



UMC Clinical Quality and Professional Affairs Committee

Monday, October 7, 2024 2:00 p.m.

UMC Trauma Building - Providence Suite - 5th Floor

Las Vegas, NV

AGENDA

University Medical Center of Southern Nevada
UMC GOVERNING BOARD
CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE
October 7, 2024 2:00 p.m.
800 Hope Place, Las Vegas, Nevada
UMC Trauma Building, Providence Suite (5th Floor)

Notice is hereby given that a meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee has been called and will be held at the time and location indicated above, to consider the following matters:

This meeting has been properly noticed and posted online at University Medical Center of Southern Nevada's website <http://www.umcsn.com> and at Nevada Public Notice at <https://notice.nv.gov/>, and at University Medical Center 1800 W. Charleston Blvd. Las Vegas, NV (Principal Office)

- The main agenda is available on University Medical Center of Southern Nevada's website <http://www.umcsn.com>. For copies of agenda items and supporting back-up materials, please contact Stephanie Ceccarelli, Board Secretary, at (702) 765-7949. The Clinical Quality and Professional Affairs Committee may combine two or more agenda items for consideration.
- Items on the agenda may be taken out of order.
- The Clinical Quality and Professional Affairs Committee may remove an item from the agenda or delay discussion relating to an item at any time.
- Consent Agenda - All matters in this sub-category are considered by the Clinical Quality and Professional Affairs Committee to be routine and may be acted upon in one motion. Most agenda items are phrased for a positive action. However, the Clinical Quality and Professional Affairs Committee may take other actions such as hold, table, amend, etc.
- Consent Agenda items are routine and can be taken in one motion unless a Committee member requests that an item be taken separately. For all items left on the Consent Agenda, the action taken will be staff's recommendation as indicated on the item.
- Items taken separately from the Consent Agenda by Committee members at the meeting will be heard in order.

SECTION 1. OPENING CEREMONIES

CALL TO ORDER

1. Public Comment
2. Approval of minutes of the regular meeting of the UMC Clinical Quality and Professional Affairs Committee meeting on August 5, 2024 *(For possible action)*
3. Approval of Agenda. *(For possible action)*

SECTION 2. BUSINESS ITEMS

4. Receive an update on Pathways to Excellence and Magnet, including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly. *(For possible action)*.
5. Receive an update on HCAPHS/CCAPHS/ICARE4U Program from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. *(For possible action)*.

6. Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of August 7, 2024 including the recommended creation, revision, and/or retirement of UMC policies and procedures; and take any action deemed appropriate. *(For possible action)*.
7. Review and recommend approval by the Board of Hospital Trustees for University Medical Center of Southern Nevada, the proposed amendments to the UMC Medical and Dental Staff Bylaws and Rules & Regulations; as approved and recommended by the Medical Executive Committee on September 24, 2024; and take any action deemed appropriate. *(For possible action)*

SECTION 3. EMERGING ISSUES

8. Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly.

COMMENTS BY THE GENERAL PUBLIC

All comments by speakers should be relevant to the Committee's action and jurisdiction.

UMC ADMINISTRATION KEEPS THE OFFICIAL RECORD OF ALL PROCEEDINGS OF UMC GOVERNING BOARD CLINICAL QUALITY AND PROFESSIONAL AFFAIRS COMMITTEE. IN ORDER TO MAINTAIN A COMPLETE AND ACCURATE RECORD OF ALL PROCEEDINGS, ANY PHOTOGRAPH, MAP, CHART, OR ANY OTHER DOCUMENT USED IN ANY PRESENTATION TO THE BOARD SHOULD BE SUBMITTED TO UMC ADMINISTRATION. IF MATERIALS ARE TO BE DISTRIBUTED TO THE COMMITTEE, PLEASE PROVIDE SUFFICIENT COPIES FOR DISTRIBUTION TO UMC ADMINISTRATION.

THE COMMITTEE MEETING ROOM IS ACCESSIBLE TO INDIVIDUALS WITH DISABILITIES. WITH TWENTY-FOUR (24) HOUR ADVANCE REQUEST, A SIGN LANGUAGE INTERPRETER MAY BE MADE AVAILABLE (PHONE: 765-7949).

University Medical Center of Southern Nevada
UMC Governing Board Clinical Quality and Professional Affairs
August 5 2024

UMC Providence Conference Room
Trauma Building, 5th Floor
800 Hope Place
Las Vegas, Clark County, Nevada
August 5, 2024 2:00 p.m.

The University Medical Center Governing Board Clinical Quality and Professional Affairs Committee met at the time and location listed above. The meeting was called to order at the hour of 2:03 p.m. by Chair Dr. Donald Mackay and the following members were present, which constituted a quorum of the members thereof:

CALL TO ORDER

Board Members:

Present:

Dr. Mackay – Chair
Laura Lopez-Hobbs
Jeff Ellis (WebEx)
Renee Franklin (WebEx)
Steve Weitman (Ex-Officio) (WebEx)

Absent:

None

Also Present:

Tony Marinello, Chief Operating Officer
Jennifer Wakem, Chief Financial Officer
Patty Scott, Quality, Safety, & Regulatory Officer
Dr. Frederick Lippmann, Chief Medical Officer
Danita Cohen, Chief Experience Officer
James Conway, Assistant General Counsel
Stephanie Ceccarelli, Board Secretary

SECTION 1. OPENING CEREMONIES

ITEM NO. 1 PUBLIC COMMENT

Chair Dr. Mackay asked if there were any persons present in the audience wishing to be heard on any item on this agenda.

Speaker(s): None

ITEM NO. 2 Approval of minutes of the regular meeting of the UMC Governing Board Clinical Quality and Professional Affairs Committee meeting on June 3, 2024. (For possible action)

FINAL ACTION: A motion was made by Member Hobbs that the minutes be approved as presented. Motion carried by unanimous vote.

ITEM NO. 3 Approval of Agenda (For possible action)

FINAL ACTION: A motion was made by Member Hobbs that the agenda be approved as presented. Motion carried by unanimous vote.

SECTION 2. BUSINESS ITEMS

ITEM NO. 4 Review and discuss the FY24 Organizational Performance Goals as they relate to the Clinical Quality and Professional Affairs Committee and make a recommendation to the Human Resources and Executive Compensation Committee; and direct staff accordingly. (For possible action)

DOCUMENT(S) SUBMITTED:

- FY24 Organizational Performance Goals

DISCUSSION:

Ms. Scott reviewed the Quality Performance Objectives for FY2024.

1. Improve or sustain improvement from prior year (CY22 / CY23) for the following patient experience measures (IP / OP):

The goal was partially met in one of five measures. Pressure injuries were met. All other measures in this goal were not met.

2. Demonstrate implementation and ensure improvement plans are in place (as necessary) for the following Health Care Equity – Social Determinants of Health (SDOH) measures (IP / OP):

This goal was met. All three measures were accomplished. Mapping of reported data and Epic implementation is complete. Patient screening for transportation and assistance in outpatient settings has been established.

There was continued discussion regarding social services, patient no-show rates for transportation and patient education.

3. Improve or sustain improvement from prior year (CY22 / CY23) for the following patient experience measures (IP / OP):

This goal was met. All measures improved over prior year. Physician and nurse communication; staff responsiveness measures still struggle to meet state and national benchmark averages.

4. Demonstrate improvement (utilizing the Star Ratings) from prior calendar year (CY22/CY23) in the overall perception of case/services at UMC Ambulatory Care through the following online review sites

This goal was met. The Google and Yelp scores have remained consistently positive or improved in both ratings.

5. Improve or sustain improvement as delineated for the following employee engagement measures (IP / OP):

All five goals were met relative to patient and employee experience.

The Committee wanted more understanding as to why there is still a struggle with improvement in the first goal. Ms. Scott explained that there are a number of factors, including the addition of various complex service lines, patient volume, and patient acuity with case mix increasing exponentially by 43% within these risk adjusted cases. There continues to be opportunities for clinical documentation improvement overall

After discussion, the Chair Mackay summarized all goals. Overall four out of five goals were met. The first goal was partially met.

Chair Mackay suggested an award of between 26%-28% of the goal met.

Member Hobbs - 26%.

Member Ellis - 25%.

Member Franklin agreed with 25%.

The Committee would like to see a trend over the years for the quality measures.

The Committee agreed unanimously to award 25% of the 30% maximum achievement for goals met.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to award 25% of the FY24 Clinical Quality and Professional Affairs Committee goals and to recommend approval to the Human Resources and Executive Compensation Committee. Motion passed unanimously.

ITEM NO. 5 Discuss an establish the Proposed FY25 Organizational Performance Goals as they relate to the Clinical Quality and Professional Affairs Committee and make a recommendation to the Human Resources and Executive Compensation Committee; and direct staff accordingly. (For possible action)

DOCUMENT(S) SUBMITTED:

- FY25 Proposed Organizational Goals

DISCUSSION:

The Committee discussed the following proposed goals for FY25:

1. Improve or sustain improvement from prior year (CY23 / CY24) for the following inpatient **quality/safety measures:**
 - CLABSI
 - CAUTI
 - SSI-COLON
 - PSI-90

- Hand Hygiene Compliance (overall)
- 2. Overall Mortality Index (observed / expected)
- 3. Improve or sustain improvement from prior year (CY23 / CY24) for the following **patient experience** measures (IP / OP):
 - Communication with Nurses
 - Communication with Physicians
 - Responsiveness of Staff (IP)
- 4. Improve or sustain improvement (utilizing the Star Ratings) from prior year (CY23 / CY24) in the **overall patient perception of care/service** at UMC Quick Cares through the following online review sites (OP):
 - Yelp
 - Google
- 5. Ensure **physician engagement / alignment** (FY25) within the employed physician practice plan / service line through the following:
 - Attain 95% compliance with all UMC practice plan onboarding including new provider orientation, ICARE training, performance metric expectations, attendance at practice plan meeting requirements, etc.
 - Gain 90% participation in physician engagement / alignment surveys, utilizing information gained to develop plans for improvement as other providers join the practice plan / service line.
- 6. Improve or sustain improvement from prior year (CY23 / CY24) as delineated for the following **employee engagement** measures (IP / OP):
 - Reach 80% of UMC employees with additional ICARE training specifically focused on service recovery.

After discussion, the Committee would like to see trended data over time in the first goal, in order to determine if there is progress over a longer length of time for sustainability instead of pass/fail. Ms. Scott will show a 3-year trending graph, as well as a case mix/risk adjustment to determine the rating. There was continued discussion regarding the verbiage in the fourth goal and the requirements related to physician engagement and compliance with medical staff bylaws.

The FY25 goals were agreed on to be listed as follows:

1. **Improve or sustain improvement over the last three (3) year trending period for the following inpatient quality/safety measures:**
 - CLABSI
 - CAUTI
 - SSI-COLON
 - PSI-90
 - Hand Hygiene Compliance (overall)
 - Overall Mortality Index (observed / expected)

- 2. Improve or sustain improvement over the last three (3) year trending period for the following patient experience measures (IP / OP):**
 - Communication with Nurses
 - Communication with Physicians
 - Responsiveness of Staff (IP)

- 3. Improve or sustain improvement (utilizing the Star Ratings) from prior year (CY23 / CY24) in the overall patient perception of care/service at UMC Quick Cares through the following online review sites (OP):**
 - Yelp
 - Google

- 4. Employed physician engagement / alignment (FY25) within the employed physician practice plan / service line through the following:**
 - Attain 100% onboarding attendance compliance with all UMC employed physicians. Onboarding is defined by the following two components: attends hospital/provider orientation, provided with performance metric expectations.
 - Attain 90% participation in physician engagement / alignment surveys, utilizing information gained to develop plans for improvement as other providers join the organization / service line.

- 5. Improve or sustain improvement from prior year (CY23 / CY24) as delineated for the following employee engagement measures (IP / OP):**
 - Reach 80% of UMC employees with additional ICARE training specifically focused on service recovery.

Member Hobbs would like examples/recommendations of how goal 4 will be measured.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to approve the FY25 Organizational Performance goals and make a recommendation to the Human Resources and Executive Compensation Committee of the FY25 Organizational Performance goals as they relate to the Clinical Quality and Professional Affairs Committee. Motion passed unanimously.

- ITEM NO. 6 Review and recommend for approval by the Governing Board, the UMC Policies and Procedures Committee's activities of June 5 & July 3, 2024 including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. (For possible action)**

DOCUMENT(S) SUBMITTED:

- Policies and Procedures

DISCUSSION:

Policy and Procedures activities for June 5th and July 3rd, 2024 were reviewed.

There were a total of 47 policies approved, 8 were retired and all were approved through the hospital Policy and Procedures Committee, Quality and Safety and Medical Executive Committee.

FINAL ACTION TAKEN:

A motion was made by Member Hobbs to approve that the UMC Policies and Procedures Committee's activities of June 5 and July 3, 2024, and recommend for approval to the UMC Governing Board. Motion carried by unanimous vote.

FINAL ACTION TAKEN:

None

SECTION 3. EMERGING ISSUES

ITEM NO. 7 Identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly

DISCUSSION:

The Committee would like to receive an update to include cost accounting for Pathways to Excellence and attainment of Magnet status.

FINAL ACTION TAKEN:

None

COMMENTS BY THE GENERAL PUBLIC:

At this time, Chair Dr. Mackay asked if there were any persons present in the audience wishing to be heard on any items not listed on the posted agenda.

SPEAKERS(S): None

There being no further business to come before the Committee at this time, at the hour of 3:04 p.m., Chair Dr. Mackay adjourned the meeting.

MINTUES PREPARED BY: Stephanie Ceccarelli, Governing Board Secretary

APPROVED:

**UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND
PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM**

Issue: Nursing Update – Pathways to Excellence and Magnet Update	Back-up:
Petitioner: Patricia Scott, Quality Patient Safety and Regulatory Officer	
Recommendation: That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on Pathways to Excellence and Magnet including associated financial costs from Deb Fox, Chief Nursing Officer (CNO); and direct staff accordingly. <i>(For possible action)</i>	

FISCAL IMPACT:

None

BACKGROUND:

The Clinical Quality and Professional Affairs Committee will receive a Pathways to Excellence and Magnet status update from Deb Fox, Chief Nursing Officer.

Cleared for Agenda
October 7, 2024

Agenda Item #

MAGNET JOURNEY



STATUS 2024

TWO JOURNEYS



P2E is the premier designation for health care organizations that demonstrate an ongoing commitment to, and provide empirical evidence of, a healthy nursing work environment.



Magnet is an international designation that continually elevates patient care in an environment where nurses, collaborating with other inter-professionals deliver excellence through leadership, scientific discovery and dissemination and implementation of new knowledge (evidence-based practice, research, innovation)

P2E- 228 US hospitals; 2 in Nevada (Carson Tahoe & UMC)
Magnet- 596/6,120 US hospitals; zero in Nevada

2024- both P2E and Magnet both have designation with Distinction to recognize stellar performance

PATHWAY TO EXCELLENCE



WHAT

ANCC Pathway to Excellence® Framework for Positive Practice Environments.
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- Improves nurse satisfaction
- Retains and recruits choice nursing staff and leaders
- Cultivates inter-professional collaboration
- Champions high-quality nursing practice
- Provides infrastructure for Magnet

WHY

- Application
- Document: 53 EOPs
- RN survey: 60% or higher must complete the survey; at least 50% of respondents must strongly agree or agree to all 28 questions; 75% of respondents must strongly agree or agree with at least 21 out of 28 questions

HOW

MAGNET RECOGNITION

1983- The AAN Task Force on Nursing Practice conducted a study to identify hospitals that attracted and retained well-qualified nurses (n=163). Forty-one hospitals were described as “Magnet.”

1990- ANCC was incorporated through the ANA. The ANA Board approved Magnet Recognition Program.

1994- U of Washington Medical Center became the first Magnet organization.

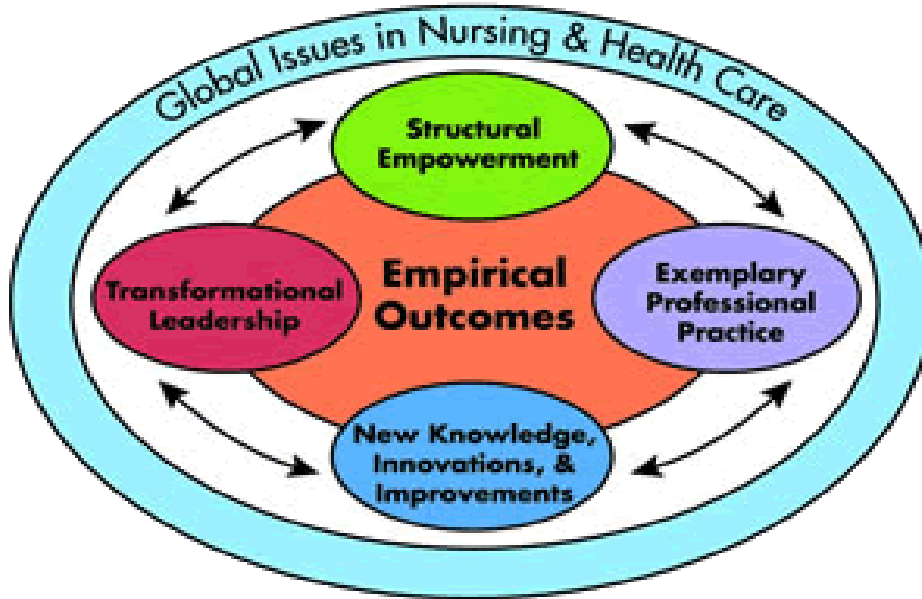
1998- Magnet expanded to include long-term care facilities.

2000- Magnet expanded to recognize hospitals internationally.

2007- Based on statistical analysis, SOEs were clustered into > 30 groups yielding an empirical Magnet model.

2008- New conceptual model distilled the 14 Forces of Magnetism into five key Components: Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge; Innovation/Improvements; Empirical Outcomes.

MAGNET RECOGNITION II



WHAT

Transformational Leadership- Quality of nursing leadership;
Management style

Structural Empowerment- Organizational structure; Personnel policies
& programs; Community partnership; Image of Nursing; Professional development

Exemplary Professional Practice- Models of care; Consultation & resources; Autonomy;
Nurses as teachers; Interdisciplinary relationships

New Knowledge & Innovation- Research; Evidence-Based Practice; Quality
Improvement; Data & Empirical outcomes

Empirical Quality Outcomes- Quality of care & Patient experience

MAGNET RECOGNITION III

Quality & Safety- Higher adoption of National Quality Forum safe practices; Lower overall missed nursing care; Higher support for evidence-based practice implementation; Higher nurse-perceived quality of care; Higher patient ratings of their hospital experience

Patient Outcomes- Lower mortality rates; Lower failure-to-rescue; Lower nosocomial infections; Lower hospital-acquired pressure ulcer rates; Lower central line-associated bloodstream infection rates; Lower fall rates

Cost Advantages- Lower RN turnover; Lower LOS; Higher net inpatient income

WHY

- Application- Hospital/OP Entities
- AACN assigns a Magnet representative who assigns the dates.
- Document- 88 SOEs. Each requires 5 pieces of supporting evidence. Organizational overview has 11 additional items. Full data and other appendices. Document must be scored “excellent.”
- Site Visit- 3-4 Magnet surveyors for 3 days of survey.
- Report submitted to Commission on Magnet who decides outcome.

HOW

UMC STATUS

**P2E
&
MAGNET**

PATHWAY TO EXCELLENCE

- Initial **designation** 2021

- **Re-Designation** 2024

- **UMC STATUS:**
 - Application accepted February 2024
 - Document submitted May 2024
 - RN Survey opened September 24 thru October 15, 2024
 - November-December 2024 results determination by P2E Board
 - 3-year re-designation by December 2024
 - UMC only P2E hospital in S. Nevada

MAGNET DESIGNATION

- **Pre-Application** requirements met January 2024
- **Application** accepted by Magnet Commission May 2024
- **Dates confirmed:**
 - Document submission June 2025
 - Expedited site visit Fall 2025
 - Magnet decision NO LATER January 1, 2026
- **UMC STATUS:**
 - 8-Rolling Quarters of Nurse Sensitive Quality Data Confirmed/4 Exemplars
 - NDNQI RN Satisfaction Survey Data 2023/Exemplar
 - HCAHP Scores IMPROVING/CHALLENGE
 - Document writing phase underway. Steering Committee and six UMC writers, plus Healthlinx writers and professional editor. Done by April 2025
 - Ramp-Up to Magnet Site Visit Plan July 2025 thru Site Visit 2025

MAGNET DESIGNATION II

- **ROLE OF HEALTHLINX:**
 - Writing 55% of SOEs
 - Writing schedule Demands
 - Professional Editor
 - Adam Upload to Magnet Commission
 - Site visit preparations
 - Assist in selecting Magnet Surveyors/Reviewers
 - Data Management/Tracking
 - HCAHP improvement campaign
- **P2E and PTAP** (Practice Transition Accreditation Program-New Graduate Nurse Residency Program) designations give UMC credit for 11 SOEs that we do not have write to in the Magnet document.

DATA STORY

- **Data Sources:**
 - NDNQI (National Database of Nursing Quality Indicators)
 - NHSN (National Healthcare Safety Network)
 - UMC SI (Safety Intelligence)
 - Academic Medical Centers- Peer Group for comparisons
- Magnet data is by unit and about showing ongoing outcomes improvement.
- UMC chooses the data points and sources. They must be nationally recognized and a useable peer group.
- Majority of units must out-perform for 8-rolling quarters in the evaluative window
- Threshold is 51% >.
- 2 Exemplars remove a deficiency.
- Quality and HCAHP data is for both IP and OP units, but the measures are different.
- UMC quality data is exceeding with multiple exemplars
- HCAHP data is the challenge (50% of IP and OP in aggregate are below threshold).

DATA STORY II

OP

- **N= 34**
- Units include all UMC quick & primary care locations, transplant, special procedures, PAT, ASU & PACU, pediatric sedation, Trauma, AED, PED, cath lab & Cardiology, BCT.
- **Data Points:**
 - Falls W/Injury
 - Patient Burns
 - Surgical Errors
- **Data Measure** is data point/1,000 patient visits
- **All exceeding unit level threshold:**
 - Falls W/Injury = 94%
 - Patient Burns = 100%
 - Surgical Errors = 100%

DATA STORY III

IP

- **N= 21**
- Units include all medical-surgical units, all ICUs, all IMCs, and all pediatric units, and peri-natal unit.
- **Data Points & Current Status:**
 - Falls W/Injury = 90%
 - HAPI 2+ = 90%
 - MDRHAPI = 100%
 - CAUTI = 84%
 - CLABSI = 80%
 - CDIFF = 65%
 - MRSA = 95%
 - PPIV Infiltrates = 100% (NICU, pediatrics, PICU)
- **Data Measures:**
 - Falls W/Injury per 1,000 Pt. Days
 - HAPI & MDRHAPI % surveyed patients
 - Other data points are total numbers

WHY DID IT TAKE SO LONG?

- The UMC journey to P2E Designation took 5-years.
- The Magnet journey to Designation has taken 9-years.
- Work on both journeys were continual with collateral efforts. A dual journey was a deliberate strategy.
- **Root Challenges:**
 - Lacked complete infrastructure and programs focused on professional nursing and clinical excellence
 - Jaded non-engaged nursing workforce
 - Lacked a well educated, complimentary nursing leadership team with a vision
 - UMC did not participate in NDNQI nor had nursing ever done a nurse satisfaction survey
 - Inconsistent to poor inter-professional and physician relationships
 - Engage nurses and other clinicians to actively solve their own issues and care delivery problems
 - Transition from “the way we’ve always done it” or “that’s what we have been told to do so we do it” culture to an evidence-based data driven culture who empowers every clinician work at the top of their education, license, and certifications
- **Majority of first time Magnet designees without P2E take 10-years to designate.**

COST DATA: ONGOING

ONGOING COST MEASURES	AMOUNT
Daisy Recognition	\$7,200/Annually or \$600/Month
statue	
certificate	
pin	
Baked Goodie Tray	
Research Day	\$3,000/Annually
Posters	Donated by UNLV SON
Printed Materials	
Certificates	
Ribbons	
CEUs	
Refreshments	
Shared Governance Activities	\$22,800/Annually
Monthly Unit Based Council	Based on 40 hours/month @ average salary of \$42/hour for both UBC and Council Day. \$1,680/Month or \$20, 160/Annually
Monthly Council Day- System Councils	
Unit Boards	\$2,640/Annually or \$10/Month/UBC or \$220/Month
n= 22 UBC	
n= 8 System Councils	
Multi-Disciplinary Clinical Ladder	
2022	\$50,000 (Level 1= \$6,500/Level 2= \$11,000/Level 3= \$19,500)
2023	\$69,000 (Level 1= \$6,500/Level 2= \$22,000/Level 3= \$40,500)
YTD 2024	\$48,000 (Level 1= \$10,500/Level 2= \$15,000/Level 3= \$22,500)
Dedicated FTEs	
P2E/Magnet Coordinator	\$122,720/Annual Salary plus 42% benefit load \$211,586
Senior Analyst	\$116,480/Annually plus 42% benefit load \$200,827
Eliminated Director	
Contract	
Healthlinx	
Magnet Excellence Agreement- June 29, 2023	\$295,350 broken into two installments \$176,810 paid in 2023 \$118,540 paid February of 2024
Addendum- August 29,2024	\$47,250 to write the most difficult 45 SOEs for the document

P2e & MAGNET COSTS 2018-2024

P2E COST MEASURES	YEAR	AMOUNT
Initial Application Fee	2018	\$2,500
Appraisal Fee/Document Submission	2019	\$50,000
Request for Additional Information	2020	\$1,800
Interim Reporting Fee	2021	\$1,200
TOTAL		\$55,500
Re-Designation Application Fee	2023	\$3,750
Re-Designation Appraisal Fee/Document Submission	2024	\$33,125
TOTAL		\$36,875
		\$92,375

MAGNET COST MEASURES	YEAR	AMOUNT
Magnet Application Fee	2024	\$6,000

SUMMARY OF EXPECTED COSTS

P2E

- Application Fee= \$3,750
- Based on Bed Size (400-599)
 - Appraisal Fee= \$33,125
 - Annual Payment Year 1-3= \$11,042
- **ONCE MAGNET WILL DROP OR RUN-OUT DESIGNATION**

MAGNET

- Application Fee= \$6,000
- Based on Bed Size (400-599)
 - Appraisal Fee= \$30,823
 - Annual Payment Year 1-3= \$10,275/Year

QUESTIONS?



OPEN

The Business Case for Magnet[®] Designation

Using Data to Support Strategy

Karen Neil Drenkard, PhD, RN, NEA-BC, FAAN

The Magnet[®] journey has increased in relevance as the sources of evidence reflect the complex role of the nurse in quality, safety, and the patient care experience. Creating a business case to secure the resources required to embark and travel on the Magnet journey is an essential tool for the chief nurse. Identifying expenses, cost savings or avoidance, and return on investment for nursing services are all important elements of a business case.

Through managing the global pandemic, it has become obvious that the RN workforce contributes to quality patient care in a pivotal role. The pandemic has highlighted the need for a strategy to ensure that the nursing workforce is valued and recognized in a meaningful way and that their well-being is addressed. Nurses are leaving their current jobs and, in some cases, the profession at an incredible rate. In 2021, 62% of hospitals in the United States reported an RN vacancy rate higher than 7.5%. According to a recent survey by Nursing Solutions, Inc,¹ less than a quarter of hospitals had an RN vacancy rate less than 5%. High percentages of RN vacancies can negatively impact hospitals.² Since 2016, “the average hospital has turned over about 83% of its RN staff and 90% of its overall workforce, with the cost of turnover for a bedside RN ranging between \$28,400 and \$51,700, enough to cause many hospitals to lose be-

tween \$3.6 and \$6.5 million per year.”² Chief nurses must reenergize and reprioritize efforts for long-term retention and support of professional nursing practice versus short-term retention strategies that do not address the reasons for the vacancies. One significant cost expenditure during the pandemic has been the extraordinary need and reliance on agency and traveler nurses due to resignations of RNs.³ Reports in some markets describe fees of \$12000/wk for each RN, paying up to \$250/h. On the basis of average reported traveler use, hospital costs are estimated at \$17 million dollar increases in annual labor budgets for an average 500-bed healthcare facility.⁴

The Importance of Magnet[®]

Magnet designation and the preceding journey are more important than ever as the sources of evidence (SOEs) reflect the role of the nurse in quality, safety, and the patient care experience.⁵ As the Magnet SOEs continue to emphasize and require outcomes in the top benchmarks, the attainment of Magnet status is an external signal that quality, service, and patient-centered care are visible and alive in the organization. There are currently approximately 580 Magnet-designated organizations, about 9% of US hospitals. In addition, Magnet recognition is a signal to the nurses in the organization, and the nurses considering joining the organization, that there is a commitment to nursing. Creating a business case to secure the resources required to embark on the Magnet journey will be an essential tool for the chief nursing officer (CNO). Each CNO should create a framework of the goals that they hope to achieve through both the Magnet journey and the Magnet designation over time.

Lake et al⁶ conducted a meta-analysis of the nursing work environment and 4 sets of outcomes. The researchers examined nurse job outcomes, safety and quality ratings, patient outcomes, and patient satisfaction. There are consistent significant associations

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The author declares no conflicts of interest.

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DOI: 10.1097/NNA.0000000000001182

between the work environment and all outcome classes; better work environments were associated with lower odds of negative nurse outcomes, higher patient satisfaction, and better quality and safety outcomes. Magnet recognition has been reported to have a positive effect on quality, safety, mortality, patient experience, and RN turnover and vacancy.⁶ Mounting evidence leads to a quantifiable business case for Magnet, and a review of the evidence will be shared.

