OCEAN UNIVERSITY MEDICAL CENTER

MEDICAL STAFF

DEPARTMENT/ INSTITUTE
DIVISION/SECTION

RULES AND REGULATIONS

REVISED March 19, 2024

TABLE OF CONTENTS

Page

MEDICAL STAFF RULES AND REGULATION

ARTICLE I: INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Trustees, to further define the general policies contained in the Medical 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 These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical 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, and Case Management/utilization standards in effect in the Hospital.

ARTICLE II: ADMISSION AND DISCHARGE

2.1 ADMISSIONS/OBSERVATIONS

2.1.1 General

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

a. **Admitting/Observation Privileges:** A patient may be admitted/authorized for observation status to the hospital only by a practitioner on the Medical Staff with admitting/observation privileges.

b. **Admitting/Observation Diagnosis:** Except in an emergency, no patient will be admitted/authorized for observation status to the hospital until a provisional diagnosis or valid reason for admission/observation has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission/Observation Procedure:** Admissions/Observations must be scheduled with the Hospital's 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 attending practitioner or his designee shall contact the Hospital's Admitting Department to ascertain whether there is an available bed.

2.1.2 Admission Priority

Admission/Registration 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/Observations:** Urgent admission/observation patients meet the criteria for inpatient admission or observation status, 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/Observations:** Elective admission/observation 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/observed on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted/observed 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 presenting to the emergency department will be evaluated and treated, admitted or placed on observation as necessary, or transferred to appropriate facility. Patients in active labor will be admitted directly to Single Room Maternity per hospital policy after determination that the patient is stable.

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. Pregnant patients, greater than twenty (20) weeks gestation, with a primary obstetrical complaint can have their medical screening exam done in the obstetrics 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 an established relationship with a practitioner, within the past three (3) years outside of that in an unassigned capacity, or does not indicate a preference;

b. the patient's established practitioner does not have admitting privileges; or the patient's

c .injuries or condition fall outside the scope of the patient's established 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 Chair, or his/her designee, shall provide the Emergency Department and the Medical Affairs Office with a list of physicians who are scheduled to take emergency call on a rotating basis. A physician shall serve either on a department or section call list.

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, should respond to calls from the Emergency Department within thirty (30) minutes by telephone, 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 the on-call physician does not respond to being called or paged, the physician's Department Chair shall 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. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action. In the case of the alternate coverage being unavailable, the on-call physician originally assigned has the responsibility to provide/find coverage.

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 a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit if the patient does not have a practitioner in the area to follow-up with.

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 Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules, regulations, and policies that are binding on the members of their department. The following rules should be used in developing departmental policies regarding unassigned emergency call obligations:

a. Unassigned call duties should be based on the appointee's clinical core privileges; physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category, as determined by the Department Chair.

b. Unassigned call duties shall be assigned by the Department Chair and approved by the MEC and Board.

c. Unassigned duties may be divided by department, specialty, or subspecialty.

d. A physician may be excused from Unassigned call roster as long as the remaining members of the specialty agree and absorb the call time of the excused physician.

e. Those Senior Attending practitioners excused from call prior to the date of adoption of these rules and regulations will not be required to take Unassigned Call. After adoption of these rules and regulations, Senior Attendings may request to be excused from call but shall have this request granted only if the Department Chair can fill the entire Unassigned Call roster and it is approved by the Board.

f. An impairment which is alleged to limit an appointee's ability to provide Unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.

g. Departmental policies concerning Unassigned call, including the frequency of call, must be approved by the Medical Executive Committee and the Board.

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.

2.2.7 Failure to Meet Unassigned Call Obligations

All failures to meet Unassigned call responsibilities shall be reported to the Department Chair and the Medical Executive Committee. Failure to provide unassigned call services will result in the physician being assigned two (2) extra call days for each missed call. These extra call days will be assigned the month following the noted failure to meet call obligations. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.3 TRANSFERS

2.3.1 Transfers To / From Other Acute Care Facilities

Transfers to/ from other acute care facilities must meet the following criteria:

a. The patient must be medically stable for transfer;

b. The patient's condition must meet medical necessity criteria;

d. The patient must require, and the Hospital transferred to must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility or it is done at patient request;

e. Responsibility for the patient must be accepted by a physician with appropriate privileges at the receiving Hospital; and

f. The transfer must be approved by the receiving Hospital representative with authority for accepting transfers.

