility for care of any hospitalized patients of the suspended individual. In addition, the affected practitioner shall be notified in writing in the most expeditious manner possible, either by certified mail or by hand delivery.

As soon as practical, but in no event later than three (3) calendar days after a summary suspension, the MEC shall convene to review the action. The affected practitioner may request to be present at this meeting, which is not a Hearing (see Appendix 1) and is not to be construed as such.

The MEC may continue the suspension, or take another action pursuant to this article. If the action taken entitles the affected practitioner to a Hearing, then the Hearing and Appeals Procedure (Appendix 1) shall apply.

**IX.8 Automatic Effects of Actions of Staff Members/Appointees**

**A. Failure to complete Medical Records**

**a. Incomplete Medical Records** All portions of each patient’s medical record shall be completed per Medical Staff Rules & Regulations, Part A. Clinical, Section III.F. Completion of Medical Records. **\*Amended 10/22/13 Approved by BoT 11/25/13.**

Failure to do so (unless there are extenuating circumstances acceptable to the Chief of Staff and Hospital President) automatically results sequentially in (i) the record being defined as delinquent, (ii) notification to the practitioner, and (iii) temporary suspension of admitting and clinical privileges if not completed within seven (7) days of notification of delinquency. Suspension shall last until such time as the delinquent record is completed.

**b. Delinquent Medical Records** Failure to complete all aspects of any patient’s delinquent medical record within ten (10) days following suspension (see A.a. above), shall constitute voluntary relinquishment of staff membership and all clinical and admitting privileges.

Reinstatement to the staff is immediate upon completion of the delinquent record.

**B. Actions Affecting State License to Practice or DEA Registration**

If a practitioner’s actions result in his/her state license to practice or DEA registration being revoked, suspended, limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the individual, then staff membership and privileges are automatically revoked, suspended or limited to at least the same extent, subject to re-application by the practitioner when/if his license is reinstated, or limitations are removed, whatever the case.

### C. Exclusion from Federal Health Programs

If a practitioner’s actions result in his/her loss of eligibility to participate in Medicare, Medicaid, veteran’s health benefits or any other federal health care program, then staff membership and privileges are automatically revoked, subject to re-application by the practitioner when/if his eligibility is reinstated, or limitations are removed, whatever the case.

**D. Failure to Comply with Meeting Requirements**

For members of staff categories requiring compliance with meeting attendance requirements, failure to comply with the meeting requirements will result in a monetary penalty, resulting in an increased charge for the reappointment application and an admonishing letter. Each subsequent reappointment cycle without satisfying the meeting attendance requirements will increase the application fee for reappointment. **\*Amended 01/11/2017 Approved by BoT 01/30/2017**

If after two (2) consecutive reappointment periods, meeting requirements are not complied with, then additional disciplinary action may be required by the Board of Trustees, upon recommendation of the Medical Executive Committee. \***Revised 10/22/13 Approved by BoT 11/25/13.**

**E. Lapse of Liability Insurance**

If the governing body and MEC have established a requirement for liability insurance coverage for practitioners with clinical privileges, and if a staff appointee’s liability insurance lapses without renewal, then the practitioner’s membership privileges and clinical privileges are automatically suspended until the effective date of his new liability insurance coverage, unless otherwise determined by the governing body, considering the input of the MEC.

**IX.9 Right to Hearing and Appeal**

Circumstances under which a medical staff applicant or member/appointee is entitled to (a) a hearing on the facts and/or (b) an Appeal of an adverse recommendation/action, and the specific procedure to be followed for Hearings and Appeals, are described in the Hearing and Appeal Procedure, Appendix 1, which is part of this Medical Staff Bylaws document.

Automatic effects of individual actions (Article IX.8) do not entitle the individual to any Hearing or Appeal rights.

**PART V MISCELLANEOUS PROVISIONS**

**ARTICLE X. HISTORY AND PHYSICAL DOCUMENTATION REQUIREMENTS** \***Added 01/26/10 Approved by BoT 2/22/10.**

The medical history and physical examination are completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. Other qualified trained and competent individuals may document the history & physical examination in accordance with hospital or medical staff policy. The requirements for completing and documenting medical histories and physical examinations are detailed in the History and Physical Documentation Requirements, Appendix 3, which is part of this Medical Staff Bylaws document. \***Amended 01/11/2017 Approved by BoT 01/30/2017.**

**ARTICLE XI. MEDICAL DIRECTOR/VP MEDICAL SERVICES**

**A. Selection and Duties**

The governing body and CEO, considering MEC input, may (might) establish a position description for, and select, a Medical Director/VP Medical Service

This individual is to be concerned with medico-administrative aspects of healthcare services provided in or under the auspices of the hospital, and with coordination of organizational functions of the medical staff, working with the Chief of Staff, MEC, and clinical department chairs.

**B. Removal**

Removal of the Medical Director/VP Medical Services shall be by the governing body/CEO, according to terms of the individual’s contract, after consultation with the MEC.

**ARTICLE XII. RULES AND REGULATIONS**

Specific rules and methods for implementation provisions of these bylaws are included in bylaws-related documents (see Definitions).

Agreement to abide by the bylaws includes agreement to abide by any accompanying rules, which are subject to the MEC and governing body approval.

Existing rules and regulations are deemed to continue in effect unless and until they are amended or replaced by action of the MEC, subject to approval of the governing body.

**ARTICLE XIII. AMENDMENT**

Amendments to these Bylaws, other than those proposed by the Bylaws Committee, will be considered upon motion of a member of the Medical Staff, which receives a majority vote of the Medical Staff at any regular or special meeting of the Medical Staff at which a quorum is present, and will be submitted to the Medical Executive Committee. The Medical Executive Committee shall consider those changes, any further revisions to them, and report their recommendation, along with the original motion, at the next regular meeting of the medical staff or at a special meeting called for such purpose, or by electronic communication. To be adopted, such an amendment shall require a majority vote of at least a quorum of the medical staff, as defined in Article VI.9. Amendments so made shall be effective when approved by the Trustees. Amendments proposed by the Bylaws Committee and approved by the Medical Executive Committee may be adopted as outlined below. \***Amended 2/10/15 Approved by BoT 2/26/15.**

Neither the Organized Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. **\*Added 2/10/15 Approved by BoT 2/26/15.**

**ARTICLE XIV. ADOPTION**

Medical Staff Bylaws proposed by the Bylaws Committee must be adopted by majority vote of a quorum of the medical staff as defined in Article VI.9. \***Amended 2/10/15 Approved by BoT 2/26/15.** Once adopted by the medical staff and approved by the Board of Trustees, they replace any existing medical staff bylaws.

Last Revised:

 November 24, 2008

 May 26, 2009

August 24, 2009

February 22, 2010

May 24, 2010

February 22, 2011

May 25, 2011

January 23, 2012

February 27, 2012

May 28, 2013

October 28, 2013

November 25, 2013

April 28, 2014

July 28, 2014

November 24, 2014

February 26, 2015

January 30, 2017

**ADOPTED** by the General Medical Staff, January 11, 2017 and **APPROVED** at the Board of Trustees Meeting, January 30, 2017.

Ron Lindler, Chairman, Board of Trustees

Dale Menard, MD, Chief, Medical Staff

J. Anthony Rose, FACHE, President & CEO

\*Original signatures on file.

# APPENDIX 1 HEARING AND APPEAL PROCEDURE

**I.1 DEFINITIONS**

**A. Hearing** means notice and an opportunity to be heard, in a formal proceeding, with some mechanism for making a verbatim transcript, following a/an recommendation/action that is adverse to the applicant or staff member, by the Medical Executive Committee, or by the Board, if the Board’s is the first adverse decision.

**B. Appeal** means review, by an appellate review panel, if a decision remains adverse, of the findings and actions preceding the appellate review.