History of the Magnet Recognition Program®

In an essay, Dr Muriel Poulin,⁷ one of the co-researchers of the original Magnet hospital study, shared how the researchers took a different research approach to examining the root causes of hospital nursing turnover. Rather than examine reasons why RNs left their jobs, researchers focused on the driving forces that resulted in organizations with low RN vacancy and turnover rates. The combination of identifying factors that attracted and retained professional nurses was combined with identified factors reported from hospitals with clinical excellence. The identification of elements that were important to nurses—autonomy in practice, shared governance, collaboration, and teamwork; and opportunities for career development through clinical ladders, professional development, and continuing education—continues to be highly valued by professional nurses today.⁷

Why Consider Magnet?

Haller et al^{8(p334)} state: “It is not the destination that matters, but the transformational journey that accompanies the effort where the true gains lie for most healthcare organizations.” Nursing leadership must examine their organization’s challenges and work toward a performance-driven culture fostered by the Magnet journey. Positive outcomes found in Magnet hospitals compared with non-Magnet hospitals reinforce the value of nursing. More than 30 years of research is highlighted here with samples of findings:

- Higher nurse job satisfaction⁹
- Higher likelihood among nurses to communicate about errors and participate in error-related problem solving,¹⁰ thereby contributing to improved patient safety
- Higher adoption of National Quality Forum safe practices in Magnet organizations¹¹
- Lower patient fall rates¹²
- Lower risk-adjusted rates of 7-day mortality, nosocomial infections, and severe intraventricular hemorrhage of very low-birth-weight infants¹³
- Lower nurse-reported adverse events¹⁴
- Lower rate of nurse occupational injuries¹⁵
- Higher patient satisfaction¹⁶

- Lower rate of catheter-associated urinary tract infections¹⁷
- Lower patient mortality¹⁸
- Lower failure to rescue¹⁹
- Lower odds of having a hospital-acquired pressure injury²⁰

With several decades of literature supporting the improvements in key clinical, nurse, and patient outcomes, working to leverage the Magnet framework to organize and elevate nursing services in an organization is worthy of the CNO’s strategic consideration. The process of assessing the organizational nursing services’ strengths and opportunities or gaps against the Magnet SOEs that are evidence-based and proven to improve outcomes is a meaningful approach to ensuring excellence in clinical quality. Although there are costs associated with obtaining Magnet recognition, there is a body of evidence that points to the multiple opportunities to demonstrate the return on investment (ROI). Identifying expenses, cost savings, or avoidance and ROI are all important elements of a business case. Rather than being seen as a “cost,” nursing care must be seen as an investment to deliver safe and high-quality care resulting in positive patient outcomes and nursing excellence.

Developing the Business Case: A Nursing Imperative

Increasingly, the CNO has a responsibility to articulate the value of nursing services.²¹ The COVID-19 pandemic has elevated the importance of this quantification. Nurses have been the foundation of care delivery during the pandemic, and the presence, innovation, knowledge, and demonstration of caring science made an indelible impression on the world. Attention to the nursing work environment and mental health needs of the nursing workforce requires structural changes in care delivery and professional practice models, and these imperatives are also in alignment with the SOEs. The SOEs highlight the contribution of nurses to improved quality outcomes, cost avoidance, and increased patient satisfaction, thus further substantiating the value recognized during the pandemic.

The development of a business case^{22,23} is “a strategic tool for change”^{22(p414)} and can help organizations make choices regarding the investment of resources. The creation of a business case for adopting or continuing the Magnet journey is essential for a CNO to ensure that there is stakeholder support and resources dedicated to address core requirements to obtain and maintain nursing excellence. Key elements of the business case include addressing strategic fit, program objectives, review of options, affordability, and achievability. Business cases should outline expected quantifiable results and benefits, as well as

risks and costs. In addition, identifying a plan for areas that are projected to improve should be accompanied by metrics and targets with a timeline for achieving the benefits. Developing a strong partnership with the chief financial officer (CFO) is a vital component to building the business case for Magnet. The CNO should be jointly accountable for achieving identified outcomes along with other key executive team members.

Building the Business Case for Magnet

There are several important steps in building a business case. The CNO must ensure that seeking Magnet recognition is aligned with the strategic priorities of the organization as well as the organizational vision and mission. A strategic plan for nursing services must be developed. Seeking Magnet designation demonstrating nursing excellence should be an important strategic effort reflected in the nursing strategic plan. Even if the CNO decides that timing is not right to apply for Magnet recognition, organizing nursing services around the Magnet conceptual model and SOEs will build a strong foundation for excellence in nursing care.

Conducting an internal and external stakeholder analysis as a 1st step is a critical process that should be carefully conducted. A stakeholder analysis includes identifying the people involved in the process, including the executive team and the Board of Trustees; understanding their level of support; and developing a plan to engage them along the journey. Without this level of thoughtful analysis, the CNO could be down the path in implementing and addressing the Magnet standards when plans could be derailed. Honestly identifying the potential objections or obstacles to obtaining Magnet recognition is important for the CNO. It is essential to develop a list of the core leaders, peers, staff, and influencers initially to gain support.

Many resources are available to a nurse executive to build a business case. A good example is available on the Agency for Healthcare Research and Quality website²⁴. The example uses a toolkit for building the case to prevent pressure injuries. An example of a stakeholder analysis and building a business case on a smaller scale are included in the toolkit, which could easily be adapted to building a business case for the pursuit of Magnet recognition.²⁴

Identifying ROI Opportunities

Decades of literature support that Magnet-recognized organizations have better outcomes in clinical care, nursing workforce, and patient experience. The CNO must identify the outcomes that are directly attributable to excellence in nursing care and areas

where strengthening the structure and process of nursing care delivery can lead to organizational cost savings. Identifying the potential cost savings, cost avoidance, and reputational and market benefits²⁵ of being Magnet designated require a comprehensive look at opportunities within the organization. Cross walking the improvement opportunities with the challenges that are present in each organization must be done to present a compelling reason to invest in the Magnet journey. Working collaboratively with the CFO to get an estimate of the attributable cost savings that can be obtained by meeting performance improvement targets will help the CNO gain evidence to support the financial expenditures. For organizations with robust cost accounting financial systems, determining the actual organizational costs for adverse events is a better way to strengthen CNO and CFO partnerships and ownership of a Magnet environment as a best practice and organizational goal.

During COVID-19, the need for agency nurses impacted the areas where surges were highest. These costs were extraordinary with some hospitals paying traveling nurses as much as \$12,000 weekly⁴ and agencies up to \$250/h. Hospitals in need of nursing staff have little choice but to pay the rates demanded or close beds. High-rate hikes shifted the finite supply of nurses toward more affluent areas and healthcare organizations, often leaving rural and urban public hospitals short-staffed.⁴ Creating a recruitment and retention strategic plan that lessens the reliance on agency nurses is a critical 1st step for the CNO. Partnerships with schools of nursing for recruitment strategies and using the Magnet framework to bolster retention efforts will aid the efforts. Clearly articulating the value that nurses bring to improved quality and clinical outcomes and patient experience will assist in value-based purchasing program²⁶ introduced by Centers for Medicare & Medicaid Services, while also having a financial benefit for the organization. The hospital value-based purchasing program encourages hospitals to improve the quality, efficiency, patient experience, and safety of care that Medicare beneficiaries receive during acute care inpatient stays to improve patient outcomes and recognize hospitals that provide high-quality care at a lower cost. Table 1 outlines the areas that the literature supports and that contribute to ROI opportunities and the implications for chief nurses.

Identifying the Expenses

Once the ROI opportunities are identified in areas of clinical quality, RN turnover and vacancy, agency cost reduction opportunities, and improved patient experience, the next important activity to build a business case is to outline the expenses. In the case of

Table 1. Selected ROI Opportunities and the Implications for Chief Nurses

Area of ROI Opportunity	Evidence	CNO Implications
Clinical quality and patient safety		
Patient falls	Lower fall rates in Magnet hospitals. Each prevented fall saved \$34294. ²⁷⁻³¹	Assess organization's current fall rate Set a target for improvement Work with the CFO to identify cost avoidance
Communication of errors and near misses	Improved patient safety ¹⁰	Analyze organizational data to determine cost avoidance
Failure to rescue	Lower failure to rescues resulting in improved mortality ^{32,33}	Identify cost of failure to rescue; set a target for improvement
Hospital-acquired pressure injuries	Lower hospital-acquired pressure injuries (HAPIs in Magnet hospitals ²⁴)	Cost of HAPI ranges from \$20900 to \$151700 per pressure ulcer. The AHRQ study suggested \$14506 as an estimate for pressure injury cost/case when hospital acquired. ²⁴ Identify current hospital-acquired pressure injuries. Set a target for improvement and calculate direct cost and estimate between \$14506 and \$43180 per event.
CLABSI, CAUTI (2017), and nosocomial infection rate	Costs of all hospital-acquired conditions ³⁴⁻³⁶ estimate CAUTI costs at \$13793 (range, \$5019-\$22568) per case. CLABSI costs estimated at \$48108 (range, \$27232-\$68983) per case.	Costs of CAUTI estimated at \$13793 and CLABSI at \$48108 for each case. Identify current hospital-acquired CLABSI and CAUTI. Set a target for improvement and calculate direct cost and estimate at \$13793 for each CAUTI event and \$48108 for each CLABSI event avoided.
Nursing satisfaction		
RN turnover	RN turnover: nurses (28%) less likely reporting intention to leave in Magnet hospitals ⁶	Each RN who leaves costs the organization approximately between \$28400 and \$51700. Determine cost for each percentage point of reduction in turnover. Identify turnover reduction cost savings and align with a recruitment and retention plan and a nurse satisfaction plan.
RN job satisfaction	Job satisfaction higher in Magnet hospitals than non-Magnet ⁶	Determine the number of new nurses needing to be hired to reduce agency. Develop an aggressive recruitment and retention plan engaging clinical nurses in the plan. Align recruitment strategies with the Magnet journey. Partner with human resources, CFO, and marketing to implement the plan. Strengthen academic/practice partnerships to ensure a predictable flow of new graduates. Implement a nurse residency program so that new graduates commit to the organization.
Agency use	Reports in some markets of agency staffing fees of \$12000/wk for ¹ RN = \$300/h ^{3,4} Each RN who leaves costs the organization approximately between \$28400 and \$51700. For every 20 travel RNs eliminated, a hospital can save, on average, \$3084000. ^{1,36}	
Patient satisfaction		
Patient satisfaction	Magnet hospitals are 16% more likely to have satisfied patients. ⁶	Patient experience benefits to having higher HCAHPS scores can be directly linked to nursing care. Capture increased reimbursement gains due to higher patient satisfaction score.
Financial outcomes		
Net inpatient income	On average, Magnet hospitals receive an adjusted net increase inpatient income of \$104.22-\$127.05 per discharge after becoming a Magnet—translating to additional \$1229770—\$1263926 in additional income/ ¹²	Calculate your inpatient revenues pre and post Magnet designation.

(continues)

Table 1. Selected ROI Opportunities and the Implications for Chief Nurses, Continued

Area of ROI Opportunity	Evidence	CNO Implications
Readmission rates	30-day readmission rates reported lower in Magnet hospitals ³⁷ Reports of 2499 hospitals in 2021 penalized for high readmission rates ³⁸ The average penalty is a 0.64% reduction in payment for each Medicare patient stay from the start of this month through September 2021. The fines can be heavy, averaging \$217000 for a hospital in 2018, according to Congress' Medicare Payment Advisory Commission. ³⁹	Calculate your readmission rates along the Magnet journey and pre and post Magnet designation. Determine improvement target and calculate cost impact of lower readmission rates.
Value-based purchasing measures	Average readmission cost of \$15200. ³⁷ Hospitals known for nursing excellence perform better on value-based purchasing measures. ^{39,40}	Work with CFO to determine nursing contribution to value-based purchasing measures.
Efficiency and effectiveness due to innovation SOEs	New knowledge, innovation, and improvement sources of evidence provide opportunity to identify nursing's value to cost effectiveness.	Calculate cost savings on innovation projects and include them in the ROI calculation

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; CAUTI, Catheter associated urinary tract infection; CLABSI, Central line blood-stream infection; HAPI, Hospital acquired pressure injury; HCAHPS, Hospital Consumer assessment of healthcare providers and systems.

Magnet recognition, identifying the costs of the application fee, the document submission and appraisal fees, the site visit fees for travel, and the ongoing annual fees is quantifiable. To aid in this, in January 2021, the American Nurses Credentialing Center (ANCC) changed the fee structure to be more predictable across budget years and better spread out the cost for a 4-year period.

As an example, for a 500-bed hospital, the document submission appraisal and support fee when an organization applies is \$39050.⁴¹ This new cost structure allows an organization to better predict the payments over 4 years. Table 2 shares the fee structure for a 500-bed hospital as of the end of 2021. Total 4-year fees in 2022 are \$78 100 (excluding site visit travel expenses).

Other costs can be incurred with the Magnet journey such as consultants and document writing editing services, but these are optional. The resources that the ANCC provides to applicants are robust, including assessment tools, strategies for conducting gap analyses, webinars, and Magnet analyst consultation support. In addition, the introduction of a Web-based, online application and document storage system called ADAM is an excellent repository for an organization's Magnet documents. The document library allows multiple users to store and manage documents in the account.

Generally, in developing a business case, “the costs should be those over and above the normal costs for running a nursing care service within a hospital.”^{23(p269)} The costs of implementing a substantial

quality infrastructure, data capture, and shared governance processes are evidence-based approaches to managing a healthcare system and should not be included in direct costs of Magnet expenses based on widespread adoption across settings. Therefore, estimates of costs for the Magnet journey can be estimated at approximately \$250000, depending on bed size and organizational resources.²³

Determining Hospital ROI

The ROI “is an understandable and easily calculated metric for determining the efficiency of an investment.”^{42(p1)} The ROI analysis provides the CNO with a percentage of return and also allows the comparison of other efforts and initiatives that the organization might be considering. The CNO needs to consider all costs that the Magnet journey might involve above those efforts that are needed to deliver patient care. The CNO must also consider all benefits that

Table 2. Magnet Fees for a 500-Bed Hospital

Assumption: 500-Bed Hospital ⁴¹	
Description of Fee	Amount
Application fee	\$6000
Appraisal and support fee for document submission	\$41395
Year 1 annual support service fee	\$13799
Year 2 annual support service fee	\$13799
Year 3 annual support service fee	\$13799
Total fees (without site visit travel)	\$88792

can reasonably be achieved. These targets should be set in partnership with the CFO, the chief human resource officer, and the chief executive officer.⁴³

Once agreement with the executive team has been reached on the expected financial benefits and the anticipated costs, the formula for ROI can be applied. The CNO should determine the cost savings and financial benefits, subtract the expenses, and divide by the costs of the Magnet journey and then multiply by 100 to determine the ROI in a percentage format. For example, to determine the ROI of a quality improvement project on a unit that will cost \$25,000 to implement and yields \$35,000 in increased reimbursement, the ROI would be expressed as

$$\frac{\text{Project benefit (35000)}}{\text{Project costs (25000)}} = \frac{10,000}{25,000}$$
$$= 0.4 \times 100 = 40\% \text{ return on investment}$$

The ROI determination is meant to make a credible effort to determine the benefit as a result of the intervention or program put in place and its impact on the improvement.

Leverage the SOEs

A review of the 2023 manual,⁴⁴ SOE reveals an opportunity for the CNO to leverage the standards to create a positive work environment where nurses want to work, attends to nurses' well-being, and addresses racial disparities in healthcare. The "Future of Nursing"⁴⁵ report clearly identified the role of the nurse as a critical lever to address the inequity in health outcomes. The "Future of Nursing" report and the new AACN Essentials⁴⁶ both speak to the important role of nurses in leveling the playing field in healthcare outcomes, to eradicate racism and health disparities so that all people receive the care that they need and deserve.

The COVID-19 pandemic heightened the awareness of systemic racism in healthcare. The complex interrelationship of factors, namely, unequal access to education, employment, housing, healthcare, and other systems, resulted in increased vulnerability of persons of color during the pandemic. The role of the nurse in identifying and addressing health inequities is vital. Nurses can provide primary, preventive, and chronic disease care in especially vulnerable populations.⁴⁷ Nurses have an important leadership role in addressing these disparities. The organizational requirements for Magnet designation require organizations to share how they are addressing these equity disparities.

Ultimately, all these efforts maximize the value on investment of nursing services. Table 3 provides

a selected look at the SOEs and provides guidance to link the SOE examples with the value that nurses bring.

Implications for International Chief Nurses

February and Holmes⁴⁸ presented a case study of an international hospital that revealed a 5-year savings of \$2.3 million through improvement in hospital-acquired infection, falls, and pressure injuries, along with nurse retention and better management of consumable goods. The authors highlighted the importance of tracking and trending progress in clinical quality and nurse outcome improvement and linking the cost savings to the Magnet journey. Adding to the evidence, Oshodi and colleagues⁴⁹ identified important aspects of the work environment related to nurse-assessed care quality measures in the United Kingdom. International CNOs need to evaluate their country's payment system, but investing in nursing services can be linked to improved patient outcomes.

Role of the Chief Nurse Executive

Exemplifying transformational leadership is no easy feat, and the last 2 years managing a pandemic has challenged even the most seasoned CNOs and the nursing leadership teams. The foundations of the forces of magnetism are evidence-based practices that result in excellence in clinical outcomes, patient experience, and nurse satisfaction. These include leadership visibility, accessibility, and communication; creating an environment where shared governance is fostered and clinical nurses are integral to decision making; and professional practice models that are in place that foster interprofessional teamwork, career development, autonomy in practice, and appropriate resource allocation. The role of the CNO is paramount in obtaining and maintaining Magnet designation. Excellent communication skills and engaging stakeholders, from the bedside to the board room, is critical. Building stakeholder support, which includes peers on the executive team, clinicians, the physician community, community members, and the Board of Trustees, is an important step in the Magnet journey. The articulation of the ROI for nursing excellence has never been more important, because resources are stretched.

Chief nurses and their nursing leadership teams have to clearly explain the benefits of a strong nursing service and explain that the ROI is robust when appropriate resources are applied to developing excellent nursing practice. The investment in resources comes with a nursing leadership responsibility to be accountable toward achieving the outcomes. Chief nurses need to be willing to monitor and evaluate the outcomes of the investment in the professional

Table 3. Leveraging the SOEs for Cost Capture: Selected Opportunities

2023 Domain/SOE	Potential Cost Capture	Impact and Value
Transformational leadership		
TL3EO Strategic planning	An improved patient outcome that aligns with a goal in the nursing strategic plan and creates value for the organization	When developing or revising the nursing strategic plan, work to impact an outcome that clearly demonstrates value, cost avoidance, or cost savings.
TL4 Advocacy and influence	Advocacy at VP, nurse manager, and clinical nurse level for resources that map to goals. Link resources obtained to goals such as reducing agency spend, improving retention efforts, and creating a predictable supply of new hires.	Evaluate carefully where resources obtained would impact cost efficiency, improved clinical or quality outcomes.
TL5 Nurses' well-being	Investment in nurses' well-being can be linked to reduction in turnover and vacancy rates.	A more stable work environment created by lower turnover
TL6 Organizational change	Consider a goal of improving value in interprofessional care models, care delivery redesign	Maximize the impact of nursing practice, which may result in cost savings
TL 8EO Nurse participation in organization-level decision-making group	Choose an improved patient outcome project that includes clinical nurses in the decision-making process	Links to lower cost/case or reduced length of stay, avoidable costs, or direct cost savings
TL 9 Mentoring plan at all levels	Mentoring plans and succession planning reduces costs of recruitment efforts and executive search firm fees	Avoid disruptions in service due to transitional and interim leadership
TL 10 Succession planning		
TL11 EO Advocacy for resources	Use the resource acquisition in an ROI model	Directly link resources that improved quality and lower costs
Structural empowerment		
SE1EO Professional development	Capture the financial impact of improved outcomes as result of nurse participation in an organization committee	Think strategically about clinical nurse appointments to committees that can demonstrate cost effectiveness
SE2EO Strategy involving organizational participation and professional organization participation	Capture the financial impact of improved outcomes as result of nurse participation in a professional organization	
Exemplary professional practice		
Organizational overview for workplace environment	Magnet requires a plan in place for caregiver well-being, diversity, equity and inclusion efforts, and zero tolerance for bullying, incivility, and workplace violence. The chief nurse should work to determine the ROI of these programs on turnover and vacancy rates.	All of these programs are well documented in the literature to create a positive work environment, which in turn decreases turnover and vacancy rate. Efforts to put these plans in place can be a recruitment tool and a retention strategy.
EP1EO Evidence-based practice changes	Improved patient outcomes (such as falls, infection rates, mortality, hospital-acquired pressure ulcers) can be linked directly to lower costs.	This evidence, supported by a professional practice model, can support the CNO efforts to articulate the value of professional nursing practice.
EP3EO Nurse satisfaction	Nurse satisfaction can be directly linked to intention to stay, turnover, and vacancy rate.	The chief nurse should consider focusing on resources and staffing, autonomy, and fundamentals of quality nursing care to capture the biggest ROI for the Magnet journey.
New knowledge, innovations, and improvements		
NK2 Research	Consider advocating for a research study that will improve cost outcomes of nursing care	New knowledge generation improves patient care outcomes.
NK7 Innovation	Consider the value proposition of innovation, and capturing the potential for saving time, money, and increased efficiency	Innovation is "establishing new ways of achieving high quality, effective, and efficient care." ^{44(p14)}
NK 8EO Technology	Conduct pre-post evaluation of cost savings with technology solutions for improving care	A technology-enabled outcome can often lead to cost savings or cost avoidance.
NK9EO Redesign of workflow	Conduct pre-post evaluation of cost savings with workflow redesign for improving care	A redesign of workflow that results in an improved outcome can often lead to cost savings or cost avoidance.

Abbreviation: VP, vice president.

practice model. Plans need to be created to track costs, identify progress on improvement, and work with the CFO to understand the ROI of excellence in nursing care. The time is ripe to reset the organization-nurse relationship based on value for concurrent quality and cost improvement.⁵⁰ The critical role nurses play in creating value depends on the work environment described by the Magnet model.

Summary

The potential for professional nursing practice to be dismantled by hiring less educated nurses, changing skill mix, and increasing patient loads during workforce shortages is a reality. Chief nurses need to work strategically to resist quick fixes and rely on evidence-based structures and processes that result in lower turnover and vacancy rates. The Magnet program outlines an evidence-based approach to creating a positive work environment that supports clinical excellence. The larger issue is that nursing services are viewed as an expense, rather than an investment. A change that needs to occur is how the value of nursing care is measured. "Accurately measuring the cost of nursing care is one of the requirements to more precisely measure the value of nursing care, conceptualized as the comparison of nursing intensity or costs and patients' health outcomes."^{50(p214)} Yakusheva et al⁵¹ put forward the concept of value in nursing practice, balancing quality with cost, and adopting value-informed nursing practice. For nurse executives, this means looking at nursing services as human capital versus a nursing resource expense and under-

standing "that nurses are a highly qualified professional whose value contributions are strengthened by knowledge, skills, and talents embedded in each individual nurse."^{52(p1)} This presents an opportunity for the CNO to present a compelling business case.

Whether you obtain Magnet recognition or not, using the Magnet framework and working on the Magnet journey of addressing gaps in leadership, decision making, professionalism, and outcome improvement will guide a CNO to create a positive work environment where nurses are engaged, feel valued, and have autonomy in practice.⁵²⁻⁵⁵ Using the framework to achieve clinical excellence is a strategic decision that can yield positive clinical, nurse, and patient outcomes.

These are extremely challenging times for nurse leaders. Chief nurses need to work to create a robust and caring environment where understanding workforce needs drives the support that is required. There is an opportunity to leverage the Magnet SOEs to increase and sustain the nursing workforce in a meaningful way. Even during a pandemic, foundational efforts must be attended to because there is clear evidence that nurses will choose one workplace over another.

Acknowledgments

The author acknowledges Dr Maureen Lal, Director of the Magnet Recognition Program, in providing subject matter expertise on the new sources of evidence for Magnet Recognition® as it relates to this article.

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The Journal of Nursing Administration

Instructions for Authors

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**UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND
PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM**

Issue: HCAPHS/CCAPHS/ICARE4U Program Updates	Back-up:
Petitioner: Patricia Scott, Quality Patient Safety and Regulatory Officer	
Recommendation: That the Governing Board Clinical Quality and Professional Affairs Committee receive an update on HCAPHS/CCAPHS/ICARE4U Program from Jeff Castillo, Director of Patient Experience; and direct staff accordingly. (<i>For possible action</i>)	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
October 7, 2024

Agenda Item #

5



The **Highest Level of Care** in Nevada

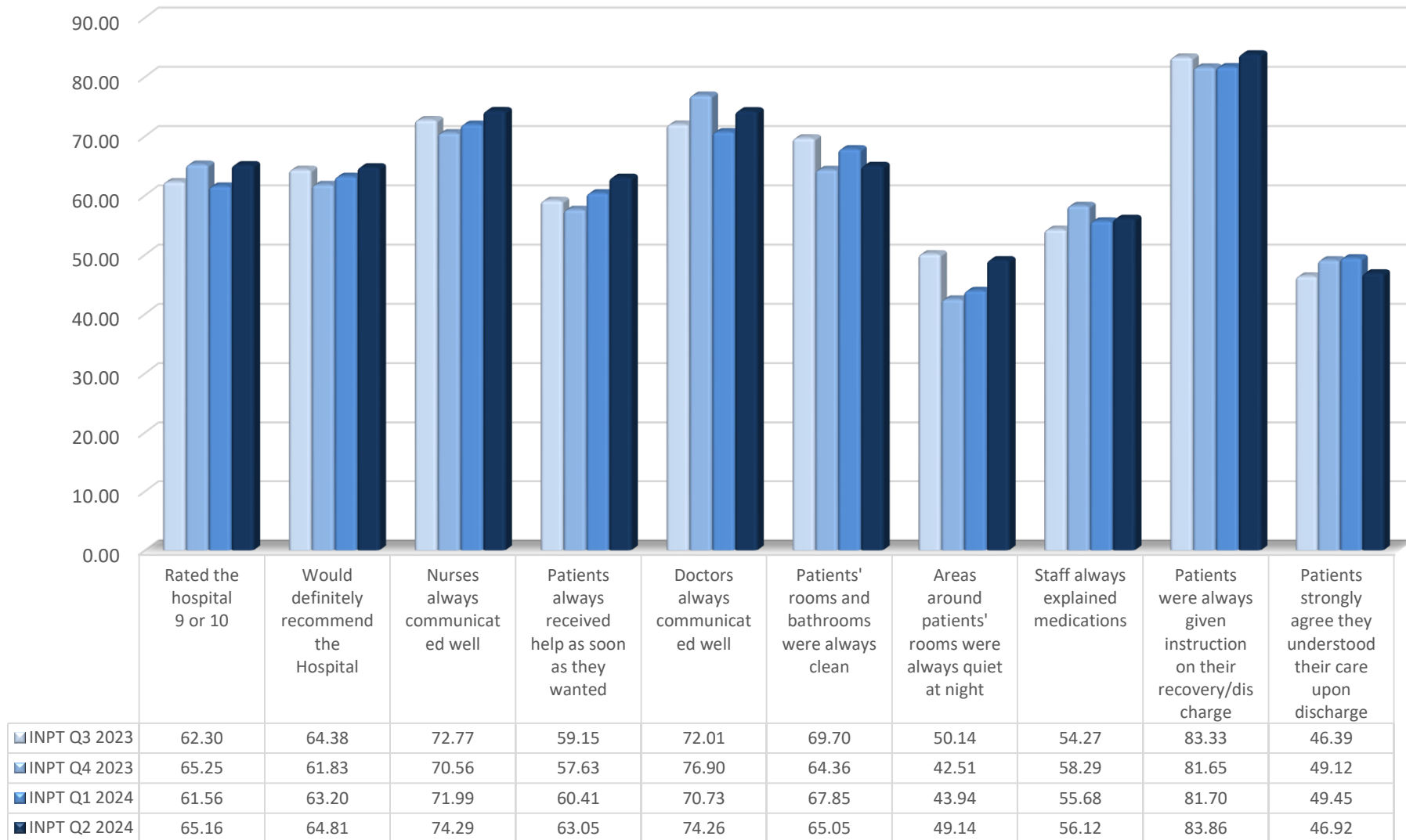
Patient Experience
10/2024

HCAHPS Scores

Q3 2023 – Q2 2024



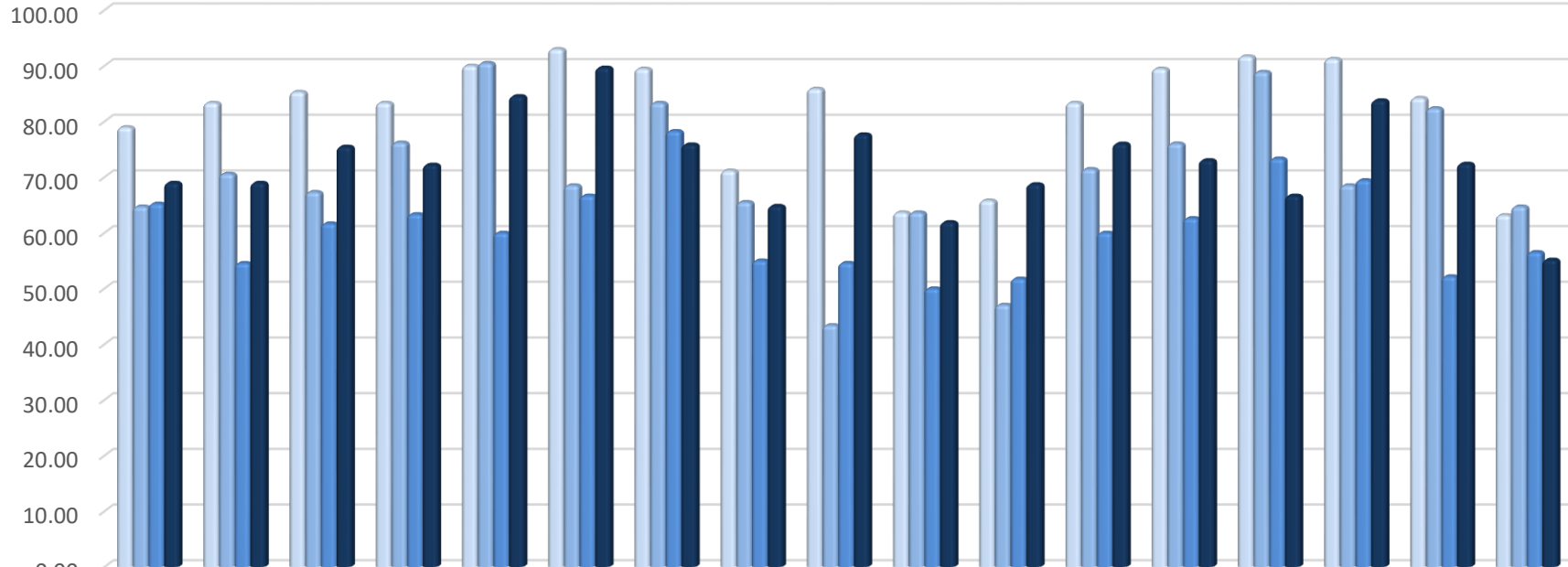
INPATIENT - ADULT



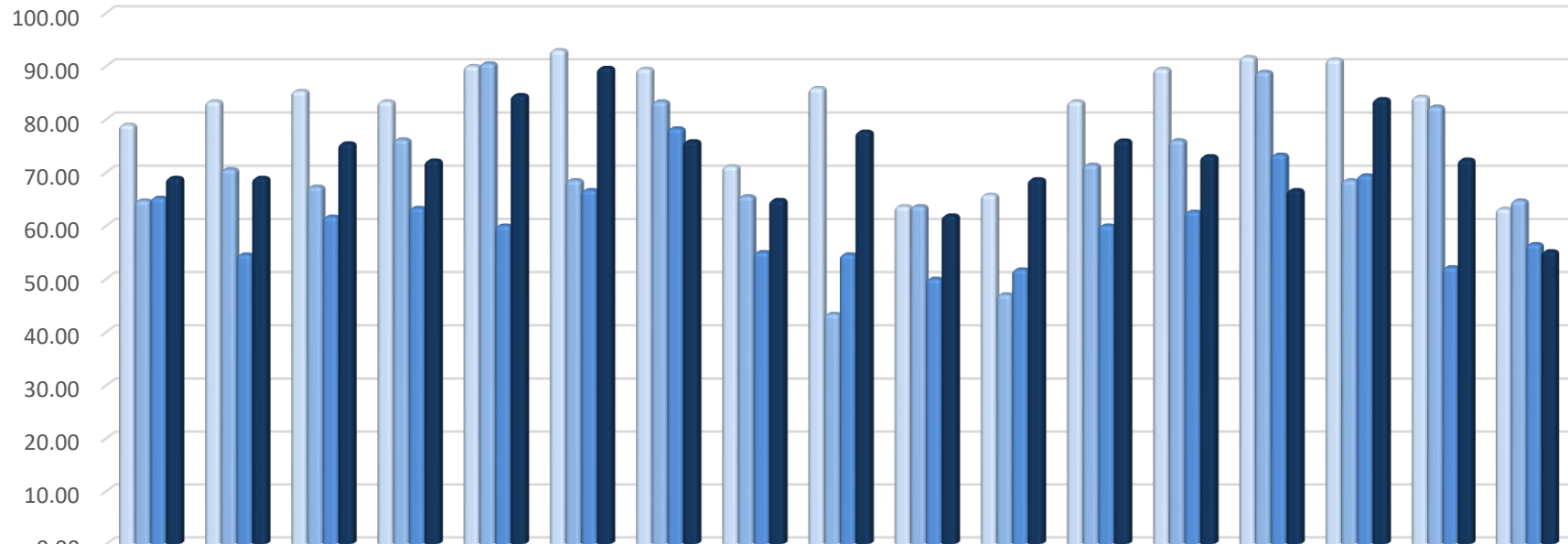
CCAHPS Scores Q3 2023 – Q2 2024



INPATIENT – PEDS Part - 1



Category	INPT PEDS Q3 2023	INPT PEDS Q4 2023	INPT PEDS Q1 2024	INPT PEDS Q2 2024
Rated the Hospital 9 or 10	78.95	64.71	65.22	68.97
Would definitely recommend the Hospital	83.33	70.59	54.55	68.97
Staff always explained medications	85.30	67.31	61.67	75.46
Nurses always communicated well w/ Child	83.33	76.19	63.33	72.22
Doctors always communicated well w/ Child	90.00	90.48	60.00	84.53
Nurses always communicated well w/ You	92.98	68.52	66.67	89.66
MD/RN always gave privacy when discussing Child's care	89.47	83.33	78.26	75.86
Child was always helped to feel comfortable	71.15	65.51	55.01	64.82
Staff always kept you informed about Child's care	85.86	43.40	54.58	77.66
Child always received help as soon as child wanted	63.64	63.64	50.00	61.90
Staff definitely informed you to report concerns about mistakes on Child's care	65.79	47.06	51.76	68.71
Staff definitely paid attention to Child's pain	83.33	71.43	60.00	76.00
Staff definitely prepared you and Child to leave the Hospital	89.47	76.03	62.61	73.04
Staff always involved Teen in their care	91.67	88.89	73.33	66.67
Doctors always communicated well w/ you	91.23	68.52	69.44	83.78
Child's room was always clean	84.21	82.35	52.17	72.41
Areas around Child's room were always quiet at night	63.16	64.71	56.52	55.17



	Rated the Hospital 9 or 10	Would definitely recommend the Hospital	Staff always explained medications	Nurses always communicated well w/ Child	Doctors always communicated well w/ Child	Nurses always communicated well w/ You	MD/RN always gave privacy when discussing Child's care	Child was always helped to feel comfortable	Staff always kept you informed about Child's care	Child always received help as soon as child wanted	Staff definitely informed you to report concerns about mistakes on Child's care	Staff definitely paid attention to Child's pain	Staff definitely prepared you and Child to leave the Hospital	Staff always involved Teen in their care	Doctors always communicated well w/ you	Child's room was always clean	Areas around Child's room were always quiet at night
INPT PEDS Q3 2023	78.95	83.33	85.30	83.33	90.00	92.98	89.47	71.15	85.86	63.64	65.79	83.33	89.47	91.67	91.23	84.21	63.16
INPT PEDS Q4 2023	64.71	70.59	67.31	76.19	90.48	68.52	83.33	65.51	43.40	63.64	47.06	71.43	76.03	88.89	68.52	82.35	64.71
INPT PEDS Q1 2024	65.22	54.55	61.67	63.33	60.00	66.67	78.26	55.01	54.58	50.00	51.76	60.00	62.61	73.33	69.44	52.17	56.52
INPT PEDS Q2 2024	68.97	68.97	75.46	72.22	84.53	89.66	75.86	64.82	77.66	61.90	68.71	76.00	73.04	66.67	83.78	72.41	55.17

UMCSN Board Reporting

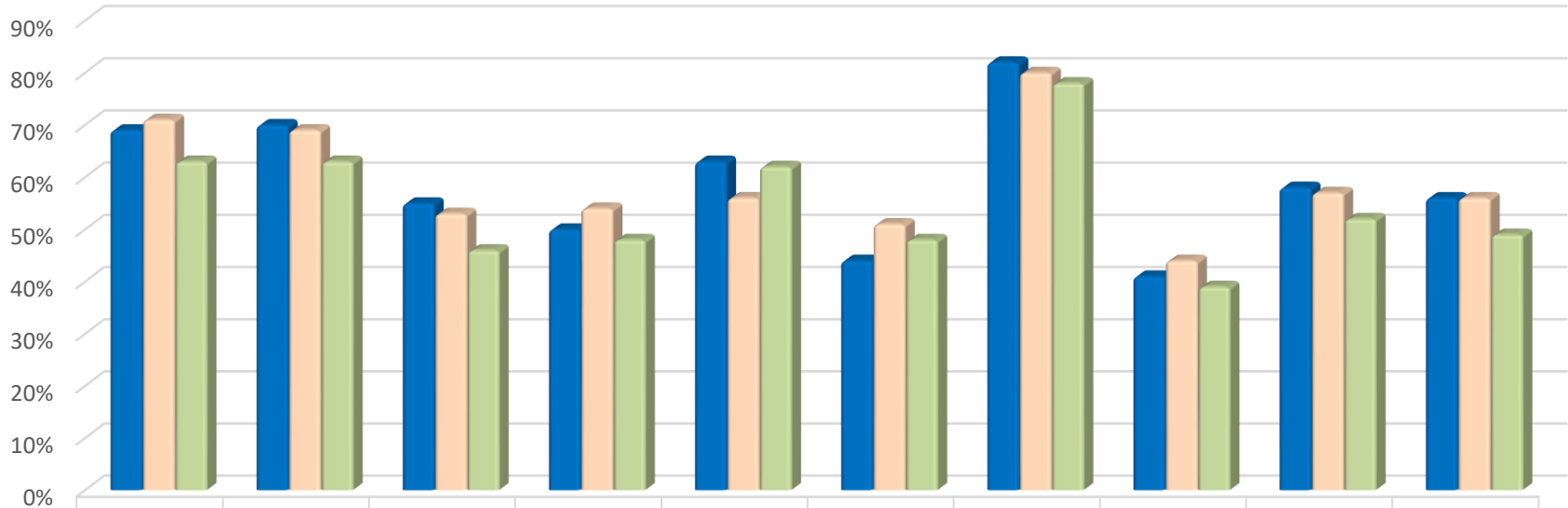
CY2021 - CY 2023 Table View

Measure	2021 Top Box	2022 Top Box	2023 Top Box
Primary Care: How well nurse/asst listened	70.43	72.72	75.36
Primary Care: How well CP listened to you	86.43	88.41	89.43
Quick Care: How well nurse/asst listened	65.42	69.01	75.14
Quick Care: How well CP listened to you	66.08	66.34	71.73
InPatient: Communication with nurses	71.54	69.82	71.84
InPatient: Communication with doctors	73.00	71.84	73.69

Data Parameters:

PC/QC data is eAdjusted for individual questions, inpatient data is adjusted for CMS reportable responses at the domain level. HCAHPS communication with nurses/doctors domain includes three individual questions (treat would courtesy/respect, listen carefully to you, explain in a way you understand).

State and national CMS benchmarks are from most recent CMS Hospital Compare Preview Report



	Patient who reported that their nurses "Always" communicate d well.	Patient who reported that their doctors "Always" communicate d well.	Patients who reported that they "Always" received help as soon as they wanted.	Patients who reported that the staff "Always" explained about medicines before giving it to them.	Patients who reported that their room and bathroom were "Always" clean.	Patients who reported that the area around their room was "Always" quiet at night.	Patients who reported that YES, they were given information about what to do during their recovery at home.	Patients who "Strongly Agree" they understood their care when they left the hospital.	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	Patients who reported YES, they would definitely recommend the hospital.
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■ UMCSN	69%	70%	55%	50%	63%	44%	82%	41%	58%	56%
■ VALLEY HOSPITAL	71%	69%	53%	54%	56%	51%	80%	44%	57%	56%
■ SUNRISE HOSPITAL	63%	63%	46%	48%	62%	48%	78%	39%	52%	49%

UMC outperforms Sunrise 9 of 10 elements

OVERVIEW	UMCSN	VALLEY HOSPITAL	SUNRISE HOSPITAL
Overall Star Rating	★ ★ ☆ ☆ ☆	★ ★ ☆ ☆ ☆	★ ☆ ☆ ☆ ☆
Patient Survey Rating	★ ★ ☆ ☆ ☆	★ ★ ☆ ☆ ☆	★ ☆ ☆ ☆ ☆

UMC outperform/tie Valley 6 of 10 elements

Updates and ongoing specific to Patient Experience

- UOTW – Unit of the Week Rounds (#3). Previous UOTW, Data with comments for leaders
- Optimizing EMS Experience – Outreach orientation and EMS new hires, increased tours, improved communication and knowledge sharing opportunities, improved amenities and EMS satisfaction.
- Data – Experience Scores/comments broadly available/posted in different areas for all staff. Custom needs
- Physician lounge – Positive comments from survey displayed on napkin holders, changed bi-weekly
- Increased experience rounding in units, focused on communication and real time resolve – mitigate complaints/grievance. Weekend support
- Celebrating Quality Care – CLABSI/CAUTI achievements
- ICARE 5.0 – refreshing with focus on experience and service recovery – *The ART!*
- Rollin with the Best – Rebranding celebrations for amazing work and accomplishments
- Optimizing ICARE – educating new hires, newly on boarded, and refreshers
- Supporting Needs/requests:
 - Magnet – Top 4 (incorporated)
 - QC to ED – Optimize transfer/ops
 - Call Center – Education
 - EMS Linen – Operation/cost savings
 - Nurse HCAHPS – support
 - Etc...

We Roll with the Best

ICARE



UMC's Experience Team recently celebrated our colleagues from the Trauma Intensive Care Unit team. The group received cinnamon rolls in recognition of their dedication to their patient care and 500 days CLASSI free. Thank you for going above and beyond for the care of our patients. We truly are Rollin' with the Best!



We Roll with the Best

ICARE

UMC's Experience Team celebrated our colleagues from the Plant Ops team on May 28. These team members help to ensure everything inside and outside the campus continues to function with little to no disruption in their colleague's daily work. Their knowledge and dedication to our mission reminds us we truly are Rollin' with the Best!



We Roll with the Best

ICARE

UMC's Southern Highlands Primary Care team was celebrated by colleagues from the UMC Experience Team on July 16. The team members were celebrated for their hard work and for bringing the UMC ICARE principles to the community they serve.



We Roll with the Best

ICARE

UMC's Experience Team celebrated our colleagues from the Supply Chain Services team on July 8. These team members help to ensure that both patients and staff are never without the vital supplies or orders they need. These behind-the-scenes heroes work tirelessly to bring the goods into your hands. Their continuing dedication reminds us we truly are Rollin' with the Best!



**UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND
PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM**

Issue: UMC Policies and Procedures	Back-up:
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	
Recommendation: That the Governing Board Clinical Quality and Professional Affairs Committee review and recommend for approval by Governing Board, the UMC Policies and Procedures Committee’s activities of August 7, 2024 including the recommended creation, revision, and /or retirement of UMC policies and procedures; and take any action deemed appropriate. <i>(For possible action)</i>	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
October 7, 2024

Agenda Item #

6

August 7, 2024 Hospital Policy / Procedure Committee

As part of our regular policy review, the attached policies have been reviewed and updated by necessary hospital leaders/experts in order to reflect current regulatory rules and industry standards. A summary of the changes to each policy is included below.

Total of 36 Approved, 0 Retired

POLICY NAME	NEW/ REVISED	HPP COMMITTEE DECISION	SUMMARY
<u>Urinalysis: Siemens Clinitek Status Connect with Siemens Multistix Reagent Strips</u>	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager and Laboratory Services Director.
<u>CLINITEK Status® Analyzer using Clinitest® Human Chorionic Gonadotropin (hCG) Pregnancy Test</u>	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by General Lab Services Manager and Laboratory Services Director.
<u>Timed Collections for Therapeutic Drug Monitoring</u>	Revised	Approved with Revisions	Scheduled review, no changes. Vetted by Quality Assurance Coordinator and Laboratory Services Director.
<u>Case Management- Wellness Center</u>	Revised	Approved as Submitted	Updated with latest RWCM standards-AR. Vetted by Ambulatory Clinical Manager, Ambulatory Executive Director and Medical Director Inpatient & Outpatient Infectious Disease Services.
<u>Evaluation and Care of the HIV Infected Patient in the Outpatient Ambulatory Health Services (OAHS) Setting (Ryan White)</u>	Revised	Approved as Submitted	Reviewed for accuracy-AR. Vetted by Ambulatory Clinical Manager, Ambulatory Executive Director and Medical Director Inpatient & Outpatient Infectious Disease Services.
<u>Outpatient Ambulatory Medical Center (OAMC)</u>	Revised	Approved as Submitted	Reviewed only-AR. Vetted by Ambulatory Clinical Manager, Ambulatory Executive Director and Medical Director Inpatient & Outpatient Infectious Disease Services.
<u>Ryan White Vision Benefits</u>	Revised	Approved as Submitted	Reviewed for latest HRSA requirements-AR. Vetted by Ambulatory Clinical Manager, Ambulatory Executive Director and Medical Director Inpatient & Outpatient Infectious Disease Services.
<u>Standard of Care for Dentures (Ryan White)</u>	Revised	Approved as Submitted	Updated with latest RW dental standards-AR. Vetted by Ambulatory Clinical Manager, Ambulatory Executive Director and Medical Director Inpatient & Outpatient Infectious Disease Services.
<u>Imposition of Charges (Ryan White)</u>	Revised	Approved as Submitted	Merged two previous policies to one (Nominal fee and Annual Cap). Vetted by Finance and Wellness.

<u>Subcontractors – Ryan White</u>	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Ambulatory Clinical Manager, Infectious Disease Medical Director and Executive Director Ambulatory Care.
<u>Clinic Hours/ After Hours</u>	New	Approved as Submitted	New policy. Vetted by Wellness.
<u>Pulmonary Function Test Protocols</u>	Revised	Approved as Submitted	Updated to align with current practice. Vetted by Ambulatory Care Clinical Director.
<u>Political Activities Within the Workplace</u>	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Human Resources and Chief Human Resources Officer.
<u>Employee Communication</u>	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Human Resources and Chief Human Resources Officer.
<u>Additional Compensation and Notice of Additional Employment</u>	Revised	Approved as Submitted	Scheduled review, no changes. Vetted by Director of Human Resources and Chief Human Resources Officer.
<u>TD-100® Automated Trans-esophageal (TEE) Ultrasound Probe High Level Disinfecter</u>	Revised	Approved as Submitted	Edit to TD-100 Operation section was added to reflect the use of disposable transport container for transporting TEE probe. Vetted by Sterile Processing Manager.
<u>Biological Monitoring of the "STERRAD®" Sterilizer</u>	Revised	Approved as Submitted	Updated the biological from 30 to 15 minutes. Vetted by Sterile Processing Manager.
<u>Case Management Process</u>	Revised	Approved as Submitted	Scheduled review, no changes. Added to new template. Vetted by Care Management Manager and CFO.
<u>Concurrent Review by External Agencies</u>	Revised	Approved as Submitted	Scheduled review, no changes. Added to new template. Vetted by Care Management Manager and CFO.
<u>Focused Professional Practice Evaluation (FPPE) Policy for Newly Privileged Practitioners</u>	Revised	Approved as Submitted	Updated section II to remove non-applicable requirements. Vetted by Medical Staff.
<u>NICU – Sibling Visitation</u>	Revised	Approved as Submitted	Updated to New template, updated references and added the Lippincott reference. Vetted by NICU Manager, Charge Nurses and Dr. Banfro.
<u>NICU Oral Care with Expressed Human Milk/Colostrum</u>	Revised	Approved as Submitted	Updated references, corrected typos. Updated when oral care should be provided. Vetted by NICU Manager, Charge Nurses and Dr. Banfro.
<u>Use of Biological Specimens for Research (IRB)</u>	Revised	Approved as Submitted	Added to new template. Scheduled review, no changes. Vetted by Clinical Research and Compliance Director and CQPS.
<u>Implantable Devices</u>	Revised	Approved as Submitted	Added to new template. Scheduled review, no changes. Vetted by Director Cardiovascular Services and ACNO.

<u>Electrophysiology Studies - EP Studies</u>	Revised	Approved as Submitted	Added to new template. Scheduled review, no changes. Vetted by Director Cardiovascular Services and ACNO.
<u>Adult Tracheostomy Care</u>	Revised	Approved as Submitted	Updated to new template; updated policy for simplification; Updated related policies; added related procedures; updated references. Approved by Critical Care Committee.
<u>Adult Tracheostomy Tube Change</u>	Revised	Approved as Submitted	Reviewed and moved to new template. Procedure brought in line with Lippincott Procedures for tracheostomy tube change/replacement. Approved by Critical Care Committee.
<u>Vendor Relations and Conflicts of Interest</u>	Revised	Approved as Submitted	Increased amount in vendor allowed gifts to reflect general increase in costs. Vetted by Compliance Officer.
<u>Contracted/Non-Employee Requirements</u>	Revised	Approved as Submitted	Changes to employee health requirement; Certification of Good Health addition. Vetted by Employee Health and HR.
<u>IV Administration and Therapy</u>	Revised	Approved as Submitted	Updated IV tubing continuous to 7 days to mimic CVC policy. Vetted by Director of Infection Prevention and ACNO.
<u>Chlorhexidine Gluconate (CHG) Daily Bathing</u>	Revised	Approved as Submitted	New template; med-surg added to daily bath; nasal decolonization added. Vetted by Director of Infection Prevention & Medical Director Inpatient/Outpatient Infectious Disease.
<u>Media, Social Media, Website/Blog Posting, and Printed Materials/Items</u>	Revised	Approved as Submitted	Updated Information to Include Media Policy. Vetted by Brand and Public Relations Director and Legal.
<u>Materials Management Information System (MMIS) Item Add or Changes</u>	New	Approved as Submitted	New policy. Vetted by Revenue Integrity Analyst, Management Analyst, Director of Patient Accounting and Revenue Integrity and Director Materials Management and Supply Chain.
<u>Charge Capture and Reconciliation Policy</u>	New	Approved as Submitted	New policy. Vetted by Revenue Integrity Analyst, Director Patient Accounting and Revenue Integrity and Compliance Officer.
<u>Preoperative Skin Cleansing with Chlorhexidine Gluconate (CHG) and Preoperative Oral Care</u>	Revised	Approved as Submitted	New policy format; Changed CHG to PM and AM prior to surgery; added nasal decolonization. Vetted by Director of Infection Prevention/Control.
<u>CT Reconstruction of Images</u>	New	Approved as Submitted	New protocol created for CT reconstruction of images by work group that included: Chief of Staff, Chief Medical Officer, Medical Director of Imaging, Medical Director of Emergency Department, Director of Imaging Services, Executive Director of Support Services, and Quality/Safety/Regulatory Officer.

**UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND
PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM**

Issue: UMC Medical and Dental Staff Bylaws and Rules and Regulations	Back-up:
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	
<p>Recommendation:</p> <p>That the Governing Board Clinical Quality and Professional Affairs Committee recommend approval by the UMC Governing Board of the proposed amendments to the UMC Medical and Dental Staff Bylaws and Rules & Regulations; as approved and recommended by the Medical Executive Committee on September 24, 2024; and take any action deemed appropriate. (<i>For possible action</i>)</p>	

FISCAL IMPACT:

None

BACKGROUND:

The Governing Board is responsible for the review and approval of the UMC Medical and Dental Staff Bylaws and Rules & Regulations, subject to final approval by the Board of Hospital Trustees. At its meeting on September 24, 2024, the UMC Medical Executive Committee recommended approval of amendments to the Medical and Dental Staff Bylaws and Rules & Regulations, subject to the completion of the approval process set forth in Bylaws, Part I, Section 9.

A summary of the proposed revisions to the Medical and Dental Staff Bylaws and Rules & Regulations have been provided for your convenience. For a complete review of the proposed amendments, please see the attached red-line version of the UMC Medical and Dental Staff Bylaws and Rules & Regulations.

Cleared for Agenda
October 7, 2024

Agenda Item #

MEDICAL STAFF SERVICES

SUBJECT: Summary of University Medical Center of Southern Nevada Medical and Dental Staff Bylaws & Medical and Dental Staff Rules and Regulations Proposed Revisions (in **Red** and **Green**)

DATE: September 24, 2024

Part I: Governance

2.6 Medical Staff Members Responsibilities

2.6.8

Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

~~All medical history and physical examinations must be completed and documented by a physician, an oral and maxillofacial surgeon, advanced practice registered nurse or Advanced Practice Professional in accordance with State law and hospital policy. A medical history and physical examination shall be completed for each patient at the hospital as follows:~~

- ~~i. For each hospital inpatient, patient under observation, or patient requiring anesthesia services, a complete medical history and physical examination shall be completed no more than seven (7) days before or twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within seven (7) days before admission or registration.~~
- ~~ii. For each hospital outpatient procedure requiring only moderate sedation, a focused medical history and physical examination shall be completed no more than thirty (30) days before or twenty four (24) hours after admission or registration, but prior to surgery or procedure. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty four (24) hours after admission or registration, but prior to surgery or a procedure, when the medical history and physical examination are completed within thirty (30) days before admission or registration.~~
- ~~iii. For patients receiving specific outpatient surgical or procedural services that do not require moderate sedation or anesthesia, an assessment of the patient, in lieu of a comprehensive history and physical examination, may be~~

~~completed and documented after registration, but prior to surgery or a procedure, when performed in accordance with the policies established by the medical staff. The assessment must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.~~

~~The requirements related to complete history and physical examinations, focused history and physical examinations, and assessments in lieu of history and physical examinations are further delineated in the Rules and Regulations.~~

2.6.13

Each practitioner will abide by the current Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association or the ethical standards governing the Member's practice. The Member shall also agree to abide by any applicable codes of conduct adopted by the Medical Staff and Hospital.

Section 3. Categories of the Medical Staff

3.4 Refer and Follow Category

3.4.1 Qualifications

The Refer and Follow category shall consist of Physicians who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty or other reasons, but who wish to remain affiliated with the Hospital for referral of patients or other patient care purposes.

3.4.2 Prerogatives: Appointees to this category may:

- a. Refer patients for outpatient diagnostic testing and specialty services provided by the Hospital.
- b. Refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment.
- c. Visit their hospitalized patients, review their Hospital medical records and may communicate with the attending physician, but shall NOT be permitted to admit patients, to attend patients, to exercise any Privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the Hospital. They are encouraged to attend educational programs sponsored by the Hospital or Medical Staff and attend meetings of the full Medical Staff.

3.4.3 Responsibilities: Appointees of this category shall:

- a. Meet the basic responsibilities of Medical Staff membership, as defined in Article 3.3 Credentials Procedures Manual.
- b. Not vote on Medical Staff matters or hold office.
- c. Acknowledge that appointment and reappointment to the Refer and Follow Staff is a courtesy which may be terminated by the Board upon recommendation of the MEC with thirty (30) days written notice, without right to process, as set forth in

these Bylaws,

- d. Conduct themselves at all times in a manner that will not diminish or tarnish the reputation of the Medical Staff or Hospital.
- e. Exempt from FPPE and OPPE requirements

3.5 Medical Officers of the Armed Forces of the United States – Military Rotator Category

3.5.1 Qualifications:

The Military Rotator category shall consist of practitioners who are authorized to provide medical care under the direct supervision of an attending at the Hospital as part of a training or educational program to further the employment of the medical officer, pursuant to an authorized agreement under NRS 449.2455 and any other applicable laws or regulations.

3.5.2 Prerogatives:

- a. Provide care when under the direct supervision of an appropriately privileged practitioner and the care is part of a training, or educational program designed to further the employment of the medical officer.

3.5.3 Responsibilities:

- a. Meet the basic responsibilities of Medical Staff membership, as defined in Article 3.4 Credentials Procedures Manual.
- b. Comply with any applicable Medical Staff or Hospital policies or procedures.
- c. Meet all standards and/or requirements under any applicable training affiliation agreement entered into between the hospital and the Armed Forces of the United States.
- d. Exempt from FPPE and OPPE requirements

5.2 Qualifications, Selection, Term, and Removal of Department Chiefs and Vice Chiefs

5.2.1 Department Chiefs and Vice Chiefs of exclusively contracted department, **whether exclusive through contract or hospital employment**, shall be governed by the contract **or assigned by the hospital, as applicable**.

5.2.3 For non-exclusively contracted departments, Department Chiefs and Department Vice Chiefs shall be elected by plurality vote of the Active members of the Department, subject to ratification by the MEC. An incumbent shall automatically be placed on the ballot without requiring nominations if he/she still wishes to run for election. **An incumbent Department Chief must have satisfied the attendance requirements set forth in Part I, Section 7.5.2 of these Bylaws to be eligible for re-election.**

5.2.4 Automatic Removal of elected Chiefs and Vice Chiefs: The Department Chief or Vice Chief may be automatically removed from his/her position if he/she no longer meets the qualifications of the position as defined in these Bylaws.

- e. **Failure to satisfy attendance requirements for the MEC meeting as set forth in Part I, Section 7.5.2 of these Bylaws**

5.2.6 If a Department Chief is removed through **these processes or resigns for any other reason**, the Vice Chief shall assume the position of Chair and a new election for Vice Chief will occur within thirty (30) days. **If a Vice Chief declines to assume the position of Department Chief, an election for a new Department Chief will occur within thirty (30) days.**

7.4.3 Quorum

Department meetings or Medical Staff committees other than those listed in 7.4.2 above: **A quorum will exist for Medical Staff Department meetings when at least fifty percent (50%) of the Department members are present. Medical Staff Departments having more than five (5) subspecialties may satisfy the quorum requirement by the attendance of fifty percent (50%) of Subspecialty Heads. For Medical Staff committees other than those listed in Section 7.4.2 above, a quorum will exist when at least fifty percent (50%) of the committee members are present.**

7.5.2 Attendance Requirements

MEC, Credentials Committee, and Professional Improvement Committee meetings: Members of these committees are expected to attend at least ~~two-thirds (2/3rds)~~ **seventy-five percent {75%} of the meetings held. A MEC member's absence may be excused upon a finding of good cause by the Chief of Staff.** Failure to meet the attendance requirements will result in removal of the member from the committee.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

- a. Composition: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff, the Department Chiefs, four (4) At-Large Members, the Credentials Committee Chair, the Professional Improvement Committee Chair, the Bylaws Committee Chair, and the Advanced Practice Professionals Committee Chair. The chair of the MEC will be the Chief of Staff. The non-voting members will include the CEO, Chief Operating Officer (COO), **Chief Medical Officer (CMO)**, Chief Nursing Officer (CNO), the Dean of the School of Medicine, and the Director of the Office of Military Medicine.

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

Section 3. Corrective Action

3.1 Automatic Relinquishment/Administrative Suspension/Voluntary Resignation

3.1 Automatic Relinquishment/~~Administrative Suspension~~/Voluntary Resignation

In the following triggering circumstances, the practitioner's privileges and/or membership will be

considered ~~automatically~~ relinquished, ~~administratively~~ suspended, or limited as described, and the action shall be final without a right to hearing. ~~The Chief of Staff may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. Except when otherwise specified below, if the triggering circumstances have not been resolved within thirty {30} days, the practitioner will be deemed to have voluntarily resigned their UMC Medical Staff membership and clinical privileges. Thereafter, reinstatement shall require a practitioner to submit a new application for membership and/or privileges.~~

It shall be the responsibility of each practitioner to report immediately to the Chief of Staff any of the following triggering circumstances or any proceeding, investigation, complaint, ~~arrest~~, or charge that might result in any of the following triggering circumstances.

Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. ~~The Chief of Staff may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within thirty days, the practitioner will have to reapply for membership and/or privileges.~~ In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following triggering circumstances occur:

3.1.4 Medical Record Completion Requirements

A practitioner's ~~will be considered to have voluntarily relinquished the~~ privilege to admit new patients or schedule new procedures ~~shall be administratively suspended~~ whenever s/he fails to complete medical records within time frames outlined in the Electronic Health Record System policy. This ~~relinquishment-suspension~~ of privileges shall not apply to patients admitted or already scheduled at the time of suspension, to emergency patients, or to imminent deliveries. The ~~relinquished~~ ~~suspended~~ privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 Professional Liability Insurance

The minimum amount per occurrence shall be \$1,000,000.00 with a minimum aggregate of \$3,000,000.00. ~~Employed~~ Physicians, dentists, podiatrists, ~~and other licensed practitioners employed by UMC~~ will provide a UMC Certificate of Insurance and Statement of Indemnification pursuant to Section 41.038 of the Nevada Revised Statutes. The Advanced Practice Professional covered under the policy of his or her sponsor is required to submit a copy of the sponsor's policy and rider with a statement signed by the sponsor stating that the Advanced Practice Professional is covered under that policy, when applicable. Failure of a practitioner to maintain professional liability insurance in this manner shall result in ~~an immediate administrative suspension automatic-relinquishment~~ of a practitioner's clinical privileges. ~~Within thirty (30) days of suspension, the suspended practitioner must present proof of adequate professional liability insurance, including coverage for any acts or potential liabilities that may have arisen during the period of any lapse in coverage (prior acts coverage). A practitioner who fails to provide evidence of appropriate coverage after thirty (30) days shall be deemed to have voluntarily resigned Medical Staff membership and clinical privileges.~~ The practitioner must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.6 Medical Staff dues/fees/assessments:

A practitioner's Medical Staff membership and clinical privileges shall be administratively suspended for any failure to promptly pay Medical Staff dues or any fees or assessments. ~~shall be considered an automatic relinquishment of a practitioner's appointment.~~ If ~~within 30 calendar days after written warning of the delinquency~~ the practitioner does not remit such payments ~~within thirty (30) calendar days after written warning of the delinquency,~~ ~~the practitioner shall be considered to have voluntarily resigned membership on the Medical Staff~~ the practitioner will be deemed to have voluntarily resigned their UMC Medical Staff membership and clinical privileges

3.1.8 Failure to Satisfy the Special Appearance Requirement

A practitioner having received two notices and who fails without good cause to appear at a meeting where his/her special appearance is required under these Bylaws shall ~~be considered to have automatically relinquished~~ have all clinical privileges, with the exception of emergencies and imminent deliveries, ~~administratively suspended~~. These privileges will be reinstated when the practitioner complies with the special appearance requirement. Failure to comply within ~~thirty (30) calendar days~~ will be considered a voluntary resignation ~~from the~~ of the practitioner's Medical Staff membership and clinical privileges.

3.1.9 Failure to participate in an Evaluation

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these Bylaws, Rules and Regulations, or Medical Staff/hospital policies (whether an evaluation of physical or mental health of clinical management skills, or of fitness to practice), shall ~~be considered to have automatically relinquished all privileges~~ have all privileges ~~administratively suspended~~. Subject to the findings of any such evaluation, these privileges may be restored following the practitioner's compliance with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation ~~of the practitioner's Medical Staff membership and clinical privileges.~~ ~~from the Medical Staff.~~

3.1.10 Failure to become Board Certified

A practitioner who fails to become board certified in compliance with the eligibility criteria set forth in the Delineation of Privileges form of his or her Department will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges, ~~unless an exception is granted, for a good cause, by the Board upon recommendation from the MEG.~~

3.1.11 Failure to Meet UMC Vaccination Requirements

Unless approved for a medical or religious exemption from such requirement, ~~any practitioner's Medical Staff membership and clinical privileges shall be administratively suspended if the practitioner who~~ fails to submit proof of full vaccination in accordance with UMC hospital policies. ~~shall be considered to have automatically relinquished all privileges.~~ If the practitioner

~~fails to~~ submits proof of compliance with UMC hospital vaccination policies within thirty {30} calendar days of notice of the ~~automatic relinquishment administrative suspension~~, the practitioner's ~~privileges may be reinstated. Thereafter, the member~~ will be deemed to have voluntarily resigned ~~from the staff and must reapply for staff membership and privileges the practitioner's Medical Staff membership and clinical privileges.~~

3.1.12 Failure to Execute Release and/or Provide Documents

A practitioner's ~~Medical Staff membership and clinical privileges shall be administratively suspended if the practitioner~~ who fails to execute a general or specific release of information and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner. ~~shall be considered to have automatically relinquished all privileges. If the release is executed~~ A practitioner's continued failure to execute the requested release of information or provide the requested ~~and/or~~ documents ~~provided~~ within thirty {30} calendar days of notice of the ~~automatic relinquishment administrative suspension shall be deemed a voluntary resignation of the practitioner's Medical Staff membership and clinical privileges., the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.~~

3.1.13 MEC Deliberation

~~As soon as feasible after action is taken or warranted as described above~~ In the event of an automatic Relinquishment, administrative suspension, or voluntary resignation, the MEC, in its sole discretion, ~~shall~~ may convene to review and consider the facts ~~related to the action., and~~ The MEC may ~~decline to take any further action or may~~ recommend such further corrective action as it ~~may~~ deems appropriate following the procedures generally set forth in these Bylaws.

4.2 Hearings Will Not Be Triggered by the Following Actions

- t. Change in assigned staff category; ~~including, without limitation, the termination of membership in the Honorary Recognition or Refer & Follow category;~~

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Chief of Staff or designee. In the event the affected individual does not request a hearing within the time and in the manner required by ~~this policy~~ ~~these~~ Bylaws, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final board action.

4.5 Notice of Hearing and Statement of Reasons

- e. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional

material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties. The date of the commencement of the hearing shall not be more than ninety (90) days from the date of the Notice of Hearing unless otherwise approved by the presiding officer or hearing officer for good cause. However, in no event shall the hearing be postponed or continued for more than one-hundred and twenty (~~150~~120) days following the Notice of Hearing.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses, **so far as reasonably known or anticipated, who are expected to give testimony on behalf of that party at the hearing intended to be called.** Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. **Under no circumstances shall a practitioner harass, retaliate against, or demand a witness to discuss the subject matter of the hearing outside of the hearing process.** The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing. **In general, the individual requesting the hearing shall be entitled, upon specific request, to the following:**

- a. **Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense; and**
- b. **Reports of experts relied upon by the MEC.**

The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing.

~~6.1.1 In general and pursuant to Nevada law, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:~~

~~6.1.2 Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense; and~~

~~6.1.3 Reports of experts relied upon by the MEC.~~

~~No information regarding other practitioners shall be requested, provided, or considered and evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.~~

~~6.1.2 The following types of information shall not be requested, disclosed, or considered during the course of the Fair Hearing:~~

- a. Information regarding practitioners other than the practitioner having requested the Fair Hearing;
- b. Information identifying individually identifiable practitioners or personnel who have participated in the peer review process, other than the practitioner having requested the Fair Hearing;
- c. Information unrelated to the reasons for the adverse recommendation made against the practitioner or the practitioner's qualifications for appointment/clinical privileges.

Furthermore, there shall be no obligation for the MEC and/or Board to modify or create documents to satisfy a practitioner's request for information.

6.1.3 Prior to the disclosure of any information, the practitioner requesting the hearing, the practitioner's counsel, and any expert retained on his behalf shall be required to execute a stipulation agreeing to maintain the confidential, privileged, or private nature of any medical records, expert reports, exhibits, testimony, or other information disclosed, exchanged, or produced during the course of the Fair Hearing. Any records, documents, information, or testimony disclosed to the practitioner during the course of Fair Hearing shall not be used for any purpose outside of the Fair Hearing. The MEC and/or Board shall not be required to disclose any documents to the practitioner absent a stipulation having been executed in accordance with this Section 6.1.

~~6.2.0 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.~~

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to **personally** appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action.

6.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or CEO. **Administrative personnel shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.** All members of the hearing panel shall be present for all stages of the hearing and deliberations.

6.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence **in response.**

Section 7. Appeal to the Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for

appellate review shall be in writing, and shall be delivered to the Chief of Staff and CEO or designee, for delivery to the Board, either in person or by certified mail, and shall include a brief statement of the ~~reasons~~ grounds for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

7.4 Nature of Appellate Review

- a. Appeals shall be heard by an Appellate Review Panel. The chair of the Board shall appoint an Appellate Review Panel composed of at least three (3) members of the Board. In its sole discretion, the Board, as a whole, may elect to sit as the Appellate Review Panel. ~~to consider the information upon which the recommendation before the Board was made.~~ Members of this Appellate Review Panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The Appellate Review Panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the Appellate Review Panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The ~~review panel~~ Appellate Review Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Nevada.
- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Appellate Review Panel ~~review panel~~ may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. ~~If the Board does not elect to serve as the Appellate Review Panel, T~~the Appellate Review Panel ~~review panel~~ shall recommend final action to the Board.
- d. ~~When the Board is not serving as the Appellate Review Panel, T~~the Board shall ~~may~~ affirm, modify, or reverse the recommendation of the Appellate Review Panel ~~review panel~~ or, in its discretion, refer the matter for further review and recommendation. ~~If the Board is serving as the Appellate Review Panel, the Board shall render a final decision in writing within thirty (30) days of hearing the appeal. or make its own decision based upon the Board's legal responsibility.~~

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested. ~~If the Board elects to serve as the Appellate Review Panel, the Board shall render a final decision in writing, including specific reasons for its action, and shall~~

deliver copies thereof to the affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

Part III: Credentials Procedures Manual

1.4.1 Files may be shown to accreditation and licensure agency representatives with permission of the Chief of Staff or designee ~~or as otherwise authorized by the hospital's legal counsel.~~

Section 2. Qualifications for Membership and/or Privileges

2.2.2 Have a current **unrestricted** state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Nevada;

2.2.10 Possess a current **unrestricted** and valid drug enforcement administration (DEA) **with the following schedules 2, 2N, 3, 3N, 4 and 5** and Nevada Pharmacy Certificate of Registration number, if applicable;

Section 3. Initial Appointment Procedure

3.1 Completion of Application

k. Verification of current, active professional liability coverage with limits of at least **\$1,000,000/\$3,000,000** and ~~verification of last 10 years of professional liability coverage;~~ **verification of claims history, if there are no claims, suites, settlements or judgments seek verification for the past five (5) years. If there are claims, suites, settlements or judgment seek verification for the past ten (10) years.**

n. Name of covering provider, who must be a member of the UMC Medical Staff that currently maintains like privileges and practices within the same specialty, for when the practitioner is unavailable unless the practitioner is solely requesting Refer and Follow ~~privileges category~~ (In rare circumstances when there is only one practitioner in a specific specialty, the Department Chief may waive this requirement and recommend coverage by another qualified practitioner with appropriate training, skillset and privileges);

s. ~~Morbidity and mortality data, when available;~~

3.1.2 ~~The Medical Staff office shall not be required to send more than one letter to the practitioner requesting additional or clarifying information.~~

3.1.5

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, ~~(if any) during the past ten (10) years;~~ **if there are no claims, suites, settlements or judgments seek verification for the past five (5) years. If there are claims, suites, settlements or judgment seek verification for the past ten (10) years.**

b. Verification of the applicant's past applicable clinical work experience for at least the past ~~ten (10)~~ **five (5)** years;

k. Information from a criminal background check **as applicable;**

~~m.—Morbidity and mortality data and relevant practitioner specific data as compared to aggregate data, when available.~~

3.3 Refer and Follow Category – Process Requirements

Physicians applying for Refer and Follow category must submit the following items for processing:

- a. Complete abbreviated application and facility specific documents
- b. Current unrestricted Nevada Medical License
- c. Evidence of continuous malpractice insurance coverage, minimum of one (1) million dollars per occurrence, three (3) million dollars in the aggregate with no shared limits of liability or in an amount that may be determined from time to time by action of the Board
- d. Evidence of current vaccinations or formal declination in accordance with hospital policy
- e. One (1) character reference (must be a physician) within knowledge of your abilities within the past two (2) years
- f. Applicable fees

3.4 Medical Officers of the Armed Forces of the United States - Military Rotator Category - Process Requirements

Practitioners applying for Military Rotator category must submit the following items for processing:

- a. Complete abbreviated application and facility specific documents
- b. Current unrestricted US State license
- c. Current Federal DEA, Pharmacy license as applicable
- d. Current Life-support certifications as applicable
- e. Evidence of current TORT malpractice insurance coverage
- f. Military transfer brief
- g. Evidence of current vaccinations or formal declination in accordance with hospital policy
- h. One (1) professional reference (must be a physician with knowledge of your abilities within the past two (2) years.
- i. Applicable fees

3.5.8 Time periods for processing: All individual and groups acting on a complete application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days of the receipt of a completed application.

4.2 Information Collection and Verification

4.2.1 From Appointee:

- d. Failure to provide a complete reappointment application at least sixty (60) calendar days prior to the expiration of the current membership and/or privileges may result in voluntary resignation at the expiration of the current approval cycle.
- i. Verification of current unrestricted licensure, DEA certificate and Nevada Pharmacy license;

5.12 Temporary

Privileges 5.12.1

When granting such privileges, the organized Medical Staff verifies current licensure and current competence and obtains the following documentation:

- a. Unrestricted license to practice in Nevada;
- b. Unrestricted federal DEA registration, as appropriate to specialty;
- c. Unrestricted Nevada Board of Pharmacy registration, as appropriate to specialty;
- d. Proof of professional liability insurance coverage in a certificate form and in amounts satisfactory to the hospital;
- e. Proof of good-standing from primary practicing facility;
- f. Report from the National Practitioner Data Bank;
- g. Proof of Board Certification or eligibility in the practitioner's specialty

University Medical Center of Southern Nevada Medical and Dental Staff Rules and Regulations Part I. Medical and Dental Staff Rules & Regulations

2.1 ADMISSIONS

2.1.1 General

- a. **Admitting Privileges:** A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges. Emergency physicians or their designee may write orders for disposition ~~admitting orders~~ but cannot be the admitting physician of record. Podiatric surgeons and Dentists who do not have full History and Physical privileges will be required to co-admit.

2.5 PROMPT ASSESSMENT

All new admissions must be personally assessed by the attending physician or his/her designated covering practitioner within ~~twelve (12)~~ six (6) hours and have a history and physical examination completed and on the record within twenty-four (24) hours. Patients admitted to intermediate care units must be seen within four (4) hours. Patients admitted to critical care units must be seen within two (2) hours. Unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

3.7 PROGRESS NOTES

3.7.2 Co-signature of Progress Notes

Progress notes documented by APPs do not need co-signature by the physician on medical/surgical units but should include attestation from the APP that the physician is involved in the care of the patient when applicable. Progress notes documented by APPs providing a critical level of care are required co-signature by the attending physician on intermediate care units and critical care units. Progress notes documented by residents or fellows do require co-signature by the physician within ~~one (1) day~~ twenty-four (24) hours, unless the attending physician documents their own note.

4.4 ORDERS

4.4.1 General Principles

f. It is preferred that admission orders be provided by the accepting practitioner or his/her designated covering practitioner within one (1) hour of communication between the Emergency Medicine

practitioner and the accepting practitioner but not to exceed: critical care units within two (2) hours, intermediate care units within four (4) hours and, medical/surgical units within six (6) hours.

4.4.2 Non-Privileged Physician Orders

- d. Current **unrestricted** Nevada Medical License number

4.7.2 Certifying the Cause of Death

Practitioners shall complete death certificates in accordance with Nevada law and the applicable Hospital policy. ~~The attending physician or Advanced Practice Registered Nurse is responsible for certifying the cause of death, and authenticating the Death Certificate within forty-eight (48) hours of death per Nevada law.~~ If the attending physician or Advanced Practice Registered Nurse will not be available within ~~forty-eight (48)~~ **twenty-four (24)** hours of death, the certificate shall be completed by an associate physician who has access to the deceased patient's medical records, the Department Chief, or the Chief of Staff **before the end of the next business day once assigned as the certifier.** In cases of death within the emergency department, the emergency physician will be responsible for certifying the cause of death and completing the Death Certificate in accordance with Nevada laws and regulations.

Section 7. Rules of Conduct

7.3 Health Documentation

All ~~privileged~~ practitioners shall **provide evidence of current vaccinations or formal declination in accordance with follow** the Hospital policies. ~~on Tuberculin (TB) Testing for Medical & Dental Staff and Advanced Practice Professionals (APPs) and vaccinations.~~

Part II. Organization and Functions Manual

Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

1.1.1 Department of Ambulatory Care

- a. **Quick Care**
- b. **Primary Care**
- c. **Telemedicine**

1.1.11 Department of Radiology

- b. **Interventional Radiology**

1.1.12 Department of Surgery

- e. ~~Oral/Maxillofacial Surgery~~ **Dentistry**

Section 2. Medical Staff

Committees

2.1.6 Professional Review Committee

- a. **Composition:** The Professional Review Committee shall consist of the Chief of Staff (or Designee), PRC Chair or PRC Vice-Chair, Chief Medical Officer (CMO), Department Chief or Vice Chief of the relevant Medical Staff Department and up to three (3) additional members of the Active Medical Staff. The PRC Chair and Vice-Chair shall be appointed by the Chief of Staff for a two-year term.

***Language update throughout the Bylaws document and ancillary manuals - “~~The Joint Commission~~” will be replaced with “an applicable CMS approved accrediting organization”

University Medical Center of Southern Nevada
Medical and Dental Staff Bylaws
&
Medical and Dental Staff Rules and Regulations

<u>MEDICAL AND DENTAL STAFF BYLAWS</u>		<u>MEDICAL AND DENTAL STAFF RULES AND REGULATIONS</u>	
Approved By:	Date	Approved By:	Date
Medical Executive Committee	July 25, 2017	Medical Executive Committee	June 27, 2017
Governing Board	August 23, 2017	Governing Board	August 23, 2017
Board of Hospital Trustees	September 5, 2017	Board of Hospital Trustees	September 5, 2017
Revised On:	Date	Revised On:	Date
Medical Executive Committee	July 24, 2018	Medical Executive Committee	July 24, 2018
Governing Board	August 29, 2018	Governing Board	August 29, 2018
Board of Hospital Trustees	September 18, 2018	Board of Hospital Trustees	September 18, 2018
Revised On:	Date	Revised On:	Date
Medical Executive Committee	August 27, 2019	Medical Executive Committee	August 27, 2019
Governing Board	September 25, 2019	Governing Board	September 25, 2019
Board of Hospital Trustees	October 15, 2019	Board of Hospital Trustees	October 15, 2019
Revised On:	Date	Revised On:	Date
Medical Executive Committee	November 24, 2020	Medical Executive Committee	November 24, 2020
Governing Board	December 16, 2020	Governing Board	December 16, 2020
Board of Hospital Trustees	January 4, 2021	Board of Hospital Trustees	January 4, 2021
Revised On:	Date	Revised On:	Date
Medical Executive Committee	May 25, 2021	Medical Executive Committee	May 25, 2021
Governing Board	June 30, 2021	Governing Board	June 30, 2021
Board of Hospital Trustees	July 20, 2021	Board of Hospital Trustees	July 20, 2021
Revised On:	Date	Revised On:	Date
Medical Executive Committee	October 26, 2021	Medical Executive Committee	October 26, 2021
Governing Board	December 15, 2021	Governing Board	December 15, 2021
Board of Hospital Trustees	December 21, 2021	Board of Hospital Trustees	December 21, 2021
Revised On:	Date	Revised On:	Date
Medical Executive Committee	May 27, 2022	Medical Executive Committee	May 27, 2022
Governing Board	August 31, 2022	Governing Board	August 31, 2022
Board of Hospital Trustees	September 20, 2022	Board of Hospital Trustees	September 20, 2022
Revised On:	Date	Revised On:	Date
Medical Executive Committee	October 25, 2022	Medical Executive Committee	October 25, 2022
Governing Board	February 22, 2023	Governing Board	February 22, 2023
Board of Hospital Trustees	March 21, 2023	Board of Hospital Trustees	March 21, 2023
Revised On:	Date	Revised On:	Date
Medical Executive Committee	July 25, 2023	Medical Executive Committee	July 25, 2023
Governing Board	July 26, 2023	Governing Board	July 26, 2023
Board of Hospital Trustees	August 15, 2023	Board of Hospital Trustees	August 15, 2023



Revised On:	Date	Revised On:	Date
Medical Executive Committee	November 23, 2023	Medical Executive Committee	November 23, 2023
Governing Board	February 28, 2024	Governing Board	February 28, 2024
Board of Hospital Trustees	March 19, 2024	Board of Hospital Trustees	March 19, 2024

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UMC MEDICAL STAFF AND DENTAL BYLAWS:

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University Medical Center of Southern Nevada
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MEDICAL AND DENTAL STAFF BYLAWS

Part I: Governance

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at University Medical Center of Southern Nevada in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the University Medical Center of Southern Nevada Board of Trustees.

1.2 Authority

Subject to the authority and approval of the Board of Clark County Commissioners, sitting as the Board of Trustees, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws, associated Rules and Regulations, policies, and under the corporate Bylaws of the University Medical Center of Southern Nevada. Henceforth, whenever the term “the hospital” is used, it shall mean University Medical Center of Southern Nevada; and whenever the term “the Board” is used, it shall mean Board of Trustees or its delegated authority. Whenever the term “CEO” is used, it shall mean the Chief Executive Officer appointed by the Board to act on its behalf in the overall management of the hospital. The term CEO includes a duly appointed acting administrator serving when the CEO is away from the hospital. Whenever the term “Medical Staff” is used, it shall mean those professionally competent licensed practitioners, including physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, and advanced practice registered nurses who have been granted membership to the Medical and Dental Staff of University Medical Center of Southern Nevada in accordance with these Bylaws.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, and advanced practice registered nurses who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, associated Rules and Regulations, policies, and procedures of the Medical Staff and the hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these Bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The Medical Staff will not discriminate in granting staff appointment and/or clinical privileges on the basis of race, color, religion, sex, age, national origin, sexual orientation, gender identity or expression, genetic information, or disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) with the exception of emergency, disaster and temporary privileges. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures Manual) of these Bylaws. A practitioner who fails to meet the minimum qualifying criteria as set forth in Part III of these Bylaws shall be ineligible to apply for Medical Staff membership and/or clinical privileges.

2.6 Medical Staff Members Responsibilities

- 2.6.1 Each staff member and practitioner with privileges, must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.
- 2.6.2 Each staff member and practitioner with privileges must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.
- 2.6.3 Each staff member, consistent with his/her granted clinical privileges, shall participate in the on call coverage of the emergency department or in other hospital coverage programs as defined in the On Call Physician Policy.

- 2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by the officers of the Medical Staff, MEC, Credentials Committee, Chief Executive Officer (CEO), and/or Department Chief when it appears necessary to protect the well-being of patients and/or staff, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician health or impairment.
- 2.6.5 Each staff member and practitioner with privileges must abide by the Medical and Dental Staff Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and hospital, including the Corporate Compliance Code of Conduct.
- 2.6.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the Chief of Staff or designee within thirty (30) days of any and all malpractice claims filed in any court of law against the Medical Staff member or any settlement agreement regarding alleged malpractice which the medical staff member or practitioner may agree to. Failure to properly notify the Chief of Staff shall be grounds for discontinuance of processing of an application or reapplication for staff membership and privileges and/or the relinquishment, or limitation, of staff membership and privileges.
- 2.6.7 Each applicant for privileges or staff member or practitioner with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct, done in good faith and without malice, in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and his/ her credentials.
- 2.6.8 Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.
- ~~a-2.6.9~~ All medical history and physical examinations must be completed and documented by a physician, an oral and maxillofacial surgeon, advanced practice registered nurse or Advanced Practice Professional in accordance with State law and hospital policy. ~~A medical history and physical examination shall be completed for each patient at the hospital as follows:~~
- ~~i. For each hospital inpatient, patient under observation, or patient requiring anesthesia services, a complete medical history and physical examination shall be completed no more than seven (7) days before or twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within seven (7) days before admission or registration.~~

~~ii.—For each hospital outpatient procedure requiring only moderate sedation, a focused medical history and physical examination shall be completed no more than thirty (30) days before or twenty four (24) hours after admission or registration, but prior to surgery or procedure. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty four (24) hours after admission or registration, but prior to surgery or a procedure, when the medical history and physical examination are completed within thirty (30) days before admission or registration.~~

~~iii.—For patients receiving specific outpatient surgical or procedural services that do not require moderate sedation or anesthesia, an assessment of the patient, in lieu of a comprehensive history and physical examination, may be completed and documented after registration, but prior to surgery or a procedure, when performed in accordance with the policies established by the medical staff. The assessment must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.~~

~~b.—The requirements related to complete history and physical examinations, focused history and physical examinations, and assessments in lieu of history and physical examinations are further delineated in the Rules and Regulations.~~

~~2.6.9~~2.6.10 Each staff member and practitioner with privileges agrees that they shall not serve as the attending or consulting practitioner for any member of their own family. Medical Staff members and practitioners with privileges may not schedule or perform operations or procedures on members of their own families in the operating room, procedure rooms, or laboratories except in emergencies when no other qualified member of the Medical Staff is available.

~~2.6.10~~2.6.11 Each staff member and practitioner with privileges will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA rules and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

~~2.6.11~~2.6.12 Each staff member and practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges. Each staff member and practitioner with privileges shall provide true and accurate information during the course of any evaluation, inquiry, or investigation of the practitioner's qualifications, conduct, competency, or suitability for medical staff membership and clinical privileges.

~~2.6.12~~2.6.13 Each practitioner on the Medical Staff shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. Medical staff leadership will deal with conflict of interest issues per the Medical Staff Conflict of Interest Statement.

2.6.14 Each practitioner will abide by the current Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association or the ethical standards governing the Member's practice. The Member shall also agree to abide by any applicable codes of conduct adopted by the Medical Staff and Hospital.

2.7 Medical Staff Member Rights

- 2.7.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Department Chief or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue. The written notice to the Chief of Staff shall adequately describe the matter to be considered by the MEC and contain a recommendation for how to address the issue.
- 2.7.2 Each privileged practitioner has the right to legal counsel, for Medical Staff organizational functions, only when in a fair hearing circumstance.
- 2.7.3 Each staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of these Bylaws, regarding removal and resignation from office.
- 2.7.4 Each staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
- 2.7.5 Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.
- 2.7.6 Each staff member in the Active category may call for a Department meeting by presenting a petition signed by twenty percent (20%) of the members of the Department. Upon presentation of such a petition the Department Chief will schedule a Department meeting.
- 2.7.7 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.
- 2.7.8 Any practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these Bylaws).

2.8 Staff Dues/Fees/Assessments

2.8.1 Annual Medical Staff dues and other fees or assessments, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues, fees, or assessments shall be considered a voluntary resignation from the Medical Staff. The MEC may pass policies that exempt certain categories of membership or members holding specified leadership positions from dues, fees, or assessments.

2.9 Indemnification

2.9.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and Medical Staff.

2.9.2 In accordance with applicable Nevada law, the hospital will provide a defense and shall indemnify a Medical Staff member against damages in connection with any pending or threatened action, suit, or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or Medical Staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

Members of this category must have served on the Medical Staff for at least one year and have:

Been involved in at least twelve (12) UMC patient encounters within the preceding year or twenty four (24) UMC patient encounters within the preceding 2 years (i.e., a UMC patient encounter is defined as a UMC inpatient admission; UMC telemedicine visitation; UMC consultation; UMC inpatient or outpatient surgical procedure; or other patient encounters within UMC hospital or a UMC clinic);

AND

Attended at least three (3) Medical Staff or hospital committee meetings per year.

Additionally, in the interest of patient welfare and continuum of care, members of the Active category must maintain an office and residence within Clark County. Exceptions may be granted by the Medical Executive Committee on a case by case basis. Use of a Post Office Box for a mailing address does not negate the requirement for a Physician, Dentist or Podiatrist to maintain an office and residence in Clark County. It is the Physician's, Dentist's or Podiatrist's responsibility to notify the Medical Staff Office when the location of his/her office address changes within thirty (30) days.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff and hospital, the member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category. Any such appointment shall not be considered a reduction of privileges or adverse action and the practitioner shall not be entitled to the procedural rights under the Fair Hearing Plan.

3.1.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff, department, and subspecialty meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Vote on all matters presented by the Medical Staff, department, subspecialty, and committee(s) to which the member is assigned; and
- c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical and Dental Staff Bylaws, Rules and Regulations, or Medical Staff policies.

3.1.3 Responsibilities

Members of this category shall:

- a. Contribute to the organizational and administrative affairs of the Medical Staff;

- b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and
- c. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

3.2 The Affiliate Category

3.2.1 Qualifications

The Affiliate category is reserved for Medical Staff members who do not meet the eligibility requirements for the Active category. Additionally, in the interest of patient welfare and continuum of care, members of the Affiliate category must maintain an office and residence within Clark County. Exceptions may be granted by the Medical Executive Committee on a case by case basis. Use of a Post Office Box for a mailing address does not negate the requirement for a Physician, Dentist or Podiatrist to maintain an office and residence in Clark County. It is the Physician's, Dentist's or Podiatrist's responsibility to notify the Medical Staff Office when the location of his/her office address changes within thirty (30) days.

3.2.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff, department, committee, and subspecialty meetings of which s/he is a member and any Medical Staff or hospital education programs; and
- b. Not vote on matters presented by the entire Medical Staff or department or be an officer of the Medical Staff.

3.2.3 Responsibilities

Members of this category shall:

- a. Have the same responsibilities as Active category members.

3.3 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. Appointment for this Recognition is entirely discretionary and may be rescinded at any time with or without cause. Procedural or fair hearing rights do not apply to the failure to grant, or termination of, membership to Honorary Recognition. Practitioners granted Honorary Recognition shall consist of those practitioners who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend the General Medical Staff meeting, social and educational meetings of the Medical Staff and continuing medical education activities. They shall not hold clinical privileges, hold office or be eligible to vote. An active member of the Medical Staff shall sponsor and provide information to the MEC regarding a practitioner being recommended for honorary recognition.

3.4 Refer and Follow Category

3.4.1 Qualifications

The Refer and Follow category shall consist of Physicians who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty or other reasons, but who wish to remain affiliated with the Hospital for referral of patients or other patient care purposes.

3.4.2 Prerogatives: Appointees to this category may:

- a. Refer patients for outpatient diagnostic testing and specialty services provided by the Hospital.
- b. Refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment.
- c. Visit their hospitalized patients, review their Hospital medical records and may communicate with the attending physician, but shall NOT be permitted to admit patients, to attend patients, to exercise any Privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the Hospital. They are encouraged to attend educational programs sponsored by the Hospital or Medical Staff and attend meetings of the full Medical Staff.

3.4.3 Responsibilities: Appointees of this category shall:

- a. Meet the basic responsibilities of Medical Staff membership, as defined in Article 3.3 Credentials Procedures Manual.
- b. Not vote on Medical Staff matters or hold office.
- c. Acknowledge that appointment and reappointment to the Refer and Follow Staff is a courtesy which may be terminated by the Board upon recommendation of the MEC with thirty (30) days written notice, without right to process, as set forth in these Bylaws.
- d. Conduct themselves at all times in a manner that will not diminish or tarnish the reputation of the Medical Staff or Hospital.
- e. Be exempt from FPPE and OPPE requirements

3.5 Medical Officers of the Armed Forces of the United States – Military Rotator Category

3.5.1 Qualifications:

The Military Rotator category shall consist of practitioners who are authorized to provide medical care under the direct supervision of an attending at the Hospital as part of a training or educational program to further the employment of the medical officer, pursuant to an authorized agreement under NRS 449.2455 and any other applicable laws or regulations.

3.5.2 Prerogatives: Appointees to this category may:

- a. Provide care when under the direct supervision of an appropriately privileged practitioner and the care is part of a training, or educational program designed to further the employment of the medical officer.

3.5.3 Responsibilities: Appointees of this category shall

- a. Meet the basic responsibilities of Medical Staff membership, as defined in Article 3.4 Credentials Procedures Manual.
- b. Comply with any applicable Medical Staff or Hospital policies or procedures.
- c. Meet all standards and/or requirements under any applicable training affiliation agreement entered into between the hospital and the Armed Forces of the United States.
- d. Be exempt from FPPE and OPPE requirements

Section 4. Officers of the Medical Staff and MEC At-Large members

4.1 Officers of the Medical Staff and MEC At-Large members

- 4.1.1 Chief of Staff
- 4.1.2 Vice Chief of Staff
- 4.1.3 Secretary-Treasurer
- 4.1.4 Immediate Past Chief of Staff

4.2 Qualifications of Officers and MEC At-Large members

- 4.2.1 Officers and MEC At-Large members must be physician-members in good standing of the Active category and be actively involved in patient care in the hospital, have previously served in a significant leadership position of the Medical Staff (e.g. department or subspecialty head, or committee chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have no licensure sanctions, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, and be in compliance with the professional conduct policies of the hospital. The Medical Staff Nominating Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria. The immediate past Chief of Staff attains his/her position by automatic succession from the office of Chief of Staff.
- 4.2.2 Officers and MEC At-Large Members may not simultaneously hold a leadership position (any position in which the Member serves on the MEC or the Board) on another hospital's Medical Staff.

4.3 Election of Officers and MEC At-Large members

- 4.3.1 The Nominating Committee shall offer one nominee for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the Active Medical Staff at least 30 days prior to the election.
- 4.3.2 A petition signed by at least three (3) Active staff Members may add nominations to the ballot. The Medical Staff must submit such a petition to the Chief of Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating committee must determine if the candidate meets the qualifications in Section 4.2 above before he/she can be placed on the ballot.
- 4.3.3 Officers and MEC At-Large members shall be elected prior to the expiration of the term of the current officers or At-Large members. Two MEC At-Large Member positions will be elected each year. There will be separate elections for each At-Large position with the Member receiving a plurality of votes elected for that position. Only members of the Active category shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes cast will be elected. In the event of a tie vote, the MEC will make arrangements for a repeat vote(s) deleting the candidate with the lowest number of votes until one candidate receives a greater number of votes.

4.3.4 An Incumbent shall be automatically placed on the ballot without requiring nominations if he/she still wishes to run for election.

4.4 Term of Office

All officers and MEC At-Large members serve a term of two (2) years. They shall take office in the month of January. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the Medical Staff year, except the office of the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term.

4.6 Duties of Officers and MEC At-Large members

4.6.1 **Chief of Staff:** The Chief of Staff (COS) is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical and Dental Staff Bylaws, Rules and Regulations, and Medical Staff/hospital policies. Specific responsibilities and authority are to:

- a. Call and preside at all general and special meetings of the Medical Staff;
- b. Serve as chair of the MEC and as ex officio member of all other Medical Staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;
- c. Enforce Medical and Dental Staff Bylaws, Rules and Regulations, and Medical Staff/hospital policies;
- d. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with hospital administration, appoint Medical Staff members to appropriate hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
- e. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;
- f. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;
- g. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

- h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;
 - i. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;
 - j. Attend Board meetings and Board committee meetings as invited by the Board;
 - k. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and
 - l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical and Dental Staff Bylaws.
- 4.6.2 **Vice Chief of Staff:** In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.
- 4.6.3 **Secretary-Treasurer:** This officer will collaborate with the hospital's Medical Staff office, assure maintenance of minutes, attend to correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.
- 4.6.4 **Immediate Past Chief of Staff:** This officer will serve as a consultant to the Chief of Staff and Vice Chief of Staff and provide feedback to the officers regarding their performance of assigned duties on an annual basis. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.
- 4.6.5 **MEC At-Large members:** There shall be four (4) MEC At-Large members who will advise and support the Medical Staff officers and are responsible for representing the needs/interests of the entire Medical Staff, not simply representing the preferences of their own clinical specialty.

4.7 **Removal and Resignation from Office**

- 4.7.1 **Automatic Removal:** A Medical Staff officer shall be automatically removed from his/her position if he/she no longer meets the qualifications of the position as defined in the Bylaws.
- a. No longer in good standing as evidenced by:
 - i. an automatic suspension of clinical privileges that lasts more than thirty days,
 - ii. a summary suspension of greater than fourteen (14) days, or
 - iii. any corrective action taken by the MEC or Board;
 - b. No longer an Active Member of the Medical Staff;
 - c. No longer actively practicing within the Hospital; or
 - d. Holds a leadership position (defined as an MEC or Board member) at another hospital.

- e. In the event that a Member-At-Large becomes the Chief/Vice Chief of a Department or holds another voting position at the MEC, he/she will vacate his/her position as Member-At-Large.
- 4.7.2 **Removal of Officer for Failure to Perform Their Duties:** The Medical Staff may initiate the removal of any officer if at least twenty percent (20%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two thirds (2/3) of those Active staff members casting ballot votes.
- 4.7.3 **Resignation:** Any elected officer or MEC At-Large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

- 5.1.1 The Medical Staff shall be organized into departments. The Medical Staff may create clinical subspecialties within a department in order to facilitate Medical Staff activities. A list of departments organized by the Medical Staff and formally recognized by the MEC is listed in the Medical and Dental Staff Rules and Regulations, Part II: Organization and Functions Manual, Section 1. .

The MEC, with approval of the Board, may designate new Medical Staff departments or clinical subspecialties or dissolve current departments or clinical subspecialties as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications, Selection, Term, and Removal of Department Chiefs and Vice Chiefs

- 5.2.1 Department Chiefs and Vice Chiefs of exclusively contracted department, whether exclusive through contract or hospital employment, shall be governed by the contract: or assigned by the hospital, as applicable.
- 5.2.2 For non-exclusively contracted departments, each Department Chief and Vice Chief shall be elected to serve a term of two (2) years commencing on January 1 and may be elected to serve successive terms. All Chiefs and Vice Chiefs must be physician-members of the Active Medical Staff, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. In addition, Department Chiefs and Vice Chiefs shall indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have no licensure sanctions, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, and be in compliance with the professional conduct policies of the hospital. Department Chiefs and Vice Chiefs may not simultaneously hold a leadership position (any position in which the Member serves on the MEC or the Board) on another hospital's Medical Staff. Noncompliance with this requirement will result in the Department Chief or Vice Chief being automatically removed from office.
- 5.2.3 For non-exclusively contracted departments, Department Chiefs and Department Vice Chiefs shall be elected by plurality vote of the Active members of the Department, subject to ratification by the MEC. An ~~Incumbent~~incumbent shall automatically be placed on the ballot without requiring nominations if he/she still wishes to run for election. An incumbent Department Chief must have satisfied the attendance requirements set forth in Part I, Section 7.5.2 of these Bylaws to be eligible for re-election. For non-incumbents, three nominations are needed from the Active members of the Department in order to qualify to be placed on the ballot. For Departments with less than 15 Members, one nomination is needed from an Active Member of the Department in order to qualify to be placed on the ballot. The election process will be the same as that for Officers of the Medical Staff other than voting shall be limited to the Active Members of the affected Department or Subspecialty. Following the election of the Department Chief and Vice-Chief, the Department Chief shall appoint the respective Subspecialty Head-

- 5.2.4 Automatic Removal of elected Chiefs and Vice Chiefs: The Department Chief or Vice Chief may be automatically removed from his/her position if he/she no longer meets the qualifications of the position as defined in these Bylaws.
- a. No longer in good standing as evidenced by:
 - i. an automatic suspension of clinical privileges that lasts more than thirty days,
 - ii. a summary suspension of greater than fourteen (14) days, or
 - iii. any corrective action taken by the MEC or Board;
 - b. No longer an Active Member of the Medical Staff;
 - c. No longer actively practicing within the Hospital; or
 - ~~m.d.~~ ~~d.~~ Holds a leadership position (defined as an MEC or Board member) at another hospital.
 - e. Failure to satisfy attendance requirements for the MEC meeting as set forth in Part I, Section 7.5.2 of these Bylaws
- 5.2.5 Removal of Elected Department Chief or Vice Chief for Failure to Perform Their Duties: The Medical Staff of the affected Department may initiate the removal of any Department Chief or Vice Chief if at least twenty percent (20%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two thirds (2/3) of those Active staff members casting ballot votes.
- 5.2.6 If a Department Chief is removed through ~~this process~~ these processes or resigns for any other reason, the Vice Chief shall assume the position of Chair and a new election for Vice Chief will occur within thirty (30) days. If a Vice Chief declines to assume the position of Department Chief, an election for a new Department Chief will occur within thirty (30) days.

5.3 Responsibilities of Department Chiefs

Department Chiefs shall carry out the following responsibilities:

- a. To oversee all clinically-related activities of the Department;
- b. To oversee all administratively-related activities of the Department, unless otherwise provided by the hospital;
- c. To provide ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted clinical privileges;
- d. To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff Department;
- e. To recommend clinical privileges for each member of the Department and other licensed practitioners practicing with privileges within the scope of the Department;
- f. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the Medical Staff Department or the hospital;
- g. To integrate the Department into the primary functions of the hospital;
- h. To coordinate and integrate interdepartmental and intradepartmental services and communication;

- i. To develop and implement Medical Staff and hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;
- j. To recommend to the CEO sufficient numbers of qualified and competent persons to provide patient care and service;
- k. To provide input to the CEO regarding the qualifications and competence of Department or service personnel who are not licensed practitioners but provide patient care, treatment, and services;
- l. To continually assess and improve of the quality of care, treatment, and services;
- m. To maintain quality control programs as appropriate;
- n. To orient and continuously educate all persons in the Department; and
- o. To make recommendations to the MEC and the hospital administration for space and other resources needed by the Medical Staff Department to provide patient care services.

5.4 Responsibilities of Department Vice Chief:

In the absence of the Department Chief, the Department Vice Chief shall assume all the duties and have the authority of the Department Chief. The Department Vice Chief shall perform such further duties to assist the Department Chief as the Department Chief may request from time to time.

5.5 Assignment to Department

The MEC will, after consideration of the recommendations of the Chief(s) of the appropriate Department(s), recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of Department assignment.

Section 6. Committees

6.1 Designation and Substitution

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

- a. Composition: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff, the Department Chiefs, four (4) At-Large Members, the Credentials Committee Chair, the Professional Improvement Committee Chair, the Bylaws Committee Chair, and the Advanced Practice Professionals Committee Chair. The chair of the MEC will be the Chief of Staff. The non-voting members will include the CEO, Chief Operating Officer (COO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), the Dean of the School of Medicine, and the Director of the Office of Military Medicine.
- b. Removal from MEC: An Officer, MEC At-Large Member, or Department Chief who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose his/her membership on the MEC. When the chair of either the Credentials Committee, Professional Improvement Committee, or Bylaws Committee resigns or is removed from these positions, his/her replacement will serve on the MEC. When a member of the MEC who was elected At-Large resigns or is removed, the MEC will arrange for an At-Large election for a replacement to serve out the remainder of the vacated term. Such an election will follow procedures established by the MEC and must take place within sixty (60) days of the removal of an MEC member.

6.2.2 Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

- a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical and Dental Staff Bylaws and provide oversight for all Medical Staff functions;
- b. Coordinate the implementation of policies adopted by the Board;
- c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, department assignments, clinical privileges, and corrective action;
- d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

- e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted;
 - f. Make recommendations to the Board on medical administrative and hospital management matters;
 - g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;
 - h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
 - i. Review and act on reports from Medical Staff committees, departments, and other assigned activity groups;
 - j. Formulate and recommend to the Board Medical Staff rules, policies, and procedures;
 - k. Request evaluations of practitioners privileged through the Medical Staff process when there are questions about an applicant or practitioner's ability to perform privileges requested or currently granted;
 - l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
 - m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;
 - n. Coordinate, with the Compliance Officer, that portion of the corporate compliance plan that pertains to the Medical Staff;
 - o. Hold Medical Staff leaders, committees, and departments accountable for fulfilling their duties and responsibilities;
 - p. Make recommendations to the Medical Staff for changes or amendments to the Medical and Dental Staff Bylaws; and
 - q. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.
- 6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained in accordance with applicable law.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

- 7.1.1 An annual meeting will be held, usually in December. Other general meetings, if any, of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously.
- 7.1.2 Except for Bylaws amendments or as otherwise specified in these Bylaws, the actions of a plurality of the members present and voting at a meeting of the Medical Staff is the action of the group. Action may be taken without a meeting of the Medical Staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a plurality of the votes cast.
- 7.1.3 Special Meetings of the Medical Staff
- a. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.
 - b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) business days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Departments

Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee or department may be called by the committee chair or Chief of the Department thereof or by the Chief of Staff.

7.4 Quorum

- 7.4.1 Medical Staff Meetings: Those eligible Medical Staff members present and voting on an issue.
- 7.4.2 MEC, Credentials Committee, and Professional Improvement Committee: A quorum will exist for the MEC and Credentials Committee when fifty percent (50%) of the voting members are present. For the Professional Improvement Committee, a quorum will exist when at least seven (7) voting members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least three members.

7.4.3 Department meetings or Medical Staff committees other than those listed in 7.4.2 above: Those eligible Medical Staff members present and voting on an issue. A quorum will exist for Medical Staff Department meetings when at least fifty percent (50%) of the Department members are present. Medical Staff Departments having more than five (5) subspecialties may satisfy the quorum requirement by the attendance of fifty percent (50%) of Subspecialty Heads. For Medical Staff committees other than those listed in Section 7.4.2 above, a quorum will exist when at least fifty percent (50%) of the committee members are present.

7.5 Attendance Requirements

7.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

7.5.2 MEC, Credentials Committee, and Professional Improvement Committee meetings: Members of these committees are expected to attend at least two-thirds (2/3rds) seventy-five percent (75%) of the meetings held. A MEC member's absence may be excused upon a finding of good cause by the Chief of Staff. Failure to meet the attendance requirements will result in removal of the member from the committee.

7.6 Special Meeting Attendance Requirements:

Whenever there is a reason to believe that a practitioner is not complying with Medical and Dental Staff Bylaws or hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Department Chief or Medical Staff committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic suspension of the practitioner's membership and privileges. Such suspension would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff. Nothing in the foregoing paragraph shall preclude the initiation of summary restriction or suspension of clinical privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.7 Participation by the CEO

The CEO or his/her designee may attend any general, committee, or department meetings of the Medical Staff as an ex-officio member without vote.

7.8 Robert's Rules of Order

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a plurality vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.9 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than three (3) business days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.10 Action of Committee or Department

Only items that appear on the agenda at least one (1) business day in advance of the meeting shall be voted upon, with the exception of items needed for regulatory/legal compliance that may appear on the agenda at the time of the meeting. The recommendation of a plurality of its members present at a meeting at which a quorum is present shall be the action of a committee or department. Such recommendation will then be forwarded to the MEC for action.

7.11 Rights of Ex officio Members

Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.12 Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department Chief shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. Records of the proceedings shall be kept in accordance with applicable law.

Section 8. Conflict Resolution

8.1 Conflict Resolution

- 8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the Board of Trustees' Chairperson, the Chief Executive Officer or designee, the Chief of Medical and Dental Staff or designee, Governing Board Chair or designee, Governing Board Clinical Quality and Professional Affairs Sub-Committee Chair, the Performance Improvement Chairperson or designee, Associate Administrator of Clinical Intervention / Quality Management, Dean of the University of Nevada School of Medicine (or any succeeding medical school operated by the Nevada State of Higher Education and affiliated with UMC) or designee, one other member of the Board of Trustees and the Nurse Executive, Medical Staff for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.
- 8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the Board, CEO, or the Chief of Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.
- 8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these Bylaws.
- 8.1.4 The Medical Staff may seek the legal advice of Hospital's Office of General Counsel on matters affecting hospital operations. Additionally, at its expense, the Medical Staff may retain and be represented by independent legal counsel. The authority to engage independent legal counsel on behalf of the Medical Staff shall be the prerogative of the Medical Executive Committee and may be required in the event that a conflict or potential conflict of interest impairs or prohibits Hospital counsel from rendering advice based on applicable rules of professional conduct or law.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

- 9.1.1 The Medical Staff shall have the responsibility to formulate, review at least triennially, and recommend to the Board any Medical and Dental Staff Bylaws, Rules and Regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws and Rules and Regulations shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.
- 9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws.

9.2 Methods of Adoption and Amendment to These Bylaws

- 9.2.1 Proposed amendments to these Bylaws may be originated by the MEC or by a petition signed by twenty percent (20%) of the members of the Active category.

Each Active member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the Medical Staff unless a simple majority of those members eligible to vote returns a ballot marked “no.”

Amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendment to any Medical Staff Rules and Regulations, and Policies

- 9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.
- 9.3.2 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, Rules and Regulations may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Medical Staff Policies and procedures will become effective upon approval of the MEC, subject to final approval by the Board.
- 9.3.3 In addition to the process described in 9.3.2 above, the organized Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.
- 9.3.4 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.

- 9.3.5 If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff. In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.
- 9.3.6 The MEC may adopt such amendments to these Bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical and Dental Staff Bylaws or Rules and Regulations.



University Medical Center of Southern Nevada



MEDICAL AND DENTAL STAFF BYLAWS

**Part II: Investigations, Corrective Actions, Hearing
and Appeal Plan**

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan – Table of Contents

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Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for Initiation

These Bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and hospital management shall be considered confidential, subject to all applicable laws, and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and hospital. Collegial intervention efforts may include but are not limited to the following:

- a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
- c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a Medical Staff officer, committee chair, Department Chief, CEO, CMO, or hospital board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons.

2.2 Preliminary Investigation

The MEC recognizes that there are situations where incidents of inappropriate conduct, disruptive behavior, or competency require an immediate preliminary investigation or review. When dealing with such circumstances, the Chief of Staff, or his or her designee, may immediately investigate or review the matter on behalf of the MEC to ensure the orderly operation of the hospital and safety of UMC patients, personnel, and practitioners. If warranted, the information developed during such a preliminary investigation or review shall be presented at the next regularly scheduled meeting of the MEC. The MEC shall determine whether to open a formal investigation as set forth in Section 2.3 or take any other appropriate action that may be warranted by the circumstances.

2.3 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

2.3.1 An external peer review consultant should be considered when:

- a. Litigation seems likely;

- b. The hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;
- c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

2.4 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation, and consistent with Section 4 of this Investigations, Corrective Action Hearing and Appeal Plan:

- a. Determining no corrective action is warranted, if the MEC determines there was not credible evidence for the complaint in the first instance;
- b. Deferring action for a reasonable time when circumstances warrant;
- c. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Department Chiefs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;
- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;
- e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;
- f. Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;
- g. Recommending suspension, revocation, or probation of Medical Staff membership; or
- h. Taking other actions deemed appropriate under the circumstances.

2.5 Subsequent Action

The Board shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Administrative Suspension/Voluntary Resignation

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered automatically relinquished, administratively suspended, or limited as described, and the action shall be final without a right to hearing. The Chief of Staff may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. ~~relinquished, or limited as described, and the action shall be final without a right to hearing.~~ ~~Except when otherwise specified below, if the triggering circumstances have not been resolved within sixty (60) thirty (30) days, the practitioner will be deemed to have voluntarily resigned their UMC Medical Staff membership and clinical privileges. Thereafter, reinstatement shall require a practitioner to submit a new application for membership and/or privileges.~~

It shall be the responsibility of each practitioner to report immediately to the Chief of Staff any of the following triggering circumstances or any proceeding, investigation, complaint, arrest, or charge that might result in any of the following triggering circumstances.

Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. ~~The Chief of Staff may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present.~~ ~~If the triggering circumstances have not been resolved within sixty days, the practitioner will have to reapply for membership and/or privileges.~~ In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following triggering circumstances occur:

3.1.1 Licensure.

- a. **Revocation and suspension:** Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.
- b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

- 3.1.2 **Medicare, Medicaid, Tricare or other Federal Program Exclusion:** Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.
- 3.1.3 **Controlled substances**
- a. **DEA certificate and Nevada Pharmacy Certificate of Registration:** Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or Nevada Pharmacy Certificate of Registration is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
 - b. **Probation:** Whenever a practitioner's DEA certificate or Nevada Pharmacy Certificate of Registration is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.
- 3.1.4 **Medical record completion requirements:** A ~~practitioner will be considered to have voluntarily relinquished the practitioner's~~ privilege to admit new patients or schedule new procedures shall be administratively suspended whenever s/he fails to complete medical records within time frames outlined in the Electronic Health Record System policy. This ~~relinquishment~~suspension of privileges shall not apply to patients admitted or already scheduled at the time of ~~relinquishment~~suspension, to emergency patients, or to imminent deliveries. The ~~relinquished~~suspended privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.
- 3.1.5 **Professional liability insurance:** The minimum amount per occurrence shall be ~~\$1001,000~~,000.00 with a minimum aggregate of ~~\$3003,000~~,000.00. ~~Employed Physicians, Dentists or Podiatrists~~dentists, podiatrists, and other licensed practitioners employed by UMC will provide a UMC Certificate of Insurance and Statement of Indemnification, pursuant to Section 41.038 of the Nevada Revised Statutes. The Advanced Practice Professional covered under the policy of his or her sponsor is required to submit a copy of the sponsor's policy and rider with a statement signed by the sponsor stating that the Advanced Practice Professional is covered under that policy, when applicable. Failure of a practitioner to maintain professional liability insurance in this manner shall result in ~~immediate, automatic relinquishment of a practitioner's clinical privileges~~an immediate administrative suspension of a practitioner's clinical privileges. Within thirty (30) days of suspension, the suspended practitioner must present proof of adequate professional liability insurance, including coverage for any acts or potential liabilities that may have arisen during the period of any lapse in coverage (prior acts coverage). A practitioner who fails to provide evidence of appropriate coverage after thirty (30) days shall be deemed to have voluntarily resigned Medical Staff membership and clinical privileges. The practitioner must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

- 3.1.6 **Medical Staff dues/fees/assessments:** ~~Failure~~ A practitioner's Medical Staff membership and clinical privileges shall be administratively suspended for any failure to promptly pay Medical Staff dues or any fees or assessment shall be considered an automatic relinquishment of a practitioner's appointment. If assessments. If the practitioner does not remit such payments within sixty (60) thirty (30) calendar days after written warning of the delinquency ~~the practitioner does not remit such payments,~~ the practitioner ~~shall~~ will be ~~considered~~ deemed to have voluntarily resigned ~~membership on their UMC Medical Staff membership and clinical privileges.~~
- 3.1.7 **Felony conviction:** A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence, or abuse (physical, sexual, child or elder) in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed.
- 3.1.8 **Failure to satisfy the special appearance requirement:** A practitioner having received two notices and who fails without good cause to appear at a meeting where his/her special appearance is required under these Bylaws shall ~~be considered to have automatically relinquished~~ all clinical privileges, with the exception of emergencies and imminent deliveries, administratively suspended. These privileges will be reinstated when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation ~~from of~~ the practitioner's Medical Staff membership and clinical privileges.
- 3.1.9 **Failure to participate in an evaluation:** A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these Bylaws, Rules and Regulations, or Medical Staff/hospital policies (whether an evaluation of physical or mental health, of clinical management skills, or of fitness to practice), shall ~~be considered to have automatically relinquished~~ all privileges administratively suspended. Subject to the findings of any such evaluation, these privileges may be restored following the practitioner's compliance with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation ~~from of~~ the practitioner's Medical Staff membership and clinical privileges.
- 3.1.10 **Failure to become board certified:** A practitioner who fails to become board certified in compliance with the eligibility criteria set forth in the Delineation of Privileges form of his or her Department will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges, ~~unless an exception is granted, for a good cause, by the Board upon recommendation from the MEC.~~

- 3.1.11 **Failure to Meet UMC Vaccination Requirements:** Unless approved for a medical or religious exemption from such requirement, ~~any practitioner who a practitioner's Medical Staff membership and clinical privileges shall be administratively suspended if the~~ practitioner fails to submit proof of full vaccination -in accordance with UMC hospital policies ~~shall be considered to have automatically relinquished all privileges.~~ If the practitioner ~~submits~~fails to submit proof of compliance with UMC hospital vaccination policies within thirty (30) calendar days of notice of the ~~automatic relinquishment~~administrative suspension, the ~~practitioner's privileges may be reinstated.~~ ~~Thereafter, the member~~practitioner will be deemed to have voluntarily resigned ~~from the staff and must reapply for staff~~the practitioner's Medical Staff membership and clinical privileges.
- 3.1.12 **Failure to execute release and/or provide documents:** A practitioner's Medical Staff membership and clinical privileges shall be administratively suspended if the practitioner ~~who~~ fails to execute a general or specific release of information and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner ~~shall be considered. A practitioner's continued failure to have automatically relinquished all privileges. If execute the requested release is executed and/of information or provide the requested documents provided~~ within thirty (30) calendar days of notice of the ~~automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be administrative suspension shall be~~ deemed ~~to have resigned voluntarily from the staff and must reapply for staff~~a voluntary resignation of the practitioner's Medical Staff membership and clinical privileges.
- 3.1.13 **MEC Deliberation:** ~~As soon as feasible after action is taken~~In the event of an automatic relinquishment, administrative suspension, or warranted as described above~~voluntary resignation, the MEC shall, in its sole discretion, may~~ convene to review and consider the facts, ~~and related to the action. The MEC may decline to take any further action or may recommend such further corrective action as it may deem~~deems appropriate following the ~~procedure~~procedures generally set forth in these Bylaws.

3.2 Summary Restriction or Suspension

- 3.2.1 **Criteria for Initiation:** A summary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person. Under such circumstances one Medical Staff leader (Chief of Staff or designee) and one administrator (CEO or designee) may suspend or restrict the Medical Staff membership or clinical privileges of such practitioner. A summary suspension or restriction of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO, and the Board. The notice shall contain the basis of the summary restriction or suspension and the findings supporting its imposition. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

- 3.2.2 **MEC action:** As soon as feasible and within 14 calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2 above. Upon request, and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this Hearing and Appeal Plan, nor shall any procedural rules with respect to hearing and appeal apply and no legal counsel will be allowed to attend. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision. Unless the MEC terminates the suspension within 14 calendar days, notice of the MEC's decision shall comply with the requirements for Notice for Recommendation of Adverse Action set forth in these Bylaws.
- 3.2.3 **Procedural rights:** Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the privileged practitioner (or applicant for privileges) shall be entitled to the procedural rights afforded by this Hearing and Appeal Plan once the restrictions or suspension last more than 14 calendar days. Unless the MEC has terminated the summary restriction or suspension, it shall remain in effect during the pendency and completion of the corrective action and hearing process.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or privileges shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following “adverse actions” when the basis for such action is related to clinical competence or professional conduct:

- a. Denial of Medical Staff appointment or reappointment;
- b. Revocation of Medical Staff appointment;
- c. Denial or restriction of requested clinical privileges, but only if such restriction is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;
- d. Involuntary reduction or revocation of clinical privileges;
- e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than fourteen (14) calendar days; or
- f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

- a. Issuance of a letter of guidance, warning, or reprimand;
- b. Imposition of a requirement for proctoring (i.e., observation of the practitioner’s performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;
- c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- e. Requirement to appear for a special meeting under the provisions of these Bylaws;
- f. Automatic relinquishment or voluntary resignation of appointment or privileges;
- g. Imposition of a summary suspension that does not exceed fourteen (14) calendar days;
- h. Denial of a request for leave of absence, or for an extension of a leave;
- i. Determination that an application is incomplete or untimely;
- j. Determination that an application will not be processed due to misstatement or omission;
- k. Decision not to expedite an application;
- l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

- m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;
- n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;
- o. Imposition of supervision, with no restriction on clinical privileges, pending completion of an investigation to determine whether corrective action is warranted;
- p. Termination of any contract with or employment by hospital;
- q. Proctoring, monitoring, and any other performance monitoring requirements, with no restriction on clinical privileges, imposed in order to fulfill any ~~Joint Commission~~ standards on focused professional practice evaluation required by an applicable CMS approved accrediting organization;
- r. Any recommendation voluntarily accepted by the practitioner;
- s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- t. Change in assigned staff category; including, without limitation, the termination of membership in the Honorary Recognition or Refer & Follow category;
- u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;
- v. Removal or limitations of emergency department call obligations;
- w. Any requirement to complete an educational assessment;
- x. Retrospective chart review;
- y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;
- z. Any action recommended or taken which is not reportable to the state or the National Practitioner Data Bank;
- aa. Grant of conditional appointment or appointment for a limited duration; or
- bb. Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation of Adverse Action

When a summary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this Hearing and Appeal Plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the Chief of Staff delivered either in person or by certified mail, return receipt requested. This notice shall contain:

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

- c. Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank;
- d. A summary of the practitioner's rights to be afforded at the hearing, including the practitioner's right to representation by counsel, to have a record made of the proceedings, to call and cross-examine witnesses, to submit a written closing statement, and to receive a written decision by the Hospital; and
- e. The individual shall receive a copy of Part II of these Bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Chief of Staff or designee. In the event the affected individual does not request a hearing within the time and in the manner required by ~~this policy~~ these Bylaws, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final board action.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the Chief of Staff shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

- a. The time, place, and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;
- c. The names of the hearing panel members and presiding officer or hearing officer, if known; and
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties. The date of the commencement of the hearing shall not be more than ninety (90) days from the date of the Notice of Hearing unless otherwise approved by the presiding officer or hearing officer for good cause. However, in no event shall the hearing be postponed or continued for more than one-hundred and twenty (150-120) days following the Notice of Hearing.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended, so far as reasonably known or anticipated, who are expected to ~~be called~~ give testimony on behalf of that party at the hearing. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. Under no circumstances shall a practitioner harass, retaliate against, or demand a witness to discuss the subject matter of the hearing outside of the hearing process. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

- a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. This panel will be appointed by a joint decision of the CEO and the Chief of Staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.
- b. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.
- c. The Chief of Staff or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the Chief of Staff, who shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the Chief of Staff.

5.2 Hearing Panel Chairperson or Presiding Officer

- 5.2.1 In lieu of a hearing panel chair, the CEO, acting for the Board and after considering the recommendations of the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no conflict of interest with either the hospital or the practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.
- 5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the Chief of Staff to serve as the presiding officer and shall be entitled to one vote.
- 5.2.3 The presiding officer (or hearing panel chair) shall do the following:
 - a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
 - b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than eight (8) hours over two (2) days;

- c. Maintain decorum throughout the hearing;
- d. Determine the order of procedure throughout the hearing;
- e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
- f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair on issues of Nevada law.

5.3 Hearing Officer (for non-clinical issues only)

- 5.3.1 As an alternative to the hearing panel described above, the Chief of Staff (or the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.
- 5.3.2 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the “hearing panel” or “presiding officer” shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal “discovery” in connection with the hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following:

- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense; and
- b. Reports of experts relied upon by the MEC.

~~6.1.1~~ The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. ~~In general and pursuant to Nevada law, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual’s counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:~~

- ~~i.a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense; and~~
- ~~j.a. Reports of experts relied upon by the MEC.~~

6.1.2 ~~No~~The following types of information ~~regarding other practitioners~~ shall not be requested, ~~provided~~disclosed, or considered ~~and evidence~~during the course of the Fair Hearing:

- a. Information regarding practitioners other than the practitioner having requested the Fair Hearing;
- b. Information identifying individually identifiable practitioners or personnel who have participated in the peer review process, other than the practitioner having requested the Fair Hearing;
- c. Information unrelated to the reasons for the adverse recommendation ~~or to the individual’s made against the practitioner or the practitioner’s~~ qualifications for appointment ~~or the relevant/~~clinical privileges.

Furthermore, there shall be ~~excluded~~no obligation for the MEC and/or Board to modify or create documents to satisfy a practitioner’s request for information.

6.1.3 Prior to the disclosure of any information, the practitioner requesting the hearing, the practitioner’s counsel, and any expert retained on his behalf shall be required to execute a stipulation agreeing to maintain the confidential, privileged, or private nature of any medical records, expert reports, exhibits, testimony, or other information disclosed, exchanged, or produced during the course of the Fair Hearing. Any records, documents, information, or testimony disclosed to the practitioner during the course of Fair Hearing shall not be used for any purpose outside of the Fair Hearing. The MEC and/or Board shall not be required to disclose any documents to the practitioner absent a stipulation having been executed in accordance with this Section 6.1.

~~6.1.26.1.4~~ Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

~~6.1.3—There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital’s witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.~~

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness’s testimony and cross-examination.

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to personally appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual’s expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Nevada.

6.5 Rights of the Practitioner and the Hospital

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

- a. To call and examine witnesses to the extent available;
- b. To introduce exhibits;
- c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may not argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
- e. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses, or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

It is the burden of the MEC (or Board) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and hospital policies.

6.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed, following the close of the hearing.

6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer or the Chief of Staff on a showing of good cause.

6.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or CEO. Administrative personnel shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties. All members of the hearing panel shall be present for all stages of the hearing and deliberations.

6.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence in response.

6.13 Basis of Recommendation

The hearing panel shall recommend in favor of the MEC (or the Board) unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.14 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the Chief of Staff and MEC who shall forward it, along with all supporting documentation, to the Board for further action. The Chief of Staff shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing.

Section 7. Appeal to the Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the Chief of Staff and CEO or designee, for delivery to the Board, either in person or by certified mail, and shall include a brief statement of the ~~reasons~~grounds for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- a. There was substantial failure to comply with the Medical and Dental Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or
- b. The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or
- c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

- a. ~~Appeals shall be heard by an Appellate Review Panel.~~ The chair of the Board shall appoint ~~a review panel~~an Appellate Review Panel composed of at least three (3) members of the Board ~~to consider the information upon which the recommendation before.~~ In its sole discretion, the Board ~~was made,~~ as a whole, may elect to sit as the Appellate Review Panel. Members of this ~~review panel~~Appellate Review Panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

- b. The ~~review panel~~Appellate Review Panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the ~~review panel~~Appellate Review Panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The ~~review panel~~Appellate Review Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Nevada.
- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the ~~review panel~~Appellate Review Panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. ~~The review panel~~If the Board does not elect to serve as the Appellate Review Panel, the Appellate Review Panel shall recommend final action to the Board.
- d. ~~The~~When the Board may is not serving as the Appellate Review Panel, the Board shall affirm, modify, or reverse the recommendation of the ~~review panel~~Appellate Review Panel or, in its discretion, refer the matter for further review and recommendation, ~~or make its own.~~ If the Board is serving as the Appellate Review Panel, the Board shall render a final decision based upon the Board's legal responsibility in writing within thirty (30) days of hearing the appeal.

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the ~~review panel's~~Appellate Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested. If the Board elects to serve as the Appellate Review Panel, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Medical Staff practitioner with privileges shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter, which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

7.7 Actions Prior to Initiating Legal Action

Practitioners shall exhaust all the administrative remedies afforded by these by laws prior to initiating legal action against the hospital or its agents.

7.8 Conflict with Law or Regulation

In the event of a conflict between this fair hearing plan and State or Federal law, the Medical Staff will abide by the law.



University Medical Center of Southern Nevada



MEDICAL AND DENTAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Part III: Credentials Procedures Manual – Table of Contents

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Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the Medical Staff Credentials Committee shall consist of at least seven (7) members of the Active Medical Staff who are experienced leaders that are not currently Department Chiefs. The members should represent the major specialties of the Medical Staff. The Chief of Staff will appoint the Chair and other members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The Credentials Chair shall have at least three (3) years' experience on the Credentials Committee and will be appointed for a three (3) year term. The Credentials Chair and members may be reappointed for additional terms without limit. The Director of the Office of Military Medicine is a non-voting member of the Credentials Committee. Any member, including the Chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. The Credentials Committee may also invite members such as representatives from hospital administration and the Board.

1.2 Meetings

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on the call of the Credentials Chair or Chief of Staff.

1.3 Responsibilities

- 1.3.1 To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;
- 1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;
- 1.3.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges;
- 1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;
- 1.3.5 To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff or hospital leaders;
- 1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

- 1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Chief of Staff or designee or as otherwise authorized by the hospital's legal counsel.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the Chief of Staff, CEO, Credentials Chair ~~or~~ ~~CMO~~. Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from or copied from the file other than material supplied by the practitioner or directly addressed to the practitioner. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

- 2.1 No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.
- 2.2 The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges:
- 2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;
 - 2.2.2 Have a current **unrestricted** state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Nevada;
 - 2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;
 - 2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence or abuse (physical, sexual, child or elder) in any jurisdiction;
 - 2.2.5 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada (RCPSC) or the American Osteopathic Association (AOA) and satisfy all eligibility criteria and applicable standards set forth in the Delineation of Privileges form of his or her Department;
 - 2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;
 - 2.2.7 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and satisfy all eligibility criteria and applicable standards set forth in the Delineation of Privileges form of his or her Department;
 - 2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and satisfy all eligibility criteria and applicable standards set forth in the Delineation of Privileges form of his or her Department;
 - 2.2.9 A psychologist must have earned a doctorate degree, (PhD or PsyD, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and satisfy all eligibility criteria and applicable standards set forth in the Delineation of Privileges form of his or her Department;

- 2.2.10 Possess a current unrestricted and valid drug enforcement administration (DEA) with the following schedules 2, 2N, 3, 3N, 4 and 5 and Nevada Pharmacy Certificate of Registration number, if applicable;
- 2.2.11 Have appropriate written and verbal communication skills;
- 2.2.12 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards in accordance with the ethical principles as defined by the professional organizations of their professions. These standards include, at a minimum:
 - a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
 - b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.
- 2.2.13 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;
- 2.2.14 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant;
- 2.2.15 Any practitioner granted privileges or Medical Staff appointment must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;
- 2.2.16 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;
- 2.2.17 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved Medical Staff development plan;
- 2.2.18 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

2.3 Exceptions

- 2.3.1 In accordance with NRS 449.2455, 635.015, 630.047, 630A.090, 632.316, and 633.171, those applicants for Medical Staff appointment, reappointment, or clinical privileges serving in the Armed Forces and exempt from the requirements of a Nevada medical license and Nevada Pharmacy Certificate shall be exempt from such requirements instilled by these Bylaws.
- 2.3.2 The Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant an application package, which will include a complete set or overview of the Medical and Dental Staff Bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

- a. A completed, signed, dated application form;
- b. A completed privilege delineation form if requesting privileges;
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- d. All applicable fees;
- e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport);
- f. A passport sized photo;
- g. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested;
- h. ECFMG, if applicable;
- i. Curriculum vitae (CV);
- j. NPI number;
- ~~k.~~ k. Verification of current, active professional liability coverage with limits of at least ~~\$1001,000/\$300,000/\$3,000,000~~ and verification of ~~last 10~~ claims history. If there are no claims, suits, settlements or judgments, seek verification for the past five (5) years of professional liability coverage;
- ~~l.~~ k. . If there are claims, suites, settlements or judgment, seek verification for the past ten (10) years. Verification of TB testing within 12 months of the application acceptance for all practitioners excluding Telemedicine (For a positive TB test, the following are required: Completion of a Signs/Symptoms Screening Form and a CXR);
- ~~m.~~ l. Verification of influenza vaccination within the past year or a formal declination of influenza vaccination in accordance with hospital policy unless the practitioner is solely requesting telemedicine privileges (All practitioners with patient contact who decline the influenza vaccine will be required to wear a surgical mask during the influenza season when in a patient care areas or when within six (6) feet of any patients);

- ~~n.m.~~ _____ Name of covering provider, who must be a member of the UMC Medical Staff that currently maintains like privileges and practices within the same specialty, for when the practitioner is unavailable unless the practitioner is solely requesting Refer and Follow ~~privilegescategory~~ (In rare circumstances when there is only one practitioner in a specific specialty, the Department Chief may waive this requirement and recommend coverage by another qualified practitioner with appropriate training, skillset and privileges);
- ~~n.~~ Signed conflict of interest statement;
- ~~o.~~ Written acknowledgement of an agreement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), UMC's Privacy and Security Practices and UMC's Corporate Compliance Handbook;
- ~~p.~~ For UMC employed physicians, a completed and approved UMC Certificate of Insurance and Statement of Indemnification from the Risk Management Department (this provision only applies if the physician is solely employed by UMC and has no outside practice);
- ~~q.~~ Relevant practitioner-specific data as compared to aggregate data, when available;
- ~~s.~~ ~~Morbidity and mortality data, when available;~~
- ~~r.~~ Nevada State Collaborative Agreement, when applicable;
- ~~s.~~ Completed Permit List signed by Supervising /Collaborating Physician, when applicable; and
- ~~t.~~ Unless otherwise exempted from this specific requirement by the MEC, evidence of an office and residence within Clark County, Nevada. This requirement will not apply to licensed practitioners who solely request Telemedicine privileges.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated, no further action will be taken and the applicant will not be entitled to a fair hearing.

- 3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. The Medical Staff office shall not be required to send more than one letter to the practitioner requesting additional or clarifying information. If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

- 3.1.3 Upon receipt of a completed application the Chief of Staff, ~~CMO~~, Credentials Chair or their designees, in collaboration with the Medical Staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.
- 3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.
- 3.1.5 Upon receipt of a completed application, the Medical Staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. These sources may include American Medical Association (AMA) Physician Master File, American Board of Medical Specialties (ABMS), American Educational Commission for Foreign Medical Graduates (ECFMG), American Osteopathic Information Association (AOIA) Physician Database, Federation of State Medical Boards (FSMB), and American Academy of Physician Assistants (AAPA) Profile. In addition, the Medical Staff office will collect relevant additional information which may include:
- ~~w.a.~~ Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, ~~(if any) during the past ten (10) years;~~; If there are no claims, suits, settlements or judgments, seek verification for the past five (5) years. If there are claims, suits, settlements or judgment, seek verification for the past ten (10) years;
 - ~~x.b.~~ Verification of the applicant's past applicable clinical work experience for at least the past ~~ten (10)~~five (5) years;
 - ~~y.c.~~ Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;
 - ~~z.d.~~ Information from the AMA or AOA Physician Profile;
 - ~~aa.e.~~ OIG list of Excluded Individuals/Entities;
 - ~~bb.f.~~ Information from the National Commission on Certification of Physician Assistants, when applicable;
 - ~~cc.g.~~ Information from professional training programs including residency and fellowship programs;
 - ~~dd.h.~~ Information from the National Practitioner Data Bank (NPDB); in addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;
 - ~~ee.i.~~ Other information about adverse credentialing and privileging decisions;

~~ff.j.~~ Three peer recommendations chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges in the last two years;

~~gg.k.~~ Information from a criminal background check, as applicable;

~~hh.l.~~ Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; ~~and~~

~~ii.~~ ~~Morbidity and mortality data and relevant practitioner specific data as compared to aggregate data, when available.~~

Note: In the event there is undue delay in obtaining required information, the Medical Staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five (45) calendar days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization, and Acknowledgement

The applicant must complete and sign the application form. By signing this application the applicant:

- 3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees that any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.
- 3.2.2 Consents to appear for any requested interviews in regard to his/her application.
- 3.2.3 Authorizes the hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.
- 3.2.4 Consents to hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of:
 - a. Professional qualifications and competence to carry out the clinical privileges requested;
 - b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;
 - c. Professional and ethical qualifications;
 - d. Professional liability actions including currently pending claims involving the applicant; and

- e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.
- 3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the Medical Staff, including otherwise privileged or confidential information to the hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.
- 3.2.6 Authorizes the hospital Medical Staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any Medical Staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.
- 3.2.7 Acknowledges that the applicant has had access to the Medical and Dental Staff Bylaws, including all rules, regulations, policies and procedures of the Medical Staff, and agrees to abide by their provisions.

Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.
- 3.2.8 Agrees to provide accurate answers to all questions and information items contained within the application for clinical privileges and medical staff membership, and agrees to notify the Medical Staff Office in writing immediately, and in no case later than 30 days, should any of the information regarding such items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the questions or information items contained within the application affirmatively and/or provides information identifying a problem with any of the questions or information items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Refer and Follow Category – Process Requirements

Physicians applying for Refer and Follow category must submit the following items for processing:

- a. Complete abbreviated application and facility specific documents
- b. Current unrestricted Nevada medical license
- c. Evidence of continuous malpractice insurance coverage, minimum of one (1) million dollars per occurrence, three (3) million dollars in the aggregate with no shared limits of liability or in an amount that may be determined from time by action of the Board
- d. Evidence of current vaccinations or formal declination in accordance with hospital policy

e. One (1) character reference (must be a physician) within knowledge of your abilities within the past two (2) years

f. Applicable fees

3.4 Medical Officers of the Armed Forces of the United States - Military Rotator Category - Process Requirements

Practitioners applying for Military Rotator category must submit the following items for processing:

a. Complete abbreviated application and facility specific documents

b. Current unrestricted US State license

c. Current Federal DEA, Pharmacy license as applicable

d. Current Life-support certifications as applicable

e. Evidence of current TORT malpractice insurance coverage

f. Military transfer brief

g. Evidence of current vaccination or formal declination in accordance with hospital policy

h. One (1) professional reference (must be a physician with knowledge of your abilities within the past two (2) years).

i. Applicable fees

3.33.5 Application Evaluation

~~3.3.13.5.1~~ **Credentialing Process:** An expedited review and approval process may be used for initial appointment or for reappointment. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Department Chief, Credentials Chair acting on behalf of the Credentials Committee, the MEC and a Board committee consisting of at least two individuals.

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Department Chief, Credentials Committee, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

- a. The final recommendation of the MEC is adverse or with limitation;
- b. The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- c. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

- d. Applicant has had an unusual pattern of malpractice cases or excessive number of professional liability actions resulting in a judgment against the applicant filed within the past five (5) years;
- e. Applicant changed medical schools or residency programs due to adverse or corrective action or has unusual gaps in training or practice;
- f. Applicant has one or more reference responses that raise concerns or questions;
- g. Discrepancy is found between information received from the applicant and references or verified information;
- h. Applicant has an adverse National Practitioner Data Bank report related to behavior, licensure, and/or clinical privileges;
- i. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- j. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- k. Applicant has potentially relevant physical, mental, and/or emotional health problems;
- l. Other reasons as determined by a Medical Staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

3.3.23.5.2 Applicant Interview

- a. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Department Chief, Credentials Committee, MEC, or Board. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The applicant shall not be permitted to be accompanied or represented by counsel in any such interview. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.
- b. Procedure: The applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.3.33.5.3 Department Chief Action

- a. All completed applications are presented to the Department Chief for review, and recommendation. The Department Chief reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chief, in consultation with the Medical Staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Department Chief may obtain input if necessary from an appropriate subject matter expert. If a Department Chief believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the Vice-Chief of the Department who will then be responsible for reviewing the application. Should both the Department Chief and Vice-Chief have an existing conflict of interest, the Department Chief will notify the Credentials Chair and forward the application without comment.
- b. The Department Chief forwards to the Medical Staff Credentials Committee the following:
 - i. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
 - ii. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
 - iii. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
 - iv. Comments to support these recommendations.

3.3.43.5.4 Medical Staff Credentials Committee Action

If the application is designated Category 1, it is presented to the Credentials Chair, or designee, for review and recommendation. The Credentials Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Credentials Chair has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the Credentials Chair acts on behalf of the Medical Staff Credentials Committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the Medical Staff Credentials Committee reviews the application and forwards the following to the MEC:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
- d. Comments to support these recommendations.

3.3.53.5.5 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing. The Chief of Staff has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
- d. Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation, a special notice, containing the requirements outlined in Section 4.3 of Part II of these Bylaws, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.63.5.6 Board Action:

- a. If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.
- b. If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:
 - i. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;
 - ii. If the board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or
 - iii. The Board shall take final action in the matter as provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

~~3.3.73.5.7~~ **Notice of final decision:** Notice of the Board's final decision shall be given, through the Chief of Staff to the MEC and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Department to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

~~3.3.83.5.8~~ **Time periods for processing:** All individual and groups acting on a complete application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days from the receipt of a completed application.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Reappointment

4.1 Criteria for Reappointment

- 4.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members or other practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 6.1 below concerning focused professional practice evaluation. The Chief of Staff, or Vice-Chief of Staff, shall substitute for the Department Chief in the evaluation of current competency of the Department Chief, and recommend appropriate action to the Credentials Committee.

4.2 Information Collection and Verification

- 4.2.1 **From appointee:** On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the Medical Staff office:
- a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues; and
 - b. Information concerning continuing training and education internal and external to the hospital during the preceding period; ~~and.~~
- ~~e.~~ By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above. Failure to provide a complete reappointment application at least sixty (60) calendar days prior to the expiration of the current membership and/or privileges may result in voluntary resignation at the expiration of the current approval cycle.
- 4.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each practitioner's professional and collegial activities to include those items and practitioner responses contained within the practitioner's application.
- 4.2.3 The following information is also collected and verified:
- a. A summary of clinical activity at this hospital for each practitioner due for reappointment;
 - b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
 - c. Documentation of any required hours of continuing medical education activity;

- d. Service on Medical Staff, Department, and hospital committees;
 - e. Timely and accurate completion of medical records;
 - f. Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff;
 - g. Any gaps in employment, affiliation or practice since the previous appointment or reappointment;
 - h. Any information and explanation for resignation or removal from staff at a hospital or other health care organization;
 - i. Verification of current unrestricted licensure, DEA certificate and Nevada Pharmacy license;
 - j. National Practitioner Data Bank query and information from the OIG List of Excluded Individuals/Entities;
 - k. When sufficient practitioner-specific data is not available to evaluate competency, one or more peer recommendations chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;
 - l. Malpractice history for the past two (2) years, which is primary source verified by the Medical Staff office with the practitioner's malpractice carrier(s); and
 - m. Other reasonable indicators of continuing competency or qualifications.
- 4.2.4 Failure, without good cause, to provide any requested information in the timeframe necessary to complete processing and obtain approval prior to the expiration of appointment will result in automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

- 4.3.1 Expedited review reappointment applications will be categorized as described in Section 3.3.1 above.
- 4.3.2 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action that would entitle the applicant to a Fair Hearing under Part II of the Medical and Dental Staff Bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

4.4 Special Conditions for Advanced Practice Professionals

- 4.4.1 In addition to the items outlined in Section 4.2 above, the following information is collected and verified at the time of reappointment for Advanced Practice Professionals:
 - a. APP Evaluation completed by the APP's Supervising/Collaborating Physician or Department Chief;

- b. At least one (1) peer reference chosen from the practitioners who have observed the applicant's clinical and professional performance who can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform privileges in the last two years;
- c. As applicable, Nevada State Supervision Agreement (Physician Assistant);
- d. As applicable, Certified Registered Nurse Anesthetists Statement of Sponsor;
- e. As applicable, current certification from the National Commission on Certification of Physician Assistants;

Section 5. Clinical Privileges

5.1 Exercise of Privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC, to practitioners having a license or other authorized credential authorizing the provision healthcare services, but who are not otherwise eligible for UMC Medical and Dental Staff Membership.

5.2 Practitioners Eligible to Apply For Privileges Without Membership

The following categories of practitioners are eligible to apply for clinical privileges but do not otherwise qualify for membership to the UMC Medical and Dental Staff:

- a. Advanced Practice Professionals (APPs) subject to hospital or regulatory physician supervision requirements, including, without limitation, Physician Assistants-Certified (PA-Cs) and Certified Registered Nurse Anesthetists (CRNAs);
- b. Physicians serving short locum tenens positions;
- c. Telemedicine physicians;
- d. House staff such as residents moonlighting in the hospital;
- ~~e.~~—Clinical psychologists;
- ~~f.e.~~ ~~;~~ or
- ~~g.f.~~ Other practitioners having been deemed appropriate by the MEC and Board.

5.3 Requests

When applicable, each application for appointment or reappointment to the Medical Staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

5.4 Basis for Privileges Determination

5.4.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

5.4.2 Privileges for which no criteria have been established:

In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:

- a. Review the community, patient, and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;
- b. Review with members of the Credentials Committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

- c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information, and staffing plans; and
 - d. Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the Credentials Committee and appropriate Department or subject matter experts (as determined by the Credentials Committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:
 - i. For the development of criteria, the Medical Staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate;
 - ii. Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and
 - iii. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Credentials Chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue.
- 5.4.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.
- 5.4.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

5.5 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record.

5.6 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff that will be recorded in the medical record.

5.7 Special Conditions for Privileges of Advanced Practice Registered Nurse

Advanced Practice Registered Nurses shall include nurse practitioners, certified nurse-midwives, and clinical nurse specialists (CNS) having a license to practice as an advanced practice registered nurse under Chapter 632 of the Nevada Revised Statutes. Requests for clinical privileges for advanced practice registered nurses are processed in the same manner as all other privilege requests. Privileges for advanced practice registered nurses shall be limited to only perform acts authorized pursuant to NRS 632.237, within the scope of practice of the advanced practice registered nurse, and authorized under the Delineation of Privileges of the applicable clinical service department.

5.8 Special Conditions for Privileges of Medical Officers of the Armed Forces of the United States Providing Medical Care Within the Hospital

Pursuant to NRS 449.2455, the Hospital may enter into an agreement with the Armed Forces of the United States to authorize a medical officer to provide medical care at the Hospital as part of a training or educational program to further the employment of the medical officer. Except as otherwise specified in Part III, Section 2.3.1 of these Bylaws, requests for clinical privileges for medical officers of the Armed Forces of the United States to provide medical services within the hospital will be processed in the same manner as all other privilege requests. All requests for clinical privileges for medical officers of the Armed Forces of the United States shall be coordinated through the Office of Military Medicine at the Hospital and such practitioners shall solely exercise privileges pursuant to an authorized agreement under NRS 449.2455 and any other applicable laws and regulations.

5.9 Special Conditions for Practitioners Eligible for Privileges without Membership

5.9.1 Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception that such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges.

5.9.2 Advance Practice Professionals (APPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the collaboration or supervision of a physician who has been accorded privileges to provide such care. The privileges of these APPs shall terminate immediately, without right to due process, in the event that the employment of the APP with the hospital is terminated for any reason or if the employment contract or sponsorship of the APP with a physician member of the Medical Staff organization is terminated for any reason.

5.10 Special Conditions for Residents or Fellows in Training

5.10.1 Residents or fellows in training in the hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the professional graduate education committee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.

5.10.2 The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.11 Telemedicine Privileges

Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed through one of the following mechanisms:

~~e.a.~~ The hospital fully privileges and credentials the practitioner; or

~~f.~~—The hospital privileges practitioners using credentialing information from the distant site if the distant site is ~~a Joint Commission~~ an appropriately accredited hospital or telemedicine entity.

5.12 Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

5.12.1 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies current licensure and current competence ~~and obtains the following~~ documentation:

- a. Unrestricted license to practice in Nevada;
- b. Unrestricted federal DEA registration, as appropriate to specialty;
- c. Unrestricted Nevada Board of Pharmacy registration, as appropriate to specialty;
- d. Proof of professional liability insurance coverage in a certificate form and in amounts satisfactory to the hospital;
- e. Proof of good-standing from primary practicing facility;
- f. Report from the National Practitioner Data Bank;
- g. Proof of Board Certification or eligibility in the practitioner's specialty

- 5.12.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in section 3 of this manual.
- 5.12.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.
- 5.12.4 Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose summary suspension under the Medical and Dental Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Chief of Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.
- 5.12.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.
- 5.12.6 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.12.7 Disaster Privileges:

- a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected licensed practitioners. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - i. A current picture hospital ID card that clearly identifies professional designation;
 - ii. A current license to practice;
 - iii. Primary source verification of the license;
 - iv. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
 - v. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - vi. Identification by a current hospital or Medical Staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed practitioner during a disaster.
- b. The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.
- c. The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.
- d. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.
- e. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.
- f. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

Practitioners shall undergo a period of FPPE for all initial and additional requests for privileges and/or as needed to address clinical quality of care concerns. The Credentials Committee, after receiving a recommendation from the Department Chief, will define the circumstances that require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for modification of appointment status or privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the Medical Staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of administrative remedies

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 Reporting requirements

The Chief of Staff shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

7.6 Reporting of Adverse Action

The hospital shall report actions taken against a practitioner to the appropriate regulatory agencies in accordance with all applicable state and federal laws, including, without limitation:

- a. Any adverse action taken by the MEC and based upon the practitioner's professional competence or conduct that adversely affects the clinical privileges of the practitioner for more than 30 days shall be reported to the National Practitioner's Data Bank;
- b. Any surrender of a practitioner's clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or any surrender of privileges in return for not conducting an investigation or taking an otherwise reportable action shall be reported to the National Practitioner's Data Bank.
- c. Any change in the practitioner's privileges while the practitioner is under investigation and the outcome of any disciplinary action taken against the practitioner concerning patient care or practitioner competency shall be reported to the Board of Medical Examiners within thirty (30) days.
- d. Any change in privileges of the practitioner based on an investigation of the practitioner's mental, medical or psychological competency, or upon suspected substance abuse shall be reported to the Board of Medical Examiners within five (5) days.

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than sixty (60) days, except for instances of maternity or paternity leave, and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and must maintain all appropriate licenses and certification during the period of the leave. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the Practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement on or before thirty (30) days of the leave of absence end date shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these Bylaws unless the leave of absence was done during the time the practitioner was undergoing an investigation. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Section 9. Practitioners Providing Contracted Services

9.1 Exclusivity Policy

Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other practitioners must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

9.2 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

9.3 Disciplinary Action

The terms of the Medical and Dental Staff Bylaws will govern disciplinary action taken by or recommended by the MEC.

9.4 Effect of Contract or Employment Expiration or Termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 10. Medical Administrative Officers

- 10.1** A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity. They shall not have clinical privileges, hold office, or be eligible to vote.
- 10.2** Notwithstanding the preceding, if desired, each medical administrative officer may achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her training and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.
- 10.3** Effect of removal from office or adverse change in appointment status or clinical privileges:
- 10.3.1 Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.
- 10.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.
- 10.3.3 A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

University Medical Center of Southern Nevada

University Medical Center of Southern Nevada
Medical and Dental Staff Rules and Regulations

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MEDICAL AND DENTAL STAFF RULES AND REGULATIONS

Part I. Medical and Dental Staff Rules &
Regulations

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Section 1. Introduction

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Clark County Commissioners sitting as the Board of Trustees or its delegated authority, to further define the general policies contained in the Medical and Dental Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical and Dental Staff Bylaws. This article supersedes and replaces any and all other Medical and Dental Staff Rules and Regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, adherence to the Code of Ethics as prescribed by his/her profession, and Case Management/utilization standards in effect in the Hospital.

Section 2. Admission and Discharge

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short-term patients for care and treatment provided suitable facilities are available.

- a. **Admitting Privileges:** A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges. Emergency physicians or their designee may write admitting orders for disposition but cannot be the admitting physician of record. Podiatric surgeons and Dentists who do not have full History and Physical privileges will be required to co-admit.
- b. **Admitting Diagnosis:** Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been entered in the medical record. In the case of emergency, such statement will be recorded as soon as possible.
- c. **Admission Procedure:** Admissions must be scheduled with the Hospital's Patient Access Services/Admitting Department. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the admitting practitioner or his designee shall contact the Hospital's Patient Access Services/Admitting Department to ascertain whether there is an available bed.
- d. **Admission to Pediatrics.** All individuals under the age of eighteen (18) must be admitted as a pediatric patient.

2.1.2 Admission Priority

Patient Access Services/Admitting personnel will admit patients on the basis of the following order of priorities:

- a. **Emergency Admission:** Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.
- b. **Urgent Admissions:** Urgent admission patients meet the criteria for inpatient admission, however their condition is not life threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.
- c. **Elective Admissions:** Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor will be admitted directly to the Family Birthing Center/Labor and Delivery area per hospital policy after determination that the patient is stable. All patients under the age of eighteen (18) shall be assigned to pediatric services.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The Medical Screening Examination must be performed by a Qualified Medical Provider which is a Physician, Advanced Practice Registered Nurse, Physician Assistant, or a Labor and Delivery Nurse with Neonatal Resuscitation training. Pregnant patients, greater than twenty (20) weeks gestation, with a primary obstetrical complaint can have their medical screening exam done in the Family Birthing Center/Labor and Delivery area.

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

- a. the patient does not have a primary care practitioner or does not indicate a preference;
- b. the patient's primary care practitioner does not have admitting privileges; or
- c. the patient's injuries or condition fall outside the scope of the patient's primary care practitioner.

2.2.2 Unassigned Call Service

- a. **Unassigned Call Schedule:** The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Department Chief, or his/her designee, shall provide the Emergency Department and the Medical Staff Services Office with a list of physicians who are scheduled to take emergency call on a rotating basis. Practitioners shall comply with all obligations, duties, and responsibilities required by Hospital policy, or applicable Hospital-practitioner contract, which relate to the maintenance of the unassigned call schedule.
- b. **Response Time:** It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame. The on-call physician, or designee, shall respond to calls from the Emergency Department within ten (10) minutes by telephone unless an earlier timeframe is stipulated by contract or other policy, and must arrive at the Hospital, if requested to see the patient, to evaluate the patient within thirty (30) minutes for emergent patients or within a time frame specified by the Emergency Department physician for non-emergent patients. If there is a difference of opinion on how quickly the on-call physician must respond, the emergency department practitioner (who has seen the patient) will determine the response time of the on-call physician. If the on-call

physician does not respond to being called or paged, the physician's Department Chief will be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

- c. **Substitute Coverage:** It is the On-Call physician's responsibility to arrange for coverage and officially update the schedule if he/she is unavailable to take call when assigned. If an On-Call Physician has an emergent case at another hospital or UMC they must provide the name of an alternate practitioner with equivalent privileges, to provide on-call coverage. Failure to notify the Medical Staff Department of alternate call coverage may result in the initiation of disciplinary action. It is the On Call physician's responsibility to provide a one (1) time and appropriate follow-up evaluation for the patient following the Emergency Department visit, regardless of the patient's ability to pay.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician's responsibility to provide at least one (1) timely and appropriate follow-up evaluation for the patient following the Emergency Department visit, regardless of the patient's ability to pay.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department will be referred to the practitioner taking unassigned call that day unless a patient-physician relationship has been developed and the patient is no longer considered "unassigned."

2.2.5 Guidelines for Unassigned Call

Unassigned call will be performed in accordance with the "On Call Physician Policy".

2.2.6 Use of the Unassigned Call Roster

The unassigned call roster may be used as default consultation coverage when a practitioner cannot obtain consultation on his/her patient on a voluntary basis. The responsible on-call practitioner will be the practitioner who is on call when the consultation request is placed.

2.2.7 Failure to Meet Unassigned Call Obligations

All failures to meet unassigned call responsibilities shall be reported to the Department Chief and the Chief of Staff. Recurrent failure to meet call obligations may result in corrective action per the Medical and Dental Staff Bylaws.

2.3 TRANSFERS

2.3.1 Transfers from Other Acute Care Facilities

Transfers from other acute care facilities shall comply with NRS Chapter 439B and EMTALA guidelines and must meet the following criteria:

- a. The patient must be medically stable for transfer;
- b. The patient's condition must meet medical necessity criteria;

- c. The patient must require, and this Hospital must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility OR it is requested by the patient or patient's family; and
- d. Responsibility for the patient must be accepted by an emergency physician, within EMTALA guidelines.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers per the methods noted in hospital policy.

2.3.3 Transfers to Another Hospital

Patients who are transferred to another hospital must follow the Hospital policy on patient transfers to ensure compliance with NRS Chapter 439B and EMTALA.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The admitting practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others.

The admitting practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners who have patients who are a danger to themselves and/or others should follow the hospital "Suicide Precautions" policy.

2.5 PROMPT ASSESSMENT

All new admissions must be personally assessed by the attending physician or his/her designated covering practitioner within ~~twelve (12)~~~~six (6)~~ hours and have a history and physical examination completed and on the record within twenty-four (24) hours. Patients admitted to intermediate care units must be seen within four (4) hours. Patients admitted to critical care units must be seen within two (2) hours. Unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or his or her privileged designee who shall provide, or assist Hospital personnel in providing, written discharge instructions in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

- a. A list of all medications the patient is to take post-discharge;
- b. Dietary instructions and modifications;
- c. Medical equipment and supplies;
- d. Instructions for pain management;
- e. Any restrictions or modification of activity;
- f. Follow up appointments and continuing care instructions;
- g. Referrals to rehabilitation, physical therapy, and home health services; and

- h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, Hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

Section 3. Medical Records

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient. At a minimum, the completed medical record must contain the following:

- a. Evidence of patient history and physical examination completed in accordance with Hospital policy.
- b. Patient diagnosis at the time of admission.
- c. The results of all consultative evaluations of the patient and the appropriate findings by clinical and other staff involved in caring for the patient.
- d. Documentation of any complications suffered by the patient, infections acquired by the patient while in the hospital and unfavorable reactions by the patient to drugs and anesthesia administered to the patient.
- e. Properly executed informed consent for all procedures and treatments specified by the Medical Staff, or federal or state law, as requiring written patient consent.
- f. All orders of practitioners, nursing notes, reports of treatment, records of medication, radiology and laboratory reports, vital signs and other information necessary to monitor the condition of the patient.
- g. A discharge summary that includes a description of the outcome of the hospitalization, disposition of the case and the provisions for follow-up care that have been provided to the patient.
- h. The final diagnosis of the patient.

In order to practice medicine, all healthcare practitioners who exercise privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All healthcare practitioners will undergo appropriate EHR training, and comply with security guidelines, per the Hospital's policy on use of the EHR. Practitioners who fail to utilize the EHR system, or who otherwise fail to comply with Hospital policy on the use of EHR, shall be subject to corrective action.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All healthcare practitioners who exercise privileges at UMC are required to utilize the electronic healthcare record. Use of other modes of documentation (i.e., paper) shall only occur during designated system downtime or where such use has otherwise been pre-approved. In such circumstances, all handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual, as noted in the "Provision for Patient Care"

policy, responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner timely. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

- 3.4.1 **Prohibited Abbreviations, Acronyms, and Symbols:** The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. All practitioners shall comply with the Hospital “Abbreviations” policy.
- 3.4.2 **Situations Where Abbreviations Are Not Allowed:** Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses and procedures on the face sheet of the medical record.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

- a. For all inpatients, patients under observation, or patients receiving anesthesia: A complete history and physical should be completed no more than seven (7) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient’s condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
- b. For outpatient procedures requiring only moderate sedation: A focused history and physical shall be completed no more than thirty (30) days before or 24 hours after admission or registration, but prior to surgery or procedure. An updated examination of the patient, including any changes in the patient's condition, is to be completed and documented within twenty-four (24) hours after admission or registration, but prior to the surgery or a procedure requiring moderate sedation.
- c. For outpatient procedures that do not require anesthesia or moderate sedation: In accordance with a policy established by the medical staff, an assessment of a patient, in lieu of a history and physical examination, may be completed and documented after registration, but prior to surgery or a procedure, when the patient is receiving specific outpatient surgical or procedural services that do not require moderate sedation or anesthesia.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

All medical history and physical examinations, or updates thereto, must be completed and documented by a physician, an oral and maxillofacial surgeon, advanced practice registered nurse or Advanced Practice Professional in accordance with State law and hospital policy.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A **complete history and physical examination** is required for all admissions, all surgeries requiring anesthesia (general, regional, monitored anesthesia care (MAC), or deep sedation), and all observation patients. A complete history and physical examination report must include the following information:

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;
- c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
- d. An age-appropriate social history;
- e. A pertinent family history;
- f. A review of systems;
- g. Cardiorespiratory exams and other relevant physical findings;
- h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A **focused history and physical examination** report is used for outpatient procedures that do not require anesthesia (general, regional, MAC, or deep sedation). A focused history and physical is required to be done for all outpatient procedures using moderate sedation. A focused history and physical should include the following information:

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;
- c. Past medical history, including current medications, allergies, and current diagnoses;
- d. A review of systems relative to the procedure planned;
- e. Relevant physical findings, including an evaluation of the cardiac and respiratory systems and the affected body area;
- f. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

In accordance with an established policy of the medical staff, an **assessment**, in lieu of a complete or focused history and physical examination, may be used when the patient is receiving

specific outpatient surgical or procedural services not requiring anesthesia or moderate sedation. The policy established by the medical staff which allows for the performance of an assessment in lieu of a history and physical examination must apply only to those patients receiving specific outpatient procedural services and be based upon the following:

- a. Patient age, diagnoses, the type and number of surgeries and procedures to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure;
- b. Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures; and
- c. Applicable State and local health and safety laws.

3.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician or his/her designee.

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

- a. all invasive procedures performed in the Hospital's surgical suites;
- b. certain procedures performed in the Radiology Department and Catheterization Lab (angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation, electrophysiological studies, and ablations); and
- c. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, central arterial line insertions, and elective electrical cardioversion).

In accordance with a policy established by the medical staff pursuant to Section 3.5.3 above, an assessment may be completed, in lieu of an otherwise required history and physical, when the patient is receiving specific outpatient surgical or procedural services not requiring moderate sedation or anesthesia.

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed. In cases of procedures performed by podiatrists and dentists who are not privileged to perform the complete H&P, another practitioner privileged to perform the complete H&P or the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESS NOTES

3.7.1 Daily Progress Notes

The attending physician, or Advanced Practice Professional (APP), will record a progress note each day for each significant patient encounter on all hospitalized (inpatient, observation, and boarded) patients excluding the day of admission and the day of discharge. A physician must do the progress note on postoperative day #1 for all patients undergoing a procedure. ICU patients

must be seen daily by a physician with documentation of a progress note. All progress notes must document the reason for continued hospitalization.

3.7.2 Co-signature of Progress Notes

Progress notes documented by APPs do not need co-signature by the physician on medical/surgical units but should include attestation from the APP that the physician is involved in the care of the patient when applicable. Progress notes documented by APPs providing a critical level of care are required co-signature by the attending physician on intermediate care units and critical care units. Progress notes documented by residents or fellows do require co-signature by the physician within ~~one (1) day~~ twenty-four (24) hours, unless the attending physician documents their own note.

3.8 OPERATIVE / PROCEDURE REPORTS

Operative/Procedure reports will be entered or dictated immediately after surgery, and in no case, later than twenty-four (24) hours after the end of the procedure, and the report promptly signed by the surgeon/proceduralist and made a part of the patient's current medical record. Operative/procedure reports will include (as applicable):

- a. the name of the licensed practitioner(s) who performed the procedure and any assistants and a description of their tasks,
- b. the pre-operative diagnosis,
- c. the name of the procedure performed,
- d. a description of the procedure performed,
- e. the type of anesthesia administered,
- f. findings of the procedure,
- g. complications, if any,
- h. any estimated blood loss,
- i. any specimen(s) removed,
- j. any prosthetic devices, transplants, grafts, or tissues implanted, and
- k. the postoperative diagnosis.

3.9 IMMEDIATE OPERATIVE/PROCEDURAL NOTES

If there is a delay in getting the operative/procedure report in the medical record, an immediate operative / procedural note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Immediate operative/procedural notes will include (as applicable):

- a. the name of the licensed practitioner(s) who performed the procedure and any assistants,
- b. the name of the procedure performed,
- c. findings of the procedure,
- d. any estimated blood loss,
- e. any specimen(s) removed, and
- f. the post-operative/procedure diagnosis.

3.10 ANESTHESIA NOTES

Practitioners must document a pre-anesthesia assessment, an intraoperative record, and a post-anesthesia assessment for all patients undergoing anesthesia. A pre-anesthesia evaluation must be completed by a practitioner qualified to administer anesthesia at least forty-eight (48) hours before surgery. A post-anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or deep sedation in accordance with CMS and ~~Joint~~ Commission applicable accreditation guidelines. The note shall be entered by an anesthesia practitioner or by the physician who administered the deep sedation. This note should contain the following information:

- a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
- b. Cardiovascular function, including pulse rate and blood pressure;
- c. Mental status;
- d. Temperature;
- e. Pain;
- f. Nausea and vomiting; and
- g. Postoperative hydration.

3.11 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed and entered in the patient's chart within the time frame specified by the physician ordering the consult and no later than twenty-four (24) hours after receipt of notification of the consult request, unless the attending ordering the consultation agrees to a longer timeframe. If there is a difference of opinion on how quickly the consulting physician must respond, the attending physician or designee (who has seen the patient) will determine the response time of the consultant. If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. If a consultation is performed by an APP other than an APRN the consulting physician must cosign the consultation.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.12 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record if available, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last prenatal visit was within seven (7) days of admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the bylaws.

3.13 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record.

3.14 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. The discharge summary should be completed no later than forty-eight (48) hours after discharge. All discharge summaries should be written and signed by the individual completing the discharge and in accordance with UMC EHR policy. The discharge summary should be a meaningful synopsis of the care rendered during the hospitalization.

3.14.1 **Content:** A discharge summary will be entered or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the discharging physician and will contain:

- a. Reason for hospitalization;
- b. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
- c. Condition of the patient at discharge;
- d. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
- e. Final diagnoses.

3.14.2 **Deaths:** A discharge summary is required on all patients who have expired and will include:

- a. Reason for admission;
- b. Summary of hospital course; and
- c. Final diagnoses.

3.14.3 **Timing:** A Discharge Summary is to be completed no case later than forty-eight (48) hours after discharge, transfer, or death.

3.15 DIAGNOSTIC REPORTS

Inpatient diagnostic reports (including but not limited to inpatient EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read by the physician scheduled to provide the interpretation service within twenty-four (24) hours of availability of the test. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list. Outpatient diagnostic reports should be read by the physician in the timeframe stipulated by contract.

3.16 ADVANCED PRACTICE PROFESSIONALS (APPs)

The attending or supervising/collaborating physician will review and authenticate all history and physical examinations, consultations and discharge summaries prepared by the Advanced Practice Professional. The signature signifies that the attending or supervising/collaborating physician has reviewed the patient's

medical record and approved the care rendered by the Advanced Practice Professional. An advanced practice registered nurse having been granted medical staff membership and clinical privileges may independently complete appropriate medical record documentation, without the need of physician co-signature, provided that the act has been authorized within the APRN's delineation of privileges, is authorized pursuant to NRS 632.237 and NAC 632.255, and within his or her authorized scope of practice.

3.17 RESIDENTS AND FELLOWS IN TRAINING

Residents and fellows in training, who are not moonlighting outside of their training program, must have their history and physical examinations, progress notes, and operative/procedure reports cosigned within one calendar day by the attending physician. They must also have their discharge summaries cosigned by the discharging physician, within forty-eight (48) hours after discharge of the patient.

3.18 MEDICAL RECORD ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records will otherwise be disclosed only pursuant to court order, subpoena, or in accordance with state or federal law and regulation. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or in accordance with state or federal law and regulation.

- 3.18.1 **Access to Old Records:** In case of readmission of a patient, all previous records will be made available to the admitting practitioner whether the patient was attended by the same practitioner or by another practitioner.
- 3.18.2 **Unauthorized Removal of Records:** Unauthorized removal of charts from their designated space(s) is grounds for corrective action of privileges of the practitioner for a period to be determined by the Medical Executive Committee.
- 3.18.3 **Access for Medical Research:** Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.
- 3.18.4 **Access for Former Members:** Provided that the use or disclosure of the information would comply with applicable federal and state law and regulation, former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.19 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

3.19.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

- a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record in the timeframes noted in the bylaws, Part I, Section 2.6.8. A privileged physician must co-sign the H&P performed by a resident/fellow or APP within one (1) calendar day;
- b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;
- c. An Admission Prenatal Record must be entered in the medical record by the attending physician or designated covering practitioner within twenty-four (24) hours after an obstetrical admission and prior to the delivery of the infant;
- d. An Operative/Procedure Report must be entered in the medical record by the performing practitioner immediately, but in no case, later than twenty-four (24) hours following the surgery or procedure;
- e. If the Operative Report is not immediately available, an Immediate Post-Operative/Procedure Note must be entered in the medical record by the performing practitioner prior to transfer of the patient to the next level of care.
- f. An Inpatient Progress Note must be recorded each day for each significant patient encounter on all hospitalized patients. A privileged physician must see the patient on the first post-operative day (if applicable). A privileged physician must see the patient daily in an intensive care unit;
- g. An Emergency Department/Ambulatory Services Record must be completed by the responsible practitioner prior to the patient leaving the Emergency Department for patients transferred outside the facility. For all other patients, an Emergency Department Record must be completed by the responsible practitioner by the end of the practitioner's shift of work;
- h. A Consultation Note must be completed by the consulting physician within twenty-four (24) hours of notification of the consult request;
- i. Inpatient Diagnostic Reports must be completed by the interpreting physician within twenty-four (24) hours after availability of the test for review or an earlier time as noted in the contract;
- j. A Discharge Summary must be entered in the medical record by the discharging physician or his/her designee no case later than forty-eight (48) hours after an inpatient or observation discharge, transfer, or death; and
- k. The Inpatient or Observation Medical Record must be completed within forty-eight (48) hours of discharge, including the authentication of all progress notes, consultation notes, operative reports, and verbal and entered orders, final diagnoses, and discharge summary.

3.19.2 Policy on Incomplete Records

All practitioners will be held to the HIM policy on "Delinquent Medical Records Policy". If a practitioner is delinquent in their medical records completion, s/he will be unable to schedule admissions or procedures and cannot have a colleague admit/schedule for them while they are delinquent with their records.

3.20 ELECTRONIC RECORDS AND SIGNATURES

“Electronic signature” means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.21 ORGANIZED HEALTH CARE ARRANGEMENT

For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act (“HIPAA”), the Medical Staff of this Hospital are deemed to be members of, and a part of, an *Organized Health Care Arrangement* (“OHCA”) as that term is defined within HIPAA. This designation is intended to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with the Hospital and the hospital’s medical staff. Except for non-compliance remedies set forth in the HIPAA regulations, no member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

The members hereby adopt the Hospital Joint Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital, and agree to comply with all requirements contained in the Joint Notice of Privacy Practices.

The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, though any portal that is not solely operated by the Hospital, shall enter into a Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Hospital information through a portal maintained by the member.

Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for authorized health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar authorized health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

Section 4. Standards of Practice

4.1 ADMITTING/ATTENDING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an admitting physician who is an appointee of the Medical Staff with admitting privileges. The admitting physician, or authorized designee, is responsible for completion of the history and physical examination.

The attending physician, or authorized designee, will be responsible for:

- a. the medical care and treatment of each patient in the Hospital;
- b. making daily rounds;
- c. the prompt, complete, and accurate preparation of the medical record; and
- d. necessary special instructions regarding the care of the patient.

4.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Service, a note covering the transfer of responsibility will be entered in the medical record by the attending physician.

4.2 COVERAGE AND CALL SCHEDULES

Each physician shall provide the Medical Staff Services Office with a list of designated Medical Staff appointees (usually the members of his/her group practice who are members of the same clinical department and have equivalent clinical and procedure privileges) who shall be responsible for the care of their patients in the Hospital when the physician is not available.

4.3 RESPONDING TO CALLS AND PAGES

4.3.1 Telephonic Response. Practitioners are expected to respond within ten (10) minutes to calls from the Hospital's patient care staff regarding their patient.

4.3.2 Physical Response. Practitioners are expected to respond in person within thirty (30) minutes to evaluate patients in the emergency department.

4.4 ORDERS

4.4.1 General Principles

- a. All orders for treatment will be entered into the medical record.

- b. All orders must be specifically given by a practitioner who is privileged by the Medical Staff.
- c. Vague or “blanket” orders (such as “continue home medication” or “resume previous orders”) will not be accepted.
- d. Instructions should be written out in plain English. Prohibited abbreviations may not be used.
- e. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his/her legible or electronic signature, date, and time.
- f. It is preferred that admission orders be provided by the accepting practitioner or their designated covering practitioner within one (1) hour of communication between the Emergency Medicine practitioner and the accepting practitioner but not to exceed: critical care units within two (2) hours, intermediate care units within four (4) hours and, medical/surgical units within six (6) hours.

4.4.2 Non-Privileged Physician Orders

Physicians who are not UMC Medical and Dental Staff members and are ordering outpatient ancillary services by writing an order or prescription must provide the following information:

- a. Physician name and address
- b. Physician contact number-telephone and/or cell
- c. Name of a qualified representative who can take a message if physician is unavailable
- d. Current unrestricted Nevada Medical License number

4.4.3 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal/telephone orders must comply with Hospital policy “Verbal/Telephone Orders”. All telephone orders must be signed by the ordering practitioner or another practitioner involved in the patient’s care within forty-eight (48) hours after discharge of the patient or in an earlier timeframe as prescribed by state law. All verbal orders must be signed by the ordering practitioner before leaving the area.

4.4.4 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

- a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;
- b. The order is legible, clear, and complete;
- c. The identity of the patient is clearly documented;

- d. The facsimile contains the name of the ordering practitioner, his/her address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;
- e. The original order, as transmitted, is signed, dated, and timed; and
- f. The facsimile, as received, is signed by the attending physician or ordering practitioner within forty-eight (48) hours of discharge.

4.4.5 **Cancellation of Orders Following Surgery or Transfer**

All previous medication orders are canceled when the patient:

- a. goes to surgery,
- b. is transferred to or from a critical care area, or
- c. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically entered following surgery or the aforementioned transfers. Instructions to “resume previous orders” will not be accepted.

4.4.6 **Drugs and Medications**

Orders for drugs and medications must follow Hospital Pharmacy policy.

4.4.7 **Radiologic Testing**

Orders for radiologic testing should include the name of the test requested and the reason for the test; rule out diagnosis are not allowed to be used. Relevant pertinent history and exam findings are recommended to be included with the request for the test.

4.5 **CONSULTATION**

4.5.1 **Consultation Requests.** Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges. The attending physician will provide written authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his/her patient. This request shall become part of the patient’s medical record and must specify:

- a. the reason for the consultation, and
- b. the urgency of the consultation (emergent/urgent – within a timeframe acceptable to the referring physician based on communication with the consultant; routine – within 24 hours; delayed – within a timeframe acceptable to the referring physician as long as it does not delay the discharge planning process).

Consultation and Treatment. All consultations will be for “consultation and treatment”

unless specified otherwise. It is recommended that the consultant not initiate new orders on patients on the teaching service until they have discussed their recommendation with the resident or fellow on the service.

- 4.5.2 **Communication.** All consultations should be communicated practitioner-to-practitioner. APPs may initiate the consultation with the knowledge of their supervising/collaborating physician.
- 4.5.3 **Notice.** Consultants should not order consultations with other specialties without informing the attending physician unless the need is urgent/emergent.
- 4.5.4 **APP Consult.** APPs may perform the consultation with the knowledge and collaboration of their supervising/collaborating physician. If the practitioner requesting the consult requests that the consulting physician perform the consultation, that request will be honored.
- 4.5.5 **Addressing Concerns.** If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to her manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.
- 4.5.6 **Suicide Precautions.** Requirements for consultation pertaining to patients deemed at high-risk for suicide should be handled in accordance with the Hospital's "Suicide Precautions" policy.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. When there are concerns regarding the continued stay within a critical care unit, consultation with the medical director of the unit will be obtained.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a physician, or designee, within two (2) hours following admission or transfer.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing of Death

In the event of a hospital death, the deceased will be pronounced by a physician, resident, or Advanced Practice Registered Nurse within a reasonable time in accordance with Nevada laws and regulations. Physician Assistants (PAs), and registered nurses may be authorized to make a pronouncement of death in accordance with Nevada laws and regulations. A physician who anticipates the death of a patient because of an illness, infirmity, or disease may authorize a Physician Assistant or Registered Nurse to make a pronouncement of death if they attend the

death of the patient. The attending physician's authorization must be a written order entered on the chart of the patient, state the personnel authorized to make the pronouncement of death, and be signed and dated by the physician. If the pronouncement of death is made by a registered nurse or Physician Assistant, the physician who authorized that action must sign the medical certificate of death within 24 hours of being presented with the certificate.

4.7.2 Certifying the Cause of Death

~~The attending physician or Advanced Practice Registered Nurse is responsible for certifying the cause of death, and authenticating the Death Certificate within forty-eight (48) hours of death per certificates in accordance with Nevada law, and the applicable Hospital policy.~~ Practitioners shall complete death, and authenticating the Death Certificate within forty-eight (48) hours of death per certificates in accordance with Nevada law, and the applicable Hospital policy. If the attending physician or advanced practice registered nurse will not be available within ~~forty-eight (48)~~ twenty-four (24) hours of death, the certificate shall be completed by an associate physician who has access to the deceased patient's medical records, the Department Chief, or the Chief of Staff, ~~before the end of the next business day once assigned as the certifier.~~ In cases of death within the emergency department, the emergency physician will be responsible for certifying the cause of death and completing the ~~Death Certificate~~ death certificate in accordance with Nevada laws and regulations.

4.7.3 Brain Death

Determinations of brain death shall be completed in accordance with the Hospital policy "Brain Death (Pediatric)" or "Determination of Brain Death in Adults."

4.7.4 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable. The Hospital policy "Organ/Tissue Donation Procurement" should be followed.

4.8 AUTOPSY

It is the responsibility of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico-legal or educational interest. All practitioners shall comply with the Hospital's "Autopsy" policy.

4.9 ADVANCED PRACTICE REGISTERED NURSES

An advanced practice registered nurse may independently perform and complete only those acts of clinical practice that have been authorized within the APRN's delineation of privileges, are authorized pursuant to NRS 632.237 and NAC 632.255, and that are within his or her authorized scope of practice.

4.10 SUPERVISION OF/COLLABORATION WITH ADVANCED PRACTICE PROFESSIONALS

4.10.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals are defined as those non-physician health care professionals having a license or other authorized credentialing, in accordance with applicable state and federal laws and regulations, to perform designated health care services within his or her scope of

practice. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical and Dental Staff Bylaws. With the exception of Advanced Practice Registered Nurses, Advanced Practice Professionals are not otherwise eligible for UMC Medical Staff membership.

The following categories of practitioners are recognized by the UMC Medical and Dental Staff as Advanced Practice Professionals (APPs):

- a. Advanced Practice Registered Nurses (nurse midwives, nurse practitioners, and clinical nurse specialists) maintaining an independent license to perform those acts of clinical practice authorized pursuant to NRS 632.237, NAC 632.255, and that are within his or her authorized scope of practice,
- b. Physician Assistants- Certified (PA-Cs) subject to hospital or regulatory physician supervision requirements;
- c. Certified Registered Nurse Anesthetists (CRNAs) subject to hospital or regulatory physician supervision requirements;
- d. Clinical psychologists;
- e. Allied health professionals (such as RNFAs or scrub techs providing a surgical level of care); or
- f. Other practitioners having been deemed appropriate by the MEC and Board.

With the exception of Advanced Practice Registered Nurses, Advanced Practice Professionals are not otherwise eligible for UMC Medical Staff membership.

4.10.2 Definition of Allied Health Professionals

Allied Health Professionals are those healthcare professionals (including scrub techs and Registered Nurse First Assistants (RNFAs)) who provide a surgical level of care are privileged to work solely under the direct supervision of the physician.

4.10.3 Guidelines for Supervising or Collaborating with Advanced Practice Professionals

- a. The physician(s) is (are) responsible for managing the health care of patients in all settings.
- b. Health care services delivered by physicians and by Advanced Practice Professionals, whether independently or under their supervision/collaboration, must be within the scope of each practitioner's authorized practice, as defined by state law.
- c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.
- d. When the Advanced Practice Professional is subject to hospital or regulatory physician supervision requirements in the delivery of care, the role of the Advanced Practice Professional shall be defined through a mutually agreed upon Supervision/Collaboration Agreement that is developed by the physician and the Advanced Practice Professional and Department Delineation of Privileges.

- e. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. A physician must be able to present to the hospital within thirty (30) minutes when needed by the Advanced Practice Professional.
- f. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.
- g. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon the Supervision/Collaboration Agreement.
- h. Each Advanced Practice Professional subject to hospital or regulatory supervision requirements must document the identity of their supervising/ collaborating physician and one or more alternate supervising/collaborating physician(s) who practices medicine in the same specialty as the supervising assistant.

4.10.4 Collaborative Practice Agreements

Each Advanced Practice Professional subject to hospital or regulatory supervision requirements must have on file in the Medical Staff Services Office written Supervision/Collaboration Agreement. This document must be signed by the Advanced Practice Professional and the supervising/collaborating physician. An APP may not provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician.

The Supervision/Collaboration Agreement, if applicable, must include:

- a. the name, license number and addresses of all supervising/collaborating physicians;
- b. the name and practice address of the Advanced Practice Professional; and
- c. the date the guidelines of the Supervision/Collaboration Agreement were developed and dates they were reviewed and amended.

4.10.5 Supervising/Collaborating Physician

An Advanced Practice Professional may not provide services to patients if the supervising/collaborating physician is more than thirty (30) minutes travel time from the Hospital. A physician may not supervise/collaborate with more Advanced Practice Professionals than allowed by State law. It is noted that Physician Assistants require in person supervision for the first thirty (30) days of the supervisory agreement with an osteopathic physician.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical and Dental Staff Bylaws.

4.10.6 Medical Record Documentation

Advanced Practice Professionals shall complete medical record documentation in accordance with applicable laws, regulations, and hospital policies. All documentation requiring Physician co-signature will be signed within 1 or 2 calendar days in accordance with the EHR Policy.

Advanced Practice Registered Nurses (APRN's) maintaining an independent license may complete medical record documentation without the need for physician co-signature as authorized by their clinical scope of practice, including, the entry of notes, orders, and consultations.

4.11 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties.

4.12 EVIDENCE-BASED ORDER SETS

Evidence-based order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The Medical Executive Committee may adopt evidenced-based order sets upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care practitioners who are expected to implement the guidelines.

4.13 TREATMENT OF FAMILY MEMBERS

Members of the Medical and Dental Staff may not serve as the Attending or Consulting Practitioner for any member of their own family. Medical and Dental Staff members may not schedule or perform operations or procedures on members of their own families in the operating room, procedure rooms, or laboratories except in emergencies when no other qualified member of the Medical Staff is available.

4.14 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall only view their own medical records through the normal medical records release process available to patients.

Practitioners cannot view family members records without either 1) receiving permission to do so via the medical records consent process, with the consent authorization being documented in the medical record, or 2) being the treating practitioner for the family member.

4.15 ABORTIONS

Abortions may only be allowed in the Hospital when it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

Section 5. Patient Rights

5.1 PATIENT RIGHTS

All practitioners shall respect patient rights in accordance with applicable state and federal law and regulation and as delineated in Hospital policy on “Patient Rights and Responsibilities.”

5.2 INFORMED CONSENT

The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner’s obligation is to present the medical facts accurately to the patient, or the patient’s surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient’s authorization or agreement to undergo a specific medical intervention. Practitioners must obtain informed consent in accordance with applicable Hospital policies.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital policies on “Withdrawing and Withholding Life Sustaining Medical Treatment” delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDERS

The Hospital policy on “Categorization of Patients” delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital policy on “Serious Reportable Events (SRE)/Sentinel Events” delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS AND SECLUSION

The Hospital policy on “Restraints, Use of” delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Hospital policy on “Advance Directives” delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy “Human Subject Research and IRB Procedures” should be followed.

Section 6. Surgical Care

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

Moderate or deep sedation and anesthesia may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist or physician privileged to perform deep sedation will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving deep sedation and anesthesia. Moderate and deep sedation shall be administered following the Hospital sedation policy and any applicable law.

The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in the Hospital's pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. The Hospital policy on "Universal Protocol for Surgical and Nonsurgical Invasive Procedures" shall be followed.

Section 7. Rules of Conduct

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The Hospital policy on “Medical Staff Professional Conduct” shall be followed.

7.2 REPORTING IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Hospital policy “Physician and APP Health and Wellness Policy”.

7.3 HEALTH DOCUMENTATION

All ~~privileged~~ practitioners shall ~~follow the~~ provide evidence of current vaccinations or formal declination in accordance with Hospital policies ~~on “Tuberculin (TB) Testing for Medical & Dental Staff and Advanced Practice Professionals (APPs)” and vaccinations.~~

Section 8. Department-Specific Rules and Regulations

8.1 DEPARTMENT-SPECIFIC RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee, Hospital Departments (Ambulatory Care, Anesthesiology, Emergency Medicine, Family Medicine, Hand Surgery, Medicine, Neurosurgery, Obstetrics & Gynecology, Orthopedic Surgery, Pathology, Pediatrics, Radiology, Surgery, and Trauma) may implement department-specific Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Department-specific rules may supplement, but shall not conflict with the Medical and Dental Staff Bylaws, Medical and Dental Staff Rules and Regulations, or Hospital Policies and Procedures. To the extent department-specific rules regulations conflict with a provision of the Medical and Dental Staff Bylaws, Rules and Regulations, or Hospital policies and procedures, the departmental rule, regulation, policy, or procedure shall be deemed void.

All Department-specific rules, regulations, policies, or procedures must be adopted via the procedures mandated by the Medical Executive Committee and shall only become effective upon the approval of the Medical Executive Committee. Amendments, changes, or additions to the department-specific Rules and Regulations may be proposed by a motion of any Active member of the Department at a Department meeting. If approved by the Department, the amendments, changes, or additions shall become effective upon approval by the Medical Executive Committee.

8.1.1 Trauma Department Specific Rules & Regulations - Available in the Trauma Department

MEDICAL AND DENTAL STAFF RULES AND REGULATIONS

Part II. Organization and Functions Manual

PART II: ORGANIZATION AND FUNCTIONS MANUAL

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Section 1. Organization and Functions of the Staff

1.1 ORGANIZATION OF THE MEDICAL STAFF

The Medical Staff shall be organized as a departmentalized staff including the following Departments and Subspecialties:

1.1.1 Department of Ambulatory Care

- a. Quick Care
- b. Primary Care
- c. Telemedicine

1.1.2 Department of Anesthesiology

1.1.3 Department of Emergency Medicine

- a. Pediatric Emergency Medicine
- b. Adult Emergency Medicine

1.1.4 Department of Family Medicine

1.1.5 Department of Medicine

- a. Allergy/Immunology
- b. Cardiology
- c. Dermatology
- d. Endocrinology/Metabolic Diseases
- e. Gastroenterology
- f. Hematology/Oncology
- g. Infectious Disease
- h. Internal Medicine
- i. Nephrology
- j. Neurology
- k. Psychiatry
- l. Pulmonary Medicine/Respiratory Care
- m. Physical Medicine/Rehabilitation
- n. Rheumatology

1.1.6 Department of Neurosurgery

1.1.7 Department of Obstetrics & Gynecology

1.1.8 Department of Orthopaedic Surgery

- a. Hand Surgery
- b. Orthopedics

- c. Podiatry
- 1.1.9 **Department of Pathology**
- 1.1.10 **Department of Pediatrics**
 - a. Neonatology
 - b. Pediatric Critical Care
- 1.1.11 **Department of Radiology**
 - a. Nuclear Medicine
 - b. Interventional Radiology
- 1.1.12 **Department of Surgery**
 - a. Bariatrics
 - b. Cardiovascular/Thoracic Surgery
 - c. General Surgery
 - d. Ophthalmology
 - e. ~~Oral/Maxillofacial Surgery~~Dentistry
 - f. Otorhinolaryngology
 - g. Pediatric Surgery
 - h. Plastic Surgery
 - i. Urology
- 1.1.13 **Department of Trauma**
 - a. Anesthesiology
 - b. Burn Surgery
 - c. Emergency Medicine
 - d. General Surgery
 - e. Neurosurgery
 - f. ~~Orthopaedics~~
 - f. Orthopedics
 - g. Pediatric Surgery
 - h. Surgical Critical Care

A Department Chief shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 RESPONSIBILITIES FOR MEDICAL STAFF FUNCTIONS

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers, Department Chiefs, hospital and Medical Staff committee chairs, are responsible for working collaboratively to accomplish required Medical Staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

1.3 DESCRIPTION OF MEDICAL STAFF FUNCTIONS

The Medical Staff, acting as a whole or through committee, participates in or has oversight over the following activities:

1.3.1 Governance, Direction, Coordination, and Action

- a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from Departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;
- b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;
- c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;
- d. Make recommendations on medical, administrative, and hospital clinical and operational matters;
- e. Inform the Medical Staff of the accreditation and state licensure status of the hospital;
- f. Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements;
- g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;
- h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;
- i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and governing body; and

- j. Ensure effective, timely, and adequate comprehensive communication between the members of the Medical Staff and Medical Staff leaders as well as between Medical Staff leaders and hospital administration and the board.

1.3.2 **Medical Care Evaluation/Performance Improvement/Patient Safety Activities**

- a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when requesting initial or additional privileges, on a request from the Department or Chief of Staff, or concerns arise from OPPE based on the general competencies defined by the Medical Staff;
- b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;
- c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that may include, but are not limited to the following:
 - i. Medical assessment and treatment of patients
 - ii. Use of medications
 - iii. Use of blood and blood components
 - iv. Operative and other procedures
 - v. Education of patients and families
 - vi. Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations
 - vii. Appropriateness of clinical practice patterns
 - viii. Significant departures from established pattern of clinical performance
 - ix. Use of developed criteria for autopsies
 - x. Sentinel event data
 - xi. Patient safety data
 - xii. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
 - xiii. Findings of the assessment process relevant to individual performance; and
- d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to Medical Staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 **Hospital Performance Improvement and Patient Safety Programs**

- a. Understand the Medical Staff's and administration's approach to and methods of performance improvement;
- b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

- c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
- d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 **Credentials Review.** See Part III: Credentials Procedures Manual

1.3.5 **Information Management**

- a. Review and evaluate medical records to determine that they:
 - i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and
 - ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.
- b. Develop, review, enforce, and maintain surveillance over enforcement of Medical Staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and
- c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 **Emergency Preparedness**

- a. Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.
- b. Assist in developing and periodically reviewing, in cooperation with Hospital Administration, a written plan for the care, reception and mass evacuation of the hospital, that adequately relates to other available resources in the community and coordinates the hospital's role with other agencies in the event of disasters in the hospital or nearby communities, and that is rehearsed by all personnel involved.

1.3.7 **Strategic Planning**

- a. Participate in evaluating existing programs, services, and facilities of the hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each;
- b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and
- c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to Medical Staff members.

1.3.8 **Bylaws Review**

- a. Conduct periodic review of the Medical and Dental Staff Bylaws, Rules and Regulations, and policies; and
- b. Submit written recommendations to the MEC and to the Board for amendments to the Medical and Dental Staff Bylaws, Rules and Regulations, and policies.

1.3.9 **Nominating**

- a. Identify nominees for election to the officer positions and to other elected positions in the Medical Staff organizational structure; and
- b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 **Infection Control Oversight**

- a. The Medical Staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;
- b. Develop and approve policies describing the type and scope of surveillance activities including:
 - i. Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;
 - ii. Review of prevalence and incidence studies, as appropriate; and
 - iii. Collection of additional data as needed.
- c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
- d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;
- e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;
- f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;
- g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and
- h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 **Pharmacy and Therapeutics Functions**

- a. Maintain a formulary of drugs approved for use by the hospital;
- b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
- c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);
- d. Perform drug usage evaluation studies on selected topics;

- e. Perform medication usage evaluation studies as required by The Joint Commission an applicable CMS approved accrediting organization;
- f. Perform practitioner analysis related to medication use;
- g. Approve policies and procedures related to The Joint Commission Patient Care Standards applicable accreditation standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;
- h. Develop and measure indicators for the following elements of the patient treatment functions:
 - i. Prescribing/ordering of medications;
 - ii. Preparing and dispensing of medications;
 - iii. Administrating medications; and
 - iv. Monitoring of the effects of medication.
- i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;
- j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;
- k. Serve as an advisory group to the hospital and Medical Staff pertaining to the choice of available medications; and
- l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 Practitioner Wellness

- a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;
- b. Evaluate the credibility of a complaint, allegation, or concern and establish a program for managing instances of inappropriate professional conduct, disruptive behavior, and harassment.
- c. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;
- d. Notify the impaired practitioner's Department Chief and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Professional Review Committee does not alter the primary responsibility of the Department Chief for clinical performance within that Chief's Department;
- e. Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible; and

- f. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

1.3.13 Utilization Management

- a. Study recommendations from Medical Staff members, quality assessment coordinators and others to identify problems in utilization and the review program;
- b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;
- c. Forward all unjustified cases in any review category to the appropriate Department or committee for review and action;
- d. Review case-mix financial data and any other internal/external statistical data;
- e. Upon review of any data, conduct further studies, perform education or refer the data to the Medical Staff peer review committee for their review and action;

Section 2. Medical Staff Committees

2.1 MEDICAL STAFF COMMITTEES

2.1.1 General.

The following shall be the standing committees of the Medical Staff: Medical Executive Committee, Credentials Committee, Professional Improvement Committee, Bylaws Committee, Professional Review Committee, and Nominating Committee. A committee shall meet as often as necessary to fulfill its responsibilities. Standing committees of the Medical Staff shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The Chief of Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the Chief of Staff when establishing the committee. The Chief of Staff and the CEO, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the Chief of Staff or by action of the MEC for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical staff members may be appointed to hospital committees. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

2.1.2 **Medical Executive Committee.** See UMC Bylaws, Part I: Governance, Section 6.2.

2.1.3 **Credentials Committee.** See UMC Bylaws, Part III: Credentials Procedures Manual, Section 1.

2.1.4 Professional Improvement Committee

- a. **Composition:** The Professional Improvement Committee shall consist of at least fourteen (14) voting members with each Medical Staff Department having one representative as set forth in the Professional Improvement Committee Charter. Current Department Chiefs are ineligible to simultaneously serve as voting PIC members. The Professional Improvement Committee shall include a Professional Improvement Committee Chair who shall be appointed by the Chief of Staff. The CEO (or designee), Chief of Staff (or designee),-and the Hospital Quality Director/Support Staff are ex-officio members of the Professional Improvement Committee without a vote.
- b. **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.2.

2.1.5 Bylaws Committee

- a. **Composition:** The Bylaws Committee shall consist of at least five (5) members. These will be chosen from the Active Medical and Dental Staff membership, with no more than two (2) members from any department, inclusive of key hospital leadership personnel.

- b. **Responsibilities:** The Bylaws Committee shall meet at least twice a year and as often as necessary to review and to make recommendations concerning the Bylaws to the Medical Executive Committee and the General Staff. The committee shall be responsible for those functions described in section 1.3.8 above

2.1.6 Professional Review Committee

- a. **Composition:** The Professional Review Committee shall consist of the Chief of Staff (or Designee), PRC Chair or PRC Vice-Chair, Chief Medical Officer (CMO), Department Chief or Vice Chief of the relevant Medical Staff Department and up to three (3) additional members of the Active Medical Staff. The PRC Chair and Vice-Chair shall be appointed by the Chief of Staff for a two-year term.
- b. **Responsibilities:** This committee shall be responsible for those functions described in section 1.3.12 above and issues involving professional conduct.

2.1.7 Nominating Committee

- a. **Composition:** The Nominating Committee shall be a special committee and shall consist of five (5) members of the Active Staff appointed by the Chief of Staff. The Committee will meet in October of the election year and forward its recommendations for candidates for office to the Active Staff. To avoid conflict of interest, members who desire to run for office shall not be appointed to the Nominating Committee.
- b. **Responsibilities:** The committee shall:
 - i. Develop criteria for leadership positions to include tenure, leadership training, previous experience in leadership positions and character; and
 - ii. Provide an annual slate of nominees for the elected Medical Staff positions;

2.1.8 Advanced Practice Professional (APP) Committee

- a. **Composition:** The APP committee shall consist of at least three (3) credentialed Advanced Practice Professionals who are Active Medical Staff where eligible. The APP chair will be appointed by the Chief of Staff for a period of two (2) years. Members shall be representative of the categories of APPs practicing in the hospital when possible (APRN, PA, CRNA, etc.), and adjunct members will be invited at the discretion of the Chair.
- b. **Responsibilities:** The APP committee is a multidisciplinary committee responsible for providing representation and coordination in all APP-related medical staff functions. The APP committee will develop and update APP core and specialty delineation of privilege documents to be aligned with current practice and applicable legal and regulatory requirements. The APP committee will oversee hospital policies that uniquely address APP practice or scope of practice. The APP committee will advise MEC committees and actively participate when APP practice and/or scope of practice are addressed. This includes consultation on items pertaining to quality, behavior, or privileging where advocacy or clarification is needed pertaining to APP practice and/or scope of practice.

2.2 HOSPITAL COMMITTEES

2.2.1 General

In addition to the Medical Staff Committees enumerated in Section 2.1, the following Hospital committees involve certain responsibilities of the Medical Staff : Burn Care Ad Hoc Committee, Cancer Committee, Center for Quality & Patient Safety Committee, Critical Care Committee, Education Committee, Ethics Committee, , Joint Conference Committee, Infection Control Committee, Institutional Review Board, P&T Committee, Point of Care Testing, Stroke Committee, Transfusion Care Committee, and Utilization Management Committee.

2.2.2 Burn Care Ad Hoc Committee

- a. **Composition:** The Burn Care Ad Hoc Committee shall consist of all Physicians or Dentists on the Burn Care call panel, unit manager, charge nurse, and representatives from Occupational Therapy, Dietary, Social Services, Pharmacy, and other hospital services as required.
- b. **Responsibilities:** The purpose of the Burn Care Ad Hoc Committee is to assure access to a high level of care for all burn patient admitted to the hospital or outpatient clinic. Assurance of that care shall include education of patients and staff, maintenance of a burn care product formulary, coordination of multidisciplinary services, and audit of care.

2.2.3 Cancer Committee

- a. **Composition:** The Cancer Committee shall consist of those physicians required by the Commission on Cancer who are members of the Medical and Dental Staff. They will be appointed by the Chair or Cancer Liaison Physician according to the requirements of the Commission on Cancer. The Chair of the Cancer Committee shall be appointed by the Chief of Staff in consultation with the CEO. Other ex-officio members without vote shall include a representative from Administration, Nursing, Social Service/hospice, Performance Improvement, Cancer Registry, and Rehabilitation. When necessary, committee composition may be adjusted as appropriate to maintain certification by the American College of Surgeons Commission on Cancer as a Hospital Cancer Program.
- b. **Responsibilities:** The purpose of the Cancer Committee is to assure access to a high level of care for all cancer patients admitted to the hospital or outpatient clinic. Assurance of that care shall include education of patients and staff, clinical conferences, audit of care and maintenance, and review of a database. It shall also provide for a Clinical Tumor Board for case evaluation and review. The committee provides program leadership with duties as described in the Standards of the Commission on Cancer.

2.2.4 Education Committee

- a. **Composition:** The Education Committee shall consist of seven (7) or more members of the Medical & Dental Staff. The members of the Medical Education Committee should be keenly interested in education and represent the major specialties and services. The members shall be appointed by the Chief of Staff, in consultation with the CEO, with approval of the Medical Executive Committee. The Administrative Director of Medical Education shall be a member, ex-officio, of the Education Committee, without vote. Voting members of the Education Committee shall serve a term of two (2) calendar years. Voting members will be replaced as needed by the Chief of Staff, in consultation with the CEO. One or more of the members will serve on The Center for Quality & Patient Safety Committee. The Chair of the Education Committee shall be appointed by the CEO, in consultation with the Chief of Staff.
- b. **Responsibilities:** The Education Committee shall be concerned with the planning and recommendation of all aspects of the Continuing Medical Education programs at University Medical Center. The Administrative Director of Medical Education, in collegial consultation with the Education Committee, is responsible for the coordination and execution of said programs. The Education Committee will ensure that all Physician or Dentist programs presented at University Medical Center adhere to the accreditation guidelines as set forth by the Nevada State Medical Association as established by the Accreditation Council for Continuing Medical Education of the American Medical Association, as well as meet program goals and objectives. The Education Committee shall plan and develop educational programs based on audit studies, Medical & Dental Staff survey of perceived educational needs, new advances in knowledge, new techniques and equipment, hospital statistics, recommendation of departmental chairs and needs apparent from Committee reports.

2.2.5 Ethics Committee

- a. **Composition:** The Ethics Committee will be appointed by the Chief of Staff, in consultation with the CEO, to serve a two (2) year term consisting of the following voting Members: Six (6) members of the active staff, one (1) member of the resident/fellow staff from the program relevant to the case will be appointed on a case by case basis, two (2) lay representatives from the community, one (1) from clergy, and two (2) members of the Nursing staff. The Committee will meet on an ad hoc basis to address specific situations concerning ethical matters and questions regarding patients' rights.
- b. **Responsibilities:** Ethical questions and concerns which arise in the hospital may be brought before this Committee by any member of the Medical & Dental Staff, Nursing staff, Advanced Practice Professional staff of this hospital, a patient or family member of the patient, a person having durable power of attorney for the patient, or other committees of the Medical and Nursing staffs of the hospital. The Committee can be contacted through the Medical Staff Office during regular business hours or through the On Duty Administrator during non-business hours. The Committee shall have the final determination as to the appropriateness of the request. Requests accepted by the Committee will be finalized with a written consultation that is included in the patient's chart. Copies of this consultation are available for the patient's Physician or Dentist and the Medical Executive Committee.

2.2.6 Infection Control Committee

- a. **Composition:** The Infection Control Committee shall include attendance by representatives from the Medical & Dental Staff, Administration, Nurse Epidemiologist, Employee Health Nurse, Director of Cardiology, Clinical Manager of MICU/SICU/NSCU and Director of Maternal Child Health with attendance, as needed by Director of Human Resources, Director of Environmental Services, Microbiology, Sterile Processing, Director of Food and Nutritional Services, Director of Plant Operations, Director of Pharmaceutical Services, Operating Room Coordinator, Chief Respiratory Therapist, and the Clark County Health District will be requested.
- b. **Responsibilities:** The purpose of the Infection Control Committee is to develop recommendations to insure there shall be an effective Infection Control Program within the hospital. The Committee is delegated by the Medical and Dental Staff to conduct continuous, ongoing review of antibiotic and drug monitoring which is in conformance with the ~~standard of the Joint Commission on Accreditation of Hospitals~~standards of an applicable CMS approved accreditation organization for infection control, and which meets the need of the hospital. The Committee shall meet as needed, but at least in accordance with ~~Joint Commission~~applicable accreditation, State, and other regulatory agency requirements, and is responsible to the Medical Executive Committee.

2.2.7 Institutional Review Board

- a. **Composition:** Membership must be comprised of at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted at University Medical Center. Membership will consist of at least one member whose primary concerns are in the scientific area and at least one member whose primary concerns are in non-scientific areas. The IRB may not consist entirely of members of one profession or gender. There will be at least one member who is not affiliated with the hospital and is not part of the immediate family of a person who is affiliated with the hospital. Physician or Dentist members of the IRB must maintain Active status on the Medical and Dental Staff of University Medical Center, unless specifically exempted by the Board Chairperson.
- b. **Responsibilities:** The Institutional Review Board reviews, approves, monitors and evaluates research projects and clinical investigations to be conducted and/or in progress, at the Hospital, following written procedures and criteria for reviewing and monitoring studies and observing all requirements of appropriately empowered regulatory authorities. It meets at least six times per year, and may meet monthly or at other times as deemed necessary by the Board Chairperson. Board minutes will be made available to the Joint Conference and the Medical Executive Committee.

2.2.8 Point of Care Testing Committee

- a. **Composition:** The Point of Care Committee shall consist of members of the Medical & Dental Staff, Allied Health Professionals, and employees of UMC, selected by the Chairman, that are stakeholder representatives.
- b. **Responsibilities:** The Point of Care Committee is a multidisciplinary committee established to govern all Point of Care Testing activities at UMC. The Committee is responsible to approve point of care devices and monitor regulatory compliance to ensure the highest level of care to all patients receiving services at any UMC facility. It shall meet quarterly, and is responsible to the Medical Executive Committee.

2.2.9 Quality & Patient Safety Committee

- a. **Composition:** Quality & Patient Safety Committee consist of representatives from various departments including: Administration, Clinical Quality and Patient Safety, Nursing Quality, Infection Control, Pharmacy, HIM, Medical Staff Nursing Administration, Nursing Units, Laboratory, Clinical Engineering, Food Services, Imaging Services, Primary Care and Urgent Care, Transplant Services, Human Resources and Disease Specific Services. The CEO, in consultation with the Chief of Staff, will appoint a Physician Representative and Chair to the Quality and Patient Safety Committee. Other members of the medical staff may participate as deemed necessary.
- b. **Responsibilities:** The Quality and Patient Safety program is responsible to monitor, evaluate and improve the quality of care provided throughout the organization in accordance with the annual Quality and Patient Safety Plan. Objectives, scope of service, responsibilities, evaluation, prioritization and performance improvement will be conducted in accordance with the annual Quality and Patient Safety Plan. The Quality and Patient Safety Committee will evaluate the effectiveness of the Quality program annually and will present its results to the Quality and Patient Safety Committee, the Medical Executive Committee and the Governing Board.

2.2.10 Stroke Committee

- a. **Composition:** The Stroke Committee shall be multidisciplinary and chaired by the Stroke Medical Director. The Committee shall meet a minimum of every other month or more frequently as determined by the Medical Director. All participants will be eligible to vote on all issues.
- b. **Responsibilities:** The Stroke Committee is responsible for the development, implementation and monitoring of the Stroke Program. Committee functions include establishing policies and procedures, reviewing process and system issues, review and analysis of process and outcome indicators. The Committee will strive to ensure that Stroke Care provided at University Medical Center meets standards of care as defined by current evidence and literature.

2.2.11 Trauma Committee

- a. **Composition:** The trauma committee shall consist of at least five (5) members of the Medical Staff. It shall also have hospital representatives as appointed by the CEO to fulfill requirements of the American College of Surgeons to comply with the guidelines for an ACS Verified trauma center and any State of Nevada Trauma Center designation guidelines.
- b. **Responsibilities:** The committee develops policies and procedures for the trauma service, oversees the on-call schedule, develops trauma-related educational programs based on the results of its evaluation of trauma care and programs on trauma prevention for the community, evaluates human and equipment resources and makes recommendations for capital expenditures, reviews the trauma registry, and reviews, evaluates, and discusses the quality of care in cases of adverse outcomes (complications and deaths) particularly focusing on those deaths statistically expected to survive, which were identified using outcome norms. Reviews monthly statistics based on injury severity score and revised trauma score as they relate to outcomes and provides a trend analysis of complications.

2.2.12 Utilization Management Committee

- a. **Composition:** The UMC Utilization Management Committee shall consist of two or more practitioners that carry out the utilization review function. At least two of these members of the committee must be doctors of medicine or osteopathy and one must be a staff member of the institution. The other members may be any of the other types of practitioners and can include other Leadership members.
- b. **Responsibilities:** This committee shall be responsible for the functions described in section 1.3.13 above.

Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- a. Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- b. Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- c. Contributions to teaching or clinical research; and
- d. Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or Medical Staff when done in good faith and without malice. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning, but not limited to:

- a. Applications for appointment/affiliation, clinical privileges, or specified services;
- b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- c. Corrective or disciplinary actions;
- d. Hearings and appellate reviews;
- e. Quality assessment and performance improvement/peer review activities;
- f. Utilization review and improvement activities;

- g. Claims reviews;
- h. Risk management and liability prevention activities; and
- i. Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

When requested by the Chief of Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the Medical Staff requested to perform a board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

**UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
GOVERNING BOARD CLINICAL QUALITY AND
PROFESSIONAL AFFAIRS COMMITTEE
AGENDA ITEM**

Issue: Emerging Issues	Back-up:
Petitioner: Patricia Scott, Quality, Patient Safety and Regulatory Officer	
Recommendation: That the Governing Board Clinical Quality and Professional Affairs Committee identify emerging issues to be addressed by staff or by the Clinical Quality and Professional Affairs Committee at future meetings; and direct staff accordingly. (<i>For possible action</i>)	

FISCAL IMPACT:

None

BACKGROUND:

None

Cleared for Agenda
October 7, 2024

Agenda Item #

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