

**APPENDIX D TO BYLAWS
OF
INGHAM REGIONAL MEDICAL CENTER
PROFESSIONAL STAFF**

GENERAL POLICIES

I. PROFESSIONAL LIABILITY INSURANCE2

 1.1 PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS FOR THE PROFESSIONAL STAFF
 AND ALLIED HEALTH PROFESSIONALS 2

II. QUERYING THE NATIONAL PRACTITIONER DATA BANK.....2

 2.1 REQUIREMENT 2

 2.2 COMPLETE APPLICATION 2

 2.3 EXCEPTIONS..... 2

 2.4 INFORMATION 2

III. DISCARDING SURGICALLY REMOVED SPECIMENS.....3

 3.1 PURPOSE 3

 3.2 SPECIMENS NOT REQUIRING ROUTINE PATHOLOGIC EXAMINATION 3

 3.3 DISPOSITION OF SURGICALLY REMOVED SPECIMENS 3

 3.4 DOCUMENTATION 3

 3.5 RESPONSIBILITY 4

IV. PRACTITIONER APPRENTICESHIP IN ESTABLISHED TECHNIQUES/4

PROCEDURES AND PRIVILEGING FOR NEW TECHNIQUES/PROCEDURES.....4

 4.1 PURPOSE 4

 4.2 ESTABLISHED TECHNIQUE/PROCEDURE – APPRENTICESHIP AT IRMC 4

 4.2-1 *Process*..... 4

 4.3 ESTABLISHED TECHNIQUE/PROCEDURE-MODIFICATIONS OF ESTABLISHED
 TECHNIQUE/PROCEDURE 5

 4.4 PROCEDURES THAT ARE NOT CURRENTLY PERFORMED AT INGHAM REGIONAL MEDICAL
 CENTER 5

 4.4-1 *Process*..... 5

 4.4-2 *New Technology/Procedure Developed By The Requesting Practitioner* 6

 4.4-3 *Emergency Use Of Technologies/Procedures*..... 6

 4.4-4 *Intradepartmental Uniformity Of Credentialing Criteria* 6

V. AMENDMENT AND APPLICATION7

 5.1 AMENDMENT 7

 5.2 APPLICATION..... 8

**INGHAM REGIONAL MEDICAL CENTER
PROFESSIONAL STAFF**

GENERAL POLICIES

I. PROFESSIONAL LIABILITY INSURANCE

1.1 PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS FOR THE PROFESSIONAL STAFF AND ALLIED HEALTH PROFESSIONALS

- 1.1-1 Members of the Professional Staff and Allied Health Professionals credentialed to practice at Ingham Regional Medical Center shall maintain minimum Professional Liability Insurance coverage of \$200,000/\$600,000 or demonstrate equivalent coverage through a self-funded insurance plan.
- 1.1-2 It shall be the responsibility of each Member of the Professional Staff to provide evidence of the required Professional Liability Insurance coverage to the CEO, or his designee, upon application for appointment/reappointment.

II. QUERYING THE NATIONAL PRACTITIONER DATA BANK

2.1 REQUIREMENT

In accordance with requirements of the Health Care Quality Improvement Act of 1986 as amended, Ingham Regional Medical Center, through the CEO, or his designee, will query the National Practitioner Data Bank:

- 2.1-1 All initial applicants to the Professional Staff and Allied Health Professionals;
- 2.1-2 All Members applying for additional clinical privileges;
- 2.1-3 All Members of the Professional Staff and Allied Health Professionals at the time of reappointment.

2.2 COMPLETE APPLICATION

Applications for Professional Staff membership and/or clinical privileges will not be considered complete until information from the Data Bank has been received. Therefore, no action on requests (including temporary privilege requests) can be considered until such requested information is received.

2.3 EXCEPTIONS

Exceptions may be considered in the event that the Data Bank does not respond timely.

2.4 INFORMATION

Information received from the National Practitioner Data Bank shall become part of the Professional Staff Member's or an Allied Health Professional's credentialing file and shall be considered confidential in nature.

III. DISCARDING SURGICALLY REMOVED SPECIMENS

3.1 PURPOSE

To identify surgically removed specimens which, at the discretion of the operating room physician, need not be submitted for routine pathological examination.

3.2 SPECIMENS NOT REQUIRING ROUTINE PATHOLOGIC EXAMINATION

Although appropriate documentation shall continue to be required, the following surgically removed specimens need not undergo routine pathologic examination:

- 3.2-1 Cataract
- 3.2-2 Teeth
- 3.2-3 Ear Tubes
- 3.2-4 Orthopedic, and other, hardware
- 3.2-5 Foreign Bodies
- 3.2-6 Intrauterine Devices
- 3.2-7 Normal tissues removed for plastic procedures including laceration repair trimmed tissues
- 3.2-8 Old, cutaneous surgical scars
- 3.2-9 Calculi not requiring chemical analysis
- 3.2-10 Nails from digits
- 3.2-11 Heal Spurs
- 3.2-12 Total knee and/or hip after replacement surgery
- 3.2-13 Foreskin from newborn circumcision
- 3.2-14 Varicose Veins

3.3 DISPOSITION OF SURGICALLY REMOVED SPECIMENS

Disposition of surgically removed specimens shall be at the direction of the attending surgeon and may be accomplished by the attending surgeon, Operating Room or Pathology Department personnel. Tissues submitted to the Pathology Department shall be accompanied by a completed surgical requisition slip.

3.4 DOCUMENTATION

Upon completion of the operative procedure, appropriate documentation shall be available for incorporation into the patient's medical record. Documentation shall, at a minimum, include a description of the discarded surgically removed specimen, which shall be summarized in the surgeon's Operative Notes.

3.5 RESPONSIBILITY

It shall be the responsibility of the attending surgeon and Operating Room supervisor to assure compliance with this policy.

IV. PRACTITIONER APPRENTICESHIP IN ESTABLISHED TECHNIQUES/ PROCEDURES AND PRIVILEGING FOR NEW TECHNIQUES/PROCEDURES

4.1 PURPOSE

This policy is to establish a process for a uniform approach to credentialing for apprenticeship in established techniques and procedures and credentialing for new techniques and procedures.

4.1-1 When national standards and/or guidelines for techniques or procedures exist, these shall be reviewed by and if felt applicable incorporated into IRMC's policies by the appropriate Department(s).

4.2 ESTABLISHED TECHNIQUE/PROCEDURE – APPRENTICESHIP AT IRMC

The applicant physician must hold Professional Staff Privileges and have completed all required monitoring of Privileges requested on initial application. He must secure a written agreement from a physician trainer**. The physician trainer must be a non-provisional Professional Staff Member in good standing who holds the Privilege requested without limitation.

The physician trainer will allow increasing levels of independence to the applicant as his skills evolve, but will remain immediately present for all cases during the apprenticeship. Upon completion of the Department-established minimum number of apprenticeship cases, the physician trainer may recommend extension of the training period if the applicant's skills are not at the expected level.

A surgical consent, listing both the physician trainer and the applicant as operators, will be obtained from each patient.

4.2-1 Process

- (a) The physician will submit a request and an agreement signed by a physician trainer to his Department for an apprenticeship.
- (b) The Department will review and, if supported, recommend a minimum number of monitored procedures.
- (c) The request and Department recommendation will be forwarded to the Credentials Committee for review and support.
- (d) The applicant may only begin performing the requested procedure/technique after approval of the Credentials Committee. Once monitoring has been satisfactorily completed, the physician may apply for Privileges to the Department.
- (e) The Department will determine an appropriate number of cases to be monitored and assign (an) independent Monitor(s). The Monitor(s) will also perform a retrospective chart review of cases performed under the physician trainer.

- (f) Upon completion of independent monitoring the Department will review the physicians' request for Privileges as well as the recommendations of the physician trainer and independent Monitor(s).
- (g) If approved at the Department level, the request for Privileges will be forwarded to the Credentials Committee for review and recommendation.

***The organized Professional Staff cannot mandate business practices to its members, however it is the sentiment of the Credentials Committee that billing issues should be clarified between the applicant and training physicians before an apprenticeship agreement is signed.*

4.3 ESTABLISHED TECHNIQUE/PROCEDURE-MODIFICATIONS OF ESTABLISHED TECHNIQUE/PROCEDURE

To institute modifications of established techniques or procedures that involve new or substantively different skills, equipment or supplies, the physician shall:

- 4.3-1 Submit a request to perform modification of an established technique/procedure to the Department for review.
- 4.3-2 Submit documentation of training in the modified technique/procedure, if applicable.
- 4.3-3 Assist the hospital is assessing the needs for staff training and equipment and participate in staff training, if necessary.

The Department will review the request and supporting documentation, and if approved, forward the request to the Credentials Committee for review and recommendation. The Department should indicate which, if any, of the requested listed in 4.2 above must be met by the physician.

4.4 PROCEDURES THAT ARE NOT CURRENTLY PERFORMED AT INGHAM REGIONAL MEDICAL CENTER

4.4-1 Process

The physician/applicant will be request to:

- (a) Attend graduate medical education programs that include the subject technology, at Accreditation Council for Graduate Medical Education (ACGME), or American Osteopathic Association (AOA) accredited institutions; or
- (b) Complete testing or certification program of ACGME or AOA affiliated certifying Boards; or
- (c) Attend programs of continuing medical education in ACGME or AOA accredited institutions; or
- (d) Provide documentation of training or practice under the direct supervision of a recognized authority in the field (Proctor).
- (e) The physician should further:
 - i. Demonstrate proficiency/experience in its use.
 - ii. Be able to interpret its results.