**I.2 GROUNDS FOR HEARING**

Only the following recommendations/actions provide cause to request a hearing/appeal:

A. Denial of medical staff appointment or reappointment;

B. Denial of clinical privilege (s) or requested additional clinical privilege(s);

C. Involuntary decrease of clinical privileges;

D. Withdrawal of medical staff appointment;

E. Suspension of any clinical privileges for a period of fourteen (14) days or more;

F. Reduction or denial of Staff Category assignment, if such reassignment or denial affects clinical privileges.

Neither voluntary nor automatic relinquishment of clinical privileges, as provided for elsewhere in these bylaws, nor the imposition of any consultation requirement, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the Clinical Department, the Credentials Committee, the Medical Executive Committee or the Board, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

Nothing herein precludes an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such action may result in an imminent danger to the health of any individual. **\*Added 01/25/11 Approved by BoT 02/22/11.**

**I.3 NOTICE, AND REQUEST FOR HEARING AND APPEAL**

**A. Request for Hearing** When a/an recommendation/action is made/taken which, according to these bylaws, entitles an individual to a hearing, he or she shall be given notice promptly by the Chief Executive Officer, in writing, return receipt requested. The notice shall include a statement of the specific action taken or recommended, reasons for the proposed action, and that the physician has the right to request a hearing within thirty (30) days following receipt of said notice. (See Appendix I.4 E for specified rights). **\*Amended 01/25/11 Approved by BoT 02/22/11.**

The applicant or staff member has thirty (30) days following receipt of such notice to request a hearing. The request must be by written notice, return receipt requested, to the Chief Executive Officer. If a hearing is not requested within thirty (30) days, the applicant or staff member has waived his right to hearing and has accepted the action which becomes effective immediately after such thirty (30) day period.

**B. Request for an Appeal** Within thirty (30) days of receiving notice of an adverse recommendation by a hearing panel or adverse decision by the Board, the applicant or staff member may request appellate review. This request must be made in writing, delivered to the Chief Executive Office, either in person or by certified mail, and must include a brief statement of the reasons for the appeal, as follows:

1. Substantial failure on the part of the medical staff , Hearing panel, or Board of Trustees to comply with these bylaws in the conduct of proceedings affecting the applicant or staff member;

2. That the recommendation was made arbitrarily, capriciously, or with prejudice;

3. That a recommendation of the Medical Executive Committee or Hearing Panel or the decision of the Board was not supported by substantial evidence.

If appellate review is not requested within the thirty (30) day time period, the applicant or staff member has accepted the decision and the action taken is immediately effective after such thirty (30) day period.

**C. One Hearing and One Appeal** No applicant or staff member shall be entitled to more than one hearing and one appeal upon the same issue or issues.

**I.4 THE HEARING: PROCEDURAL DETAILS**

**A. Arrangements for the Hearing** The Chief Executive Officer schedules the hearing and provides notice, in writing, return receipt requested, to the person who asked for the hearing, of its time, place, and date, which shall not be less than thirty (30) days after the date of this notice, but as soon thereafter as possible, considering the schedules and availability of all concerned. The written notification shall include a statement of the reasons for the action taken, as well as those acts, omissions, charges, and violations which serve as the grounds for the action together with the identity of patient records and any other relevant information supporting the action, and a list of witnesses (if any) expected to testify at the hearing on behalf of the professional body recommending the adverse action. The statement and attached information may be amended or added to at any time, even during the hearing, if the additional material is relevant to the hearing, and provided that the person requesting the hearing and his counsel have sufficient time to study the additional information and offer rebuttal.

**B. Presiding Officer** The Chief Executive Officer may appoint a presiding hearing officer, usually an attorney. The presiding officer may be legal counsel to the hospital, but in any event must not act as a prosecuting officer or as an Advocate for the board or medical staff. He may participate in private deliberations of the hearing panel, and may provide legal advice to it, but is not entitled to vote on its recommendations. He may, following the hearing, continue to advise the Board and medical staff on the matter.

The presiding officer may not be in direct economic competition with the physician against whom an adverse action or recommendation has been proposed. **\*Added 01/25/11 Approved by BoT 02/22/11.**

If no presiding officer is appointed, the specified chairman of the hearing panel is the presiding officer.

#### The presiding officer ensures that all participants have a reasonable opportunity to be heard, maintains order, determines the order of procedure of the hearing in accordance with these bylaws, and makes rulings on questions pertaining to matters of procedure and admissibility of evidence. It is understood that the presiding office at all times is concerned that all relevant information be made available to the hearing panel for its deliberations and recommendations to the Board. The presiding officer may take official notice of matters relating to the issues under consideration, which may be judicially noticed by the courts of this state. All participants in the hearing should be informed of such matters, and may request that a matter be officially noticed or may provide a counter argument as to such matter to be included in the hearing record.

**C. The Hearing Panel** The Chief Executive Officer, after considering the recommendations of the Chief of Staff and Board Chairman, shall appoint a hearing panel of not less than three members, at least one of whom must be a physician. Knowledge of the matters being considered does not preclude appointment to the hearing panel, but medical staff members who have actively participated in the consideration of the matter at any previous level are not eligible for appointment to the hearing panel. A hearing panel chairman shall be designated.

Individuals appointed to the Hearing Panel shall not be in direct economic competition with the physician against whom an adverse recommendation or action has been proposed. **\*Added 01/25/11 Approved by BoT 02/22/11.**

Instead of the foregoing procedure, the hearing may be conducted before an arbitrator mutually acceptable to the physician and the Chief Executive Officer of the hospital and who is not in direct economic competition with the physician involved.

**D. Representation** The individual requesting the hearing may be represented by an attorney or other person of the individual’s choice, who shall enter his appearance in writing with the Chief Executive Officer of the hospital at least ten (10) days prior to the date of the hearing. The hospital may be represented by counsel in all hearings and proceedings under this Appendix, and counsel for the hospital shall enter his or her appearance in the same manner.

**E. Specified Rights** The person requesting the hearing and the hospital may:

1. Call and examine witnesses;

2. Introduce exhibits;

3. Cross-examine witnesses, on matters relevant to the issues;

4. Provide rebuttals for any evidence presented;

5. Submit an oral and a written statement at the close of the hearing.

Even if the person requesting the hearing decides not to participate on his own behalf, he may still be called as a witness.

**F. Burden of Proof** It is incumbent on the Medical Executive Committee or the Board, whichever made the decision that initially prompted the hearing, to come forward with evidence in support of its recommendation. The burden of proof shall be on the Medical Executive Committee, or on the board, or on the individual who is seeking to change the status quo.

**G. Admissibility of Evidence** Any evidence which is relevant to the issues before the hearing panel, and is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, shall be admitted by the presiding officer at the hearing, without regard to the admissibility of such evidence in a court of law. The hearing panel may itself question witnesses, call additional witnesses, and request documentation of charges or claims made.

**H. List of Witnesses** Each party must provide the other in writing, at least ten (10) days in advance of the hearing, a written list of names and addresses of witnesses to be called. The witness list of either party may be amended at any time during the course of the hearing for good cause shown.

**I. Failure to Appear** If the person requesting the hearing, without good cause, fails to appear at the time the hearing is scheduled, this constitutes voluntary acceptance of the recommendations or actions pending, which then become effective immediately.

**J. Postponements and Extensions** Postponements and extensions may be requested by any of the participants, but will be permitted by the hearing panel only for good cause.

**K. Hearing Record** A record of the hearing will be maintained by a reporter retained by the hospital. Copies of the record may be obtained by the applicant or staff member upon payment of any reasonable charges associated with the preparation thereof.

**L. Attendance by Panel Members** A majority of the hearing panel is required in order for the hearing panel to proceed, and the decision of the hearing panel must be by majority of all those appointed to the hearing panel.

**M. Conclusion of the Hearing Procedure** After both parties have concluded their presentation of oral and written evidence, the hearing is closed.

**N. Recommendation** Within twenty (20) days after conclusion of the hearing and following any private deliberations that may be necessary, a recommendation and a report containing the reasons for the recommendation shall be delivered to the Chief Executive Officer. The decision must be based on the evidence produced at the hearing.

Upon presentation of its recommendation and report, the hearing body’s obligation is fulfilled.

**O. Further Distribution of Hearing Recommendation and Report** The Chief Executive Officer sends a copy of the report and recommendation, return receipt requested, to the person who requested the hearing, and to the body whose recommendation initiated these procedures. This body then decides whether to modify its original recommendation or action, considering the findings of the hearing.

P. **Distribution of Decision**. After receipt of the report and recommendation of the hearing body from the Chief Executive Officer, the Medical Executive Committee shall decide whether to modify its original recommendation or action. The body’s written decision including a statement of the basis for the decision, shall be sent, return receipt requested, to the person who requested the hearing. **\*Added January 25, 2011; Approved by BoT February 22, 2011.**

**I.5 APPEAL: PROCEDURAL DETAILS**

**A. Arrangements for Appellate Review** When an appeal is requested, the Board Chairman, within ten (10) days of receiving such request, schedules and arranges for an appellate review. Notice is given to the appealing party. The date for appellate review must not be less than thirty (30) days after the request is received; however, when the individual appealing is under suspension, the appellate review is held as soon as arrangements can reasonably be made, but not more than fourteen (14) days from receiving the appeal request. The stated times within which appellate review must be accomplished may be extended by the Board for good cause.

**B. Appellate Review Panel and Procedures**

1. The Board Chairman appoints an appellate review panel of not less than three (3) persons, which may include members of the hospital Board. The appellate review panel considers the record upon which the recommendation or action being appealed was made.

The appellate review panel may accept additional oral or written evidence only if the party seeking to admit additional evidence can demonstrate that he was deprived of the opportunity to admit it at the hearing which preceded the appellate review.

Each of the two parties in the matter have the right to present a written statement in support of its position on the appeal and, in its sole discretion, the appellate review panel may allow a representative of each party to appear personally and make oral arguments.

The appellate review panel recommends final action to the Board.

The Board may accept or, for good cause, modify or reverse the recommendation of the appellate review panel, sometimes after requesting further review by the appellate review panel. When further review is necessary, a report back to the Board shall be accomplished within thirty (30) days, unless a reasonable extension is granted by the Board.

The final Board decision is arrived at within thirty (30) days after the conclusion of appellate review, and is provided in writing to the affected individual and to the Medical Executive Committee, including a statement of the basis for the decision, in person or by certified mail.

2. The decision of the Board following the appeal is effective immediately, and is not subject to further review.

**C. Only One Appeal** There is no exception to the rule that the applicant or staff member is entitled to only one appellate review of any single matter.

**D. Reapplication Following Adverse Decision on Appellate Review**

If the final decision of the Board, following appellate review, is adverse, the applicant or staff member may re-apply for reappointment to the staff, or for the denied clinical privileges, whichever is applicable, one (1) year or later from the Board’s final decision, unless the Board provides otherwise in its final written decision.

**APPENDIX 2 IMMUNITY FROM LIABILITY**

The following shall be express conditions to any practitioner’s application for, or exercise of, clinical privileges at this hospital.

First, that any act, communication, report, recommendation, or disclosure with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Second, that such privileges shall extend to appointees of the Hospital’s medical staff and its Board of Trustees, its other practitioners, its administrator and his/her representatives, and to third parties, who supply information to any of the foregoing who are authorized to receive, release or act upon the same. For the purpose of this Article, the term “third parties” means both individuals and organizations from whom information has been requested by an authorized representative of the Board of Trustees or the Medical Staff.

Third, that there shall to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to (1) application for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews and (7) other hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.

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

Sixth, that in furtherance of the foregoing, each practitioner shall upon the request of the hospital execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph Second above, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State.

Seventh, that the contents, authorizations, releases, rights and privileges provided in the Medical Staff Membership and Clinical Privileges (“Credentials”) Procedure Manual for the protection of this hospital’s practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

Last Revised: November 22, 2004

 August 27, 2005

 October 25, 2005

 November 27, 2006

 January 28, 2008

 November 24, 2008

 May 26, 2009

 August 24, 2009

February 22, 2010

May 24, 2010

February 22, 2011

January 23, 2012

APPENDIX 3

# HISTORY AND PHYSICAL DOCUMENTATION REQUIREMENTS

| DOCUMENTATIONELEMENT/REQUIRED BY | TIMELINESS | FORMAT | DOCUMENTLOCATION | CONTENTS | BY WHOM | REQUIREDCOSIGNATURE |
| --- | --- | --- | --- | --- | --- | --- |
| INPATIENT |
| History and Physical1. Joint Commission
2. Medicare Conditions of Participation
 | 1. within 24 hours of admission (unless readmitted within 30 days, see Interval Note section)
2. Surgical H&P must be done within 30 days prior to procedure and patient reassessed the day of surgery-– if it is a surgical emergency, procedure may be performed without an H&P if the surgeon documents pre-op diagnosis, pertinent physical findings and exam of heart and lungs prior to the induction of anesthesia
3. H&Ps may be completed by a physician licensed to practice in NC but not a member of the medical staff; however the update prior to surgery must be completed by a member of the CVMC Medical Staff
4. H&P Update: An update must be completed, by a member of the medical staff, immediately prior to a procedure requiring anesthesia indicating that the H&P was reviewed, the patient examined, and “no change” has occurred since H&P completion OR document any changes in patient condition prior to procedure requiring anesthesia.
 | Dictated or handwritten | 1. Physician’s Progress Notes
2. Physician’s office note
3. Transcribed report
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Relevant Systems
5. Physical Exam of all pertinent systems (minimum mandatory requirement of heart and lung exam) to include vital signs.
6. Admitting/Provisional Diagnosis and Impression
7. Treatment Plan and documentation of discussion of reasons for any limited treatment plan and patient and/or family informed of the plan
8. Documentation of what is to be done as an inpatient that cannot be done as an outpatient, how outpatient therapy failed, and reasons why problems were not resolved during previous or recent admissions for the same diagnosis
 | 1. Attending MD, DO, oral surgeon
2. Resident
3. PA
4. NP
5. Midwife
6. PA, NP, Midwife and Medical Students
7. Scribe\*\*
 | Supervising physician must co-sign all H&Ps performed and documented by a resident.For PA, NP, Midwife and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated at the time of the entry by the supervising provider and prior to leaving the patient unit. |
| **SAME DAY SURGERY PATIENTS/INVASIVE PROCEDURES are defined as procedures that involve puncture or incision of the skin or insertion of an instrument or foreign material into the body except for PICC lines, paracentesis and/or thoracentesis \*** **Amended 04/24/12 Approved by BoT 05/29/12** |
| History and Physical1. Joint Commission
2. Medicare Conditions of Participation
 | 1. Surgical H&P must be done within 30 days prior to procedure and patient reassessed the day of surgery – if it is a surgical emergency, procedure may be performed without an H&P if the surgeon documents pre-op diagnosis, pertinent physical findings and exam of heart and lungs prior to the induction of anesthesia
2. H&Ps may be completed by a physician licensed to practice in NC but not a member of the medical staff; however the update prior to surgery must be completed by a member of the CVMC Medical Staff
3. H&P Update: : An update must be completed, by a member of the medical staff, immediately prior to a procedure requiring anesthesia indicating that the H&P was reviewed, the patient examined, and “no change” has occurred since H&P completion OR document any changes in patient condition prior to procedure requiring anesthesia.
4. If the Same Day Surgery patient converts to inpatient status and the H&P of record was completed by a dentist or podiatrist, a complete History and Physical must be completed by an MD or DO.
 | Dictated or handwritten | 1. Physician’s Progress Notes
2. Physician’s office notes
3. Transcribed report
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Relevant Systems
5. Physical Exam of all pertinent systems (minimum mandatory requirement of heart and lung exam) to include vital signs,
6. Admitting/Provisional Diagnosis and Impression
7. Treatment Plan and documentation of discussion of reasons for any limited treatment plan and patient and/or family informed of the plan
 | 1. MD, DO, oral surgeon, dentist, or podiatrist
2. Resident
3. PA
4. NP
5. PA, NP and Medical Students
6. Scribe\*\*
 | Supervising physician must co-sign all H&Ps performed and documented by a resident. For PA, NP and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider. For Scribes, H&Ps must be authenticated at the time of the entry by the supervising provider and prior to leaving the patient unit. |
| **NONOPERATIVE INVASIVE PROCEDURES (i.e. CARDIAC CATH, TEE, STEROID INJECTIONS, MYELOGRAM, ANGIOPLASTY, etc., as defined in PC-38)** |
| History and Physical1. Joint Commission
2. Medicare Conditions of Participation
 | 1. Non-operative invasive procedure H&Ps must be done within 30 days prior and the patient must be reassessed the day of the procedure
2. H&P Update: An update must be completed, by a member of the medical staff, immediately prior to a procedure requiring anesthesia indicating that the H&P was reviewed, the patient examined, and “no change” has occurred since H&P completion OR document any changes in patient condition prior to procedure requiring anesthesia.
3. If the patient converts to inpatient status and the H&P of record was completed by a dentist or podiatrist, a complete History and Physical must be completed by an MD or DO.
 | Dictated or handwritten | 1. Physician’s Progress Notes
2. Physician’s office notes
3. Transcribed report
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Systems
5. Relevant Physical Examination of all pertinent systems (minimum mandatory requirement of heart and lung exam).
6. Diagnosis/Impression
7. Treatment Plan and documentation of discussion of reasons for any limited treatment plan and patient and/or family informed of plan
 | 1. MD, DO, oral surgeon, dentist, or podiatrist
2. Resident
3. PA
4. NP
5. Midwife
6. PA, NP, Midwife and Medical Students
7. Scribe\*\*
 | Supervising LIP must co-sign all H&Ps performed and documented by a resident. For PA, NP, Midwife and MedicalStudents, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated at the time of the entry by the supervising provider and prior to leaving the patient unit. |
| **OBSERVATION PATIENTS** |
| History and Physical1. Joint Commission
2. Medicare Conditions of Participation
 | 1. for medical observation patients H&P must be completed within 24 hours of placement in observation (unless readmitted within 30 days, see Interval Note section)
2. Surgical H&P must be done within 30 days prior to procedure and patient reassessed the day of surgery – if it is a surgical emergency, procedure may be performed without an H&P if the surgeon documents pre-op diagnosis, pertinent physical findings and exam of heart and lungs prior to the induction of anesthesia
3. H&P’s may be completed by a physician licensed to practice in NC but not a member of the medical staff; however the update prior to surgery must be completed by a member of the CVMC Medical Staff
4. H&P Update: An update must be completed, by a member of the medical staff, immediately prior to a procedure requiring anesthesia indicating that the H&P was reviewed, the patient examined, and “no change” has occurred since H&P completion OR document any changes in patient condition prior to procedure requiring anesthesia.
5. If the Observation patient converts to inpatient status and the H&P of record was completed by a dentist or podiatrist, a complete History and Physical must be completed by an MD or DO.
 | Dictated or handwritten  | 1. Physician’s Progress Notes
2. Physician’s office note
3. Transcribed report
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Relevant Systems
5. Physical Exam of all pertinent systems (minimum mandatory requirement of heart and lung exam) to include vital signs,
6. Admitting/Provisional Diagnosis and Impression
7. Treatment Plan and documentation of discussion of reasons for any limited treatment plan and patient and/or family informed of the plan
8. failure of outpatient treatment or inability to perform in an outpatient setting
 | 1. MD, DO, oral surgeon, dentist, or podiatrist
2. Resident
3. PA
4. NP
5. PA, NP, Midwife and Medical Students
6. Scribe\*\*
 | Supervising physician must co-sign all H&Ps performed and documented by a resident. For PA, NP, Midwife and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated by at the time of the entry by the supervising provider and prior to leaving the patient unit. |
| **OUTPATIENT (including Chemotherapy, Transfusions, etc.)** |
| No History and Physical Required |  |  |  |  |  |  |
| **WOUND CENTER** |
| History and Physical1. Joint Commission
 | 1. H&Ps must be done within 30 days prior to the initial visit
2. H&P Update – Unless moderate sedation or anesthesia is used to perform the treatment, an upate is not required for subsequent visits for the same wound if a progress note with a description of the wound is documented for each visit.
 | Dictated or handwritten | 1. Physician’s Notes
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Systems
5. Relevant Physical Examination of all pertinent systems (minimum mandatory requirement of heart and lung exam)
6. Diagnosis/Impression
7. Treatment Plan and documentation of discussion of reasons for any limited treatment plan and patient and/or family informed of the plan
 | 1. MD, DO, oral surgeon, dentist, or podiatrist
2. Resident
3. PA
4. NP
5. PA, NP, Midwife and Medical Students
6. Scribe\*\*
 | For PA, NP, Midwife and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated at the time of entry by the supervising provider and prior to leaving the patient unit. |
| EMERGENCY DEPARTMENT PATIENTS |
| Emergency Department Report1. Joint Commission
2. Medicare Conditions of Participation
 | Completed upon discharge from the ED | Dictated or handwritten  | 1. Emergency Department Report – dictated
2. ED Physician Record – handwritten
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Relevant Systems
5. Physical Exam of the systems pertinent to the chief complaint to include vital signs
6. Final Diagnosis
7. Treatment Plan and documentation of discussion of reasons for any limited treatment plan and patient and/or family informed of the plan
8. Documentation of what is to be done as an inpatient that cannot be done as an outpatient, how outpatient therapy failed, and reasons why problems were not resolved during previous or recent admissions for the same diagnosis
 | 1. MD/DO
2. PA
3. NP
4. Midwife
5. PA, NP, Midwife and Medical Students
6. Scribe\*\*
 | For PA, NP, Midwife and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated at the time of entry by the supervising provider and prior to leaving the patient unit. |
| HOSPICE PATIENTS |
| History and Physical | History and Physical from the acute inpatient stay will be copied to the Hospice record. |  |  | See Inpatient on page ix. |  |  |
| OB PATIENTS |
| History and Physical1. Joint Commission
2. Medicare Conditions of Participation
 | 1. Within 24 hours of admission
2. Prior to performing a cesarean section
3. H&P Update: An update must be completed, by a member of the medical staff, immediately prior to a procedure requiring anesthesia indicating that the H&P was reviewed, the patient examined, and “no change” has occurred since H&P completion OR document any changes in patient condition prior to procedure requiring anesthesia.
 | Dictated or handwritten  | 1. OB H&P
2. Physician Progress Notes
3. Dictated
4. Prenatal Record must be filed on the inpatient record
 | 1. Chief Complaint
2. History of Present Illness
3. Relevant Past, Social, and Family Histories
4. Review of Relevant systems
5. Physical Exam of all pertinent systems (minimum mandatory requirement of heart and lung exam) to include vital signs, and labor progress
6. Admitting/Provisional Diagnosis or Impression
7. Treatment Plan and documentation of discussion of reasons for limited treatment plan and patient and/or family informed of the plan
 | 1. MD, DO
2. Midwife
3. Resident
4. PA, NP, Midwife and Medical Students
5. Scribe\*\*
 | Supervising physician must co-sign all H&Ps performed and documented by a resident. For PA, NP, Midwife and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated at the time of entry by the supervising provider and prior to leaving the patient unit. |
| NORMAL NEWBORNS (level 3 newborns use Inpatient grid) |
| History and Physical1. Joint Commission
2. Medicare Conditions of Participation
 | 1. Within 24 hours of admission
2. Prior to performance of a surgical or invasive procedure
 | Handwritten | 1. Newborn Physical Examination Record
 | 1. Birth weight, head circumference, chest circumference, length
2. Physical Exam and description of abnormal findings
3. Impression
 | 1. Attending MD, DO
2. PA
3. NP
4. PA, NP, Midwife and Medical Students
5. Scribe\*\*
 |  For PA, NP, Midwife and Medical Students, H&Ps must be co-signed at the time of entry by the supervising provider.For Scribes, H&Ps must be authenticated by the supervising provider prior to leaving the patient area and prior to leaving the patient unit. |

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**\*Amended 04/23/13 Approved by BoT 05/28/13**

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