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.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending 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.

Acute care admissions of suicidal patients will be accepted subject to bed availability. Other acute care admissions for suicidal patients will not be accepted except for those patients requiring medical stabilization or when transfer to an inpatient psychiatric facility cannot be facilitated. In these instances, once the patient's medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

The attending 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.

2.5 PROMPT ASSESSMENT

All new admissions must be personally assessed and have a history and physical examination completed and on the record within 24 hours. Patients admitted to critical care units must be seen in a timely manner as determined by the patient's condition by the attending physician or designee if the patient is

stable. 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 instruction 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.

ARTICLE III: 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.

In order to practice medicine, all healthcare providers 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 providers will undergo appropriate EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

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 handwritten entries in the medical record shall be made in ink and shall be clear, complete, legible, signed, dated and timed. Orders which are, in the opinion of the authorized individual 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 immediately. 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:

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 as noted in the hospital policy "Do Not Use Abbreviations"

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

Time limits for performance of the history and physical examination are noted in the medical staff bylaws.

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

Who may perform the history and physical examination are noted in the medical staff bylaws.

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 or regional), and all observation patients. A complete history and physical examination report must include the following information:

a. Chief Complaint
b. History of Present Illness
c. Past Medical History, Past Surgical History, Family History and Social History d. Medications
e. Allergies
f. Review of Systems
g. Recording of vital signs
h. Physical examination by body systems
i. Impression
j. Treatment plan

A focused history and physical examination report, used for outpatient procedures that require only moderate sedation, deep sedation, or MAC, should include the following information:

a. Reason for the procedure
b. Significant past medical history
c. Current medications
d. Allergies
e. Postoperative plan
f. Recording of vital signs, examination of heart, lungs and part to be invaded

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

A Physician is Responsible for the Admission History and Physical. Completion is the responsibility of the physician or his/her designee. An Advanced Practice Provider (APP) can write-up the History and Physical, however, the collaborative/supervising physician must physically see the patient within 24 hours and counter-sign the History and Physician.

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, or pacemaker implantation); and

c. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, bone marrow biopsy, port-a-cath placement, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be postponed or cancelled if an H&P is not completed. The procedural **H&P,** or the update, should be performed by the proceduralist. In cases of procedures performed by podiatrists and dentists, the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESS NOTES

The attending of record or his/her/their covering physician will record a progress note or meaningful attestation every day for all hospitalized patients and indicate that they have seen and personally directed care. If a consultant progress note is written by an APP, the collaborating physician must co-sign the note within 24 hours acknowledging that they have reviewed the APP note and agree with the findings and plan. It is the responsibility of the consulting physician to cosign the note.

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written 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 and made a part of the patient's current medical record. Operative/procedure reports will include:

a. the name of the licensed independent 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, any specimen(s) removed,

j. any prosthetic devices, transplants, grafts, or tissues implanted, and

k. the postoperative diagnosis.

3.9 POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:

a. the name of the licensed independent 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 the post-operative/procedure diagnosis.

3.10 PRE-ANESTHESIA NOTES

A pre-anesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, shall be made by the physician administering or supervising, as applicable, the administration of anesthesia and entered into the medical record of each patient receiving anesthesia at any anesthetizing location.

3.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Department of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES

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. The note shall be entered by an anesthesia provider 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.

3.13 CONSULTATION REPORTS

An APP may write the consultation. The consulting physician must then be contacted prior to initiation of diagnostics or treatment. The consulting physician must see and evaluate the patient and write an attestation or full formal consultation within 24 hours of the consult being ordered for the consult to be considered complete.

3.14 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 thirty (30) 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 will be documented.

3.15 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.

3.16 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. The discharge summary must be completed within thirty (30) days after discharge. All discharge summaries are the responsibility of the attending physician.

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

   1 Reason for hospitalization;

   2 Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;

   3 Condition of the patient at discharge;

   4 Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and

   5 Final diagnoses.

b. **Short-term Stays:** A discharge summary is not required for uncomplicated inpatient and observation hospital stays of less than 48 hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician enters a fmal progress note or completes a Discharge Form documenting: 1. The condition of the patient at discharge; and

   1 Instructions given to the patient and family, including medications, referrals, and followup appointments.

c. **Deaths:** A discharge summary is required on all inpatients who have expired and will include:

   1 Reason for admission;

   2 Summary of hospital course; and

   3 Final diagnoses.

d. **Timing:** A Discharge Summary is required to be entered and signed in the medical record within thirty (30) days after discharge, transfer, or death.