- iii. Be aware of potential complications and their treatment.
 - iv. Understand the basic science upon which the technology is based.
 - v. Assist the hospital in assessing the needs for staff training and equipment and participate in staff training, if necessary.
 - vi. Perform the technology only in a clinical environment with adequately trained staff and facility resources (including support by insurers that the technology performed is reimbursable to the facility and the physician).
- (f) The physician will submit a request for Privileges accompanied by a Proctor's recommendation, if applicable, and evidence of fulfillment of requirements listed in (a) through (e) above.
- (g) The Department will review the physician's request for Privileges and accompanying documentation and, if approved, forward the request to the Credentials Committee for review and recommendation.

4.4-2 New Technology/Procedure Developed By The Requesting Practitioner

If the physician is the developer of a new technology/procedure, its use shall be approved through the peer review mechanisms of the Institutional Review Board.

4.4-3 Emergency Use Of Technologies/Procedures

Emergency use of any new technologies/procedures is defined in the Professional Staff Bylaws, Section 5.5-8 Emergency Privileges. Use of procedures/technologies that are considered investigational must meet the conditions and requirements of the Institutional Review Committee's "Emergency Use" policy.

4.4-4 Intradepartmental Uniformity Of Credentialing Criteria

Ensuring quality patient care is best done with a uniform approach to monitoring. If Departments cannot reach a consensus, each Department shall determine its own competencies, subject to Credentials Committee approval. The Credentials Committee Minutes will reflect the differences between Departments, and its consideration of these variances. If, in the opinion of the Credentials Committee, the Departments' requirements, although not identical, are appropriate and should produce practitioners of essentially equivalent competence, they will recommend approval to the PSEC.

V. EMERGENCY PRIVILEGES FOR CREDENTIALING PHYSICIANS/ ALLIED HEALTH PROFESSIONALS IN THE EVENT OF A DISASTER

5.1 PURPOSE

This policy provides for emergency privileging of physicians and Allied Health Professionals in response to a disaster situation when IRMC or its Professional Staff are unable to provide all the medical services required. When such a disaster is declared by the CEO, or his designee, this policy provides expedited credentialing for physicians and Allied Health Professionals of known reputation and quality who hold medical staff membership at another fully accredited institution.

This policy is designed for a disaster situation and is not related to emergency privileges (“good Samaritan”) as defined in the Professional Staff Bylaws, Article V-Appointment and Privileges, Section 5.5-8 Emergency Privileges.

5.2 CREDENTIALING REQUIREMENTS

5.2.1 The following elements are required for credentialing:

5.2.1.1 Evidence of Current License

5.2.1.2 Evidence of Professional Liability Insurance

5.2.1.3 Photo Identification

5.2.2 To be done concurrently:

5.2.2.1 National Practitioner Data Bank Query

5.2.2.2 Office of Inspector General Query

5.2.2.3 List of Current Hospital Affiliations

5.3 MISCELLANEOUS PROVISIONS

Emergency designees will only exercise these emergency privileges at the request of and under direction of an existing Professional Staff Member. Emergency privileges terminate once the emergency need subsides as determined by the CEO and either the CoChief(s) of Staff or the Chief Medical Officer. Termination of emergency privileges does not give the practitioner the right to a hearing or review.

5.4 PROCESS

The Medical Staff Services Department gather required documents and obtains approval signature from the CEO or his designee and one of the following: CoChief of Staff or Chief Medical Officer.

VI. AMENDMENT AND APPLICATION

6.1 AMENDMENT

These Policies may be amended or repealed, in whole or in part, in the same manner that Rules and policies of the Professional Staff may be amended.

6.2 APPLICATION

Any matter subject to review or hearing pursuant to the Professional Staff Bylaws after adoption of these Policies by the Board of Trustees shall be governed by its terms; the prior review and hearing procedures shall be deemed superseded by the terms of this Policy.

The foregoing Policies to the Bylaws of the Professional Staff was adopted by the Active Professional Staff Members of the Hospital on the 24th day of January, 2006.

CO-CHIEF OF THE PROFESSIONAL STAFF

CO-CHIEF OF THE PROFESSIONAL STAFF

SECRETARY OF THE PROFESSIONAL STAFF

ADOPTED by the Board of Trustees of the Hospital on the 21st day of February 2006.

SECRETARY OF THE BOARD