3.17 DIAGNOSTIC REPORTS

Pathology reports must be read by the pathologist within one (1) business day after availability of the complete test (and all other necessary studies are present) to read. Diagnostic reports (including but not limited to inpatient EEGs, EKGs, echocardiograms, stress tests, Doppler studies, and radiology studies) must be read by the physician scheduled to provide the interpretation service within one (1) calendar day after the complete test (and all other necessary studies are present) is available to read.

3.18 ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals are Physician Assistants (PAs) and Advanced Practice Registered Nurses (certified nurse midwives (CNMs), nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs) and clinical nurse specialists providing direct patient care).

1:1 The collaborating/supervising physician will review and authenticate all discharge summaries prepared by the Advanced Practice Professional; With the exception of CNMs, the collaborating/supervising physician will either enter their own note or attest to the APP's note, within twenty-four (24) hours, for all history and physical examinations;

Routine orders of an Advanced Practice Professional do not need co-signature by a physician. Orders for controlled substances need to be cosigned by a physician if the APP does not have their own independent DEA number;

With the exception of CNMs, the collaborating/supervising physician will cosign any progress notes performed by APPs within twenty-four (24) hours; and delivery notes done by CNMs do not require co-signature by a physician.

3.19 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, operative notes, and operative reports cosigned within one calendar day by the attending physician, or their physician designee;
- Discharge summaries cosigned by the attending physician, or their physician designee, within thirty (30) days after discharge of the patient;
- Progress notes cosigned within one calendar day, unless the attending physician enters their own independent note for that day; and
- Orders of the resident or fellow do need to be cosigned within one calendar day.

Residents 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.

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.

3.20 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 statute.

Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

a. **Access to Old Records:** In case of readmission of a patient, all previous records will be made available to the attending practitioner whether the patient was attended by the same practitioner or by another practitioner.
b. **Unauthorized Removal of Records:** Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.
c. **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.
d. **Access for Former Member**s: 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

3.21 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 Quality Improvement and Outcomes Committee.

3.21.1 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, Section 2.4;
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 with update, or a de novo history and physical, must be entered in the medical record by the attending physician or designated covering practitioner within twenty-four (24) hours after an obstetrical admission;
d. An Operative 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, a Post-Operative 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 and authenticated by the attending physician, or designee, each day and for each significant patient encounter on all hospitalized patients;
g. An Emergency Department Record must be completed by the responsible practitioner: Prior to transfer for all transferred patients; Before discharge from the Emergency Department of all admitted patients and patients discharged home;
h. A Consultation Note must be completed by the consulting physician, or designee, within twenty-four (24) hours of notification of the consult request; Routine Inpatient Diagnostic

Reports must be completed, after availability of the complete test to read (along with any other necessary studies), within one (1) business day for pathology and within one (1) calendar day for all other diagnostic reports. Stat reports must be completed as soon as possible;

i. A Discharge Summary must be entered in the medical record by the discharging physician or his/her designee preferentially within thirty (30) days after an inpatient or observation discharge, transfer, or death; and

j. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary

3.21.2 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, he/she will follow the process noted below:

History and physical, operative/procedural reports, and consultations not dictated within twenty-four (24) hours will be considered delinquent. Discharge summaries will be considered delinquent if not completed within fourteen (14) days of discharge. Medical and Dental Staff members and Allied Health Professionals will be required to notify the Medical Staff Office of any changes made to their email address as that will be used for official correspondence regarding medical records. Additionally, Physicians and other AHPs are required to contact the Medical Staff Office and confirm the email address on file.

It is the responsibility of the Medical and Dental Staff members and AHP to maintain and monitor their email.

In the event the HIM Department determines a physician is delinquent, they will contact the Medical Staff Office for the current official email address on file.

Notifications of the delinquency will be sent to the email address fpr the providers at a regular interval. If the H&P is unsigned after 14 days, the provider is eligible for suspension. If the discharge summary is incomplete after 30 the provider is eligible for suspension. Upon suspending the provider, the HIM department will fax a notice of suspension to the physician office as a courtesy and retain fax confirmation.

Official notification is based on the aforementioned email/failure to monitor or verify with the Medical Staff Office the email address on file, does not excuse the physician. Notification will also be sent to the Department Chairperson.

If a physician's privileges are restricted (Medical Record Suspension) three (3) times in a rolling 12-month calendar, the provider will be required to present to the Medical Executive Committee to explain how this will be prevented.

Habitual delinquencies may be considered during reappointment.

Any physician on Medical Record Suspension will be unable to admit new patient or schedule new surgeries or procedures. Call will be at the discretion of the Department Chairperson based on department needs.

Restriction means a physician will be unable to admit new patients or schedule new surgeries or procedures, but may care for existing patients and perform scheduled surgeries. Physicians placed on restriction three (3) times or more within a twelve (12) month period will have to appear before QI&O and will make further recommendations to the MEC for further action if necessary.

3.22 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.

3.23 COPY FUNCTIONALITY FOR DOCUMENTATION WITHIN THE ELECTRONIC HEALTH RECORD (EHR)

3.23.1 Copy Functionality

The purpose of the health record is to provide a basis for planning patient care and for the continuity of care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the use of copy functionality when documenting in the Electronic Health Record (EHR). For the purpose of this rule, copy shall be understood to include cut/paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.

Providers or other individuals permitted to document in the EHR ("Providers" hereafter) must avoid indiscriminately copying and pasting another provider's documentation as well as the process of copying forward information from previous notes, without clear attribution in an effort to increase documentation in a current visit. Indiscriminate use of copying and pasting lengthens the note, may lead to fraudulent provider billing, adds redundant information that may be unnecessary, and may adversely impact quality and patient safety. Inappropriate use of copy functionality may be deemed to be pre-documentation or falsification. The following procedure shall be used:

a. Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.
b. If any information is imported or reused from a prior note, the provider is responsible for its accuracy and medical necessity. A provider may not copy another practitioner's note.
c. Providers are responsible for correcting any errors identified within documentation. Providers must notify the Director of Health Information (H.I.) immediately regarding any error(s) in the source note. All notes from the original source that contain errors must be corrected.
d. Providers are responsible for citing and attributing as applicable all lab data, pathology, and radiology reports
e. Providers are responsible for clearly identifying who performed each service documented within the note. When entering patient data into the medical record that the provider did not personally take or test, the provider must attribute the information to the person who did.
f. If the provider references a form or other entries within the record (e.g., review of system form), he/she must reference the form or other entry with sufficient detail to uniquely identify the source. Example: See review of systems dated 1/1/08.
g. Providers are required to document in compliance with all federal, state, and local laws and Medical Staff Rules and Regulations. Once a note has been signed as final, additional information may only be added as an addendum
h. Failure to comply with this procedure subjects the provider to corrective disciplinary action.

3.23.2 Medical Record Copy Function Sanction Policy

When practitioner's fall to comply with the procedure noted above, the following will occur:

a. Inappropriate copying will be referred for Open Record Review and to the Medical Record Committee for review, validation and facility-wide trending.
b. The Chairman of the Quality Improvement and Outcomes Committee is responsible for reviewing all substantiated inappropriate use of copy functionality and facility wide trending reports. This Committee Chairman will work with the respective department Chairman and shall make recommendations on disciplinary action in which continued inappropriate use of copy technology is identified.
c. Failure to comply with the organizational policy regarding copy functionality will be deemed a violation of hospital policy. Non-compliance with this policy will assessed as part of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) or under the Human Resources Performance Management Policy.
d. Further action, up to and including automatic suspension from the Medical Staff, may be taken by the President of the Medical Staff based on the recommendation of the respective department chairman when the HIM director informs him/her of repeated violations or single violations deemed to be falsification or presenting a serious threat to patient safety in accordance with policy and the Medical Staff Bylaws.
e. Providers are responsible for citing applicable lab data, pathology, and radiology reports without copying such reports in their entirety into the note.

3.24 ORGANIZED HEALTH CARE ARRANGEMENT

a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA"), the Medical Staff of [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 care setting." As "clinically integrated such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with Ocean University Medical Center and the hospital's medical staff. Except for noncompliance 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.
b. The members hereby adopt the Ocean University Medical Center 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.
c. 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 Ocean University Medical Center, 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 Ocean University Medical Center information through a portal maintained by the member.

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

ARTICLE IV: STANDARDS OF PRACTICE

4.1 ADMITTING, ATTENDING AND DISCHARGING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges.

The admitting physician, or designee, is responsible for completion of the history and physical examination.

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

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

The discharging physician, or designee, is responsible for completion of the Discharge Summary.

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

a. Telephonic Response. Practitioners are expected to respond within thirty (30) minutes to calls from the Hospital's patient care staff regarding their patient.

b. Physical Response: Practitioners are expected to respond in person within thirty (30) minutes to evaluate emergent requests from staff. If not available within thirty (30) minutes, the practitioner should provide for back-up response.

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 or an individual approved by the appropriate GME training director.

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 signature, date, and time.

4.4.2 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 orders are given directly practitioner-to-hospital staff; telephone orders are given practitioner-to hospital staff via telephonic communication means. Verbal/telephone orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in hospital policy.

b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All verbal orders must be signed by the ordering practitioner prior to leaving the treatment area.

e. All telephone orders must be promptly signed by the ordering practitioner or another practitioner involved in the patient's care.

f. Orders for cancer chemotherapy may not be given verbally.

g. Verbal/telephone orders may be given only by practitioners privileged at the hospital or working under training protocols.

4.4.3 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; and
d. The facsimile contains the name of the ordering practitioner, his 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.

4.4.4 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,
c. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

4.4.5 Drugs and Medications

Orders for drugs and medications must follow Hospital Pharmacy policy "Prescribing and Ordering Medication"

4.5 CONSULTATION

a. 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, or designee, will provide written authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his/her patient. This request shall specify:
    i. the reason for the consultation, and
    ii. the urgency of the consultation (STAT — in a timeframe determined by conversation between the referring physician and the consultant; routine — within 24 hours). All STAT consultations require physician-to-physician communication.
    iii. All consultations will be for "consultation and treatment"
b. All urgent and emergent consultations should be communicated practitioner-to-practitioner. Nurse practitioners and physician assistants may initiate the consultation. Routine consultations can be ordered through the EMR; if the consultation does not occur within twenty-four (24) hours, then the ordering physician shall directly contact the consultant.

c. Consultants are strongly encouraged to notify the attending physician before ordering consultations with other specialties, unless the need is urgent/emergent.

d. APRNs and physician assistants may collect information to initiate the consultation with the knowledge and collaboration of their collaborating/supervising physician. Nurse practitioners and physician assistants may not order diagnostics or treatments without discussing this, and documenting the discussion in the record, with the supervising/collaborating physician. The consultant then must see and evaluate the patient and dictate the complete consultation. If the practitioner requesting the consult requests that the consulting physician perform the consultation, that request will be honored.

e. The attending physician may utilize consultants of their choice. In general, if a patient has chronic consultative care by a consultant prior to this episode of care, that physician should be consulted if that medical issue is unstable. If desired, the attending physician may utilize the ED on call list for consultation.

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 a timeframe as determined by the patient's condition 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 and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced by the attending practitioner or an alternate physician. The attending physician or licensed resident is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner, not to exceed twenty-four (24) hours after pronouncement of death. In cases of death within the emergency department, the primary care physician will be responsible for certifying the cause of death and completing the Death Certificate in a timely manner, not to exceed twenty-four (24) hours after pronouncement of death.

4.7.2 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.

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. For all autopsies done in the hospital, a provisional anatomic diagnosis will be recorded on the medical record within seventy-two (72) hours, and the complete autopsy report will be made part of the medical record within thirty (30) days unless an explanatory note is written.

4.9 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (nurse midwives, CRNAs, nurse practitioners, and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is an appointee to the Medical Staff, and are not eligible for Medical Staff membership.

4.9.2 Guidelines for Supervising 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 under their supervision/collaboration must be within the scope of each practitioner's authorized practice, as defmed 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. The role of the Advanced Practice Professional in the delivery of care shall be defmed through mutually agreed upon Scope of Practice Guidelines that are developed by the physician and the Advanced Practice Professional.

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. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician(s).

g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

h. 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 Scope of Practice

Guidelines

i. The supervising/collaborating physician(s) is (are) responsible for clarifying and familiarizing the Advanced Practice Professional with his or her supervising methods and style of delegating patient care.

j. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and one or more alternate supervising physician(s).

4.9.3 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Services Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional, the supervising/collaborating physician, and all alternate supervising/collaborating physicians. The Supervision/Collaboration Agreement shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the Advanced Practice Practitioner can provide services to patients at the Hospital.

4.9.4 Supervising/Collaborating Physician

An Advanced Practice Professional may not provide services to patients if the supervising/collaborating physician, or alternate physician, is more than thirty (30) minutes travel time from the Hospital. A physician may not supervise more than four (4) Physician Assistants at one time.

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 Staff Bylaws.

4.9.5 Medical Record Documentation

Advanced Practice Professionals medical record documentation is noted in Section 3.18.

4.9.6 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Services Office,
b. provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician, or
c. enter orders on patients in intensive care units.

4.10 INFECTION CONTROL

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

4.11 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 providers who are expected to implement the guidelines.

ARTICLE V: PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital policy.

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. Informed consent should follow Hospital policy.

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 "Do Not Resuscitate" 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 "Disclosure of Unanticipated Outcomes" 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 and Seclusion" 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 should be followed.

ARTICLE VI: 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

A complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic followup) of the patient's condition must be completed for each patient receiving general/regional/MAC anesthesia. Only anesthesiologists, certified registered nurse anesthetists, or physicians privileged to perform deep sedation (which is part of MAC) shall be able to perform these procedures.

Moderate sedation may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

Moderate and deep sedation is performed under the authority of the anesthesia department.

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 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" shall be followed.

6.6 DEPARTMENT CHAIR

The department Chair has the option of not taking emergency department call.

6.7 SURGICAL REGIONAL STAFF

Surgical regional staff are limited to six (6) operative room cases, twelve (12) minor surgery procedures or twelve consultations per year. Encounters over and above those noted may result in transfer to Active surgical staff at the discretion of the Department Chair.

ARTICLE VII: 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 policy on "Medical Staff Code of Conduct Disruptive Behavior" shall be followed.

7.2 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 "Practitioner Impairment"

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics'* Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on TB testing, influenza vaccination, and any testing/vaccinations as noted in policy. Verification of MMR status and screening drug testing will be done only upon initial credentialing.

ARTICLE VIII: MEDICAL STAFF ORGANIZATION AND LEADERSHIP

8.1 MEDICAL STAFF ORGANIZATION

8.1.1 List of Departments

a. Department of Anesthesiology
b. Department of Emergency Medicine
c. Department of Medicine
d. Department of Obstetrics and Gynecology
e. Department of Orthopedic Surgery
f. Department of Pathology
g. Department of Pediatrics
h. Department of Physical Medicine and Rehabilitation
i. Department of Radiation Oncology
j. Department of Radiology
k. Department of Surgery

8.1.2 List of Sections

a. Medicine
    i. Cardiology
    ii. Endocrinology
    iii. Family Medicine
    iv. Gastroenterology
    v. Hematology/Oncology
    vi. Infectious Disease
    vii. Internal Medicine
    viii. Nephrology
    ix. Psychiatry
    x. Pulmonology
    xi. Rheumatology

b. Surgery
    i. General Surgery
    ii. Neurosurgery
    iii. Ophthalmology
    iv. Oral and Maxillofacial Surgery
    v. Otolayrngology
    vi. Plastic Surgery
    vii. Thoracic Surgery
    viii. Urogynecology
    ix. Urology
    x. Vascular Surgery

c. Orthopedic Surgery
    i. Podiatric Surgery

8.2 FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS, INSTITUTES, AND SECTIONS

Functions and responsibilities of departments and department chairs, vice-chairs, and section chief are set forth in Article XII of the Bylaws.

8.3 RULES AND REGULATIONS OF DEPARTMENTS, INSTITUTES, AND SECTIONS

Each department, institute, division, and section may have their own rules and regulations which 1) cannot be in conflict with the Medical Staff Bylaws or Medical Staff Rules and Regulations, and 2) must be approved by the MEC and Board of Trustees.

8.4 MEDICAL STAFF COMMITTEES AND FUNCTIONS

This section outlines the Medical Staff committees of Ocean University Medical Center that carry out quality assessment and other functions delegated to the Medical Staff. Procedures for appointment of committee chairpersons and members are set forth in Article V of the Bylaws. All standing committees and committee Chairpersons will be appointed by the Medical and Dental Staff President with the approval of the MEC as noted in the Bylaws, Article XIII.

8.4.1 Standing Committees

- Medical Executive Committee
- Bioethics Committee;
- Bylaws Committee
- Credentials Committee;
- Critical Care Committee;
- Operating Room Committee;
- Nominating Committee;
- Pharmacy and Therapeutics Committee;
- Quality Improvement and Outcomes Committee;
- Professional Assistance Committee; and
- Joint Conference Committee.

8.4.2 Description of Committees

a. Bioethics Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.1

b. Credentials Committee
The Credentials Committee shall consist of a representative from each Department as determined by the Department Chair. The chairperson will be appointed by the Medical and Dental Staff President. Service on the committee shall be considered the primary medical staff obligation of each member of the committee and other medical staff duties shall not interfere. The duties of this committee are noted in the Bylaws in Section 13.4.3.

c. Critical Care Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.4

d. Operating Room Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.5

e. Nominating Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.6. The Department representative shall be the Department Chair, or designee.

f. Pharmacy and Therapeutics Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.7

g. Medical and Dental Staff Quality Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.8.

h. Professional Assistance Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.9.

i. Joint Conference Committee
The composition and duties of this committee are noted in the Bylaws in Section 13.4.10.

j. IT Advisory Committee
The IT Advisory Committee will consist of three to five (3-5) Medical and Dental Staff Members and at least one (1) IT representative. This committee provides Medical and Dental Staff input into IT issues such as the Electronic Health Record.

8.5 MEC AT-LARGE MEMBER QUALIFICATIONS

MEC At-Large Members must be members of the Attending Staff for at least two (2) years at the time of nomination. In addition, MEC At-Large Members must have no pending adverse recommendations concerning their medical staff appointment or clinical privileges, must be willing to faithfully discharge the duties and exercise the authority of the position held, and must have demonstrated and maintain the ability to work well with others.

8.6 DEPARTMENTS

8.6.1 Department Chairperson

Qualification and selection process are noted in Section 12.2.2 of the Bylaws.

8.6.2 Department Meetings

a. Quorum is fifteen percent (15%) of the voting Members of the department, but not fewer than two (2) voting members.
b. Attendance: Department members are required to attend fifty percent (50%) of the department meetings, or may be transferred to a non-voting status.

8.7 SECTIONS

8.7.1 Selection of Section Chiefs

Each Section Chief shall be an Attending or Senior Attending in good standing in the Section, have demonstrated ability, have significant clinical activity (defined as direct clinical contact with patients such as admissions and consultations on inpatients, excluding telemedicine) at OMC as determined by the MEC, a fifty percent (50%) meeting attendance, be Board Certified in the appropriate specialty upon appointment and otherwise be qualified for medico-administrative service. Selection of the Section Chief will be the same as that for the Department Chair, with the exception that only Active Section Members may vote. Section Chiefs shall serve a term of two (2) years and can serve up to three (3) consecutive terms.

8.7.2 Section Meetings

a. Quorum is twenty-five percent (15%) of the voting Members of the Section, but not fewer than two (2).
b. Attendance: Section members are required to attend fifty percent (50%) of the section meetings, or may be transferred to a non-voting status.

8.8 CLINICAL DIVISIONS

Ocean University Medical Center does not have Clinical Divisions.

8.9 DUES

Dues will be collected annually, in an amount to be determined by the Medical Executive Committee. There shall be a penalty if $100 if the payment is more than thirty (30) days late. Membership and privileges will be automatically suspended if payment is not received within sixty (60) days after due.

8.10 MEDICAL STAFF EXPENDITURES

The Medical Executive Committee may spend no more than $10,000 on any single expenditure without the approval of the Medical Staff.

8.11 VOTING

8.11.1 Quorum for Medical and Dental Staff Meetings

Fifty (50) members present, who are eligible to vote, shall constitute a quorum of any regular or special meeting of the Medical and Dental Staff. This quorum must exist for any action to be taken. Votes are subject to quorum call.

8.11.2 Communication regarding Bylaws amendments

Bylaws amendments shall be announced at a Medical and Dental Staff meeting, either regular or special, prior to a vote.

8.11.3 Committee Voting

a. MEC, Credentials Committee, Quality Improvement Committee, and Bioethics
    i Requires a quorum of fifty percent (50%) to conduct business
    ii Voting will require a majority vote
b. All other committees
    i Requires a quorum of at least of two (2) Medical and Dental Staff Members to conduct business
    ii Voting will require a majority vote

8.11.4 Methods of voting

The Medical Staff shall vote by written ballot with the physical presence of the voter. Electronic voting may be allowed for the election of Officers and Department Chairs where permitted, during an emergency situation, by the President of the Medical and Dental Staff.

8.13 TERM OF OFFICERS

The Officers of the Medical Staff may serve an optional third year in their term, with the consent of the Medical Staff.

ARTICLE IX: OTHER MEDICAL STAFF ISSUES

9.1 REPORTING REQUIREMENTS

9.1.1 State reporting requirements

The Medical Center will report to the State Medical or Dental Board, as appropriate, specific information as requested on the "Adverse Action Report" form, when the following actions are taken:

1. Any professional review action, based on professional competence or conduct, which results in a reduction, restriction, suspension, revocation, or denial of clinical privileges of a physician or dentist for a period longer than 30 days
2. Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist:
    a. While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or
    b. In return for not conducting such an investigation or proceeding.

Hospitals must report adverse actions as noted above to the State Medical or Dental Board, as appropriate, within 15 days from the date the adverse action was taken by the Board of Trustees. That section of the Adverse Action Report form requiring a description of the action taken will be completed by the hospital's General Counsel. The completed form will be reviewed by the Chair of the Medical Executive Committee before submission. In the absence of the Chair of the Medical Executive Committee, the President of the Medical Staff will assume that responsibility.

9.1.2 National Practitioner Data Bank

Hospitals must also report adverse actions taken against physicians and dentists for the above activities to the National Practitioner Data Bank. In addition, the NPDB must be notified when a practitioner resigns while under a formal focused review authorized by the MEC.

9.1.3 Notification to the practitioner

In addition, the Medical Executive Committee and the physician in question will be notified whenever an adverse action report is submitted to the State Board of Medical Examiners in compliance with the Professional Medical Conduct Reform Act (the Codey Bill).

9.2 FPPE FOR NEW GRANTS OF PRIVILEGES

The Medical and Dental Staff of Ocean University Medical Center will perform a focused professional practice evaluation on all practitioner upon the grant of new privileges. This shall consist of a minimum of five (5) cases (at least one of which must be done at Ocean University Medical Center), with more at the discretion of the Department Chair.

9.3 MEDICAL STAFF CATEGORIES

9.3.1 Medical Associates

The Medical Staff Categories at Ocean University Medical Center does not include Medical Associates.

9.3.2 Regional Staff

Regional Staff at Ocean University Medical Center consists of physician who go to multiple facilities, AND

If the specialty is already on the Active Staff, the Regional Staff Member will be limited to five (5) contacts per year or he/she will be transferred to the Active Staff, or h. If the specialty is not already on the Active Staff, the Regional Staff Member will be allowed an unlimited number of cases without transfer to the Active category.

9.4 ALLIED HEALTH PROFESSIONALS (AHPS)

9.4.1 Duties

The duties of Allied Health Professionals/Advanced Practice Professionals are delineated on the AHP/APP privilege forms.

9.4.2 Qualifications

The qualifications for Allied Health Professionals are delineated on the AHP privilege forms.

9.4.3 Responsibilities

The responsibilities of Allied Health Professionals are the same as those of the Medical and Dental Staff, as outlined in Article 6, Section 6.1 of the Bylaws, with the exception of Article 6, Section 3.8(g).

9.4.4 Dues

Dues will be assessed at a rate consistent with the Medical and Dental Staff.

9.5 GEOGRAPHIC AREA

Ocean University Medical Center will ensure that all practitioners have a practice within a geographic area of thirty (30) minutes from the Medical Center.

9.6 PRE-APPLICATION

A pre-application will not be used at Ocean University Medical Center.

9.7 DRUG TESTING

Routine screening for drugs of abuse will be conducted on initial appointment only.

9.8 PSYCHIATRY

Minimum 10 initial (first time) consultations entailing physical interaction (face-to-face) with patients per one calendar year (ex. 20 consults are required during reappointment) is to be considered for advancement during provisional review and reappointment.

9.8.1 Addiction Medicine

Time in Practice: Applicants must submit documentation of a minimum of 1,920 hours in which they were engaged in the practice of Addiction Medicine at the subspecialty level; this minimum of 1920 hours must occur over at least 24 of the previous 60 months prior to application. The minimum of 24 months of practice time need not be continuous; however, all practice time must have occurred in the five-year period preceding June 30 of the application year. Practice must consist of broad-based professional activity with significant

Addiction Medicine responsibility. Applicants must also demonstrate a minimum of 25% (or 480 hours) as Direct Patient Care. Addiction Medicine practice outside of direct patient care, such as research, administration, and teaching activities, may count for a combined maximum of 75% (or 1440 hours).Only 25% (480 hours) of general practice can count towards the required hours for the Practice Pathway, and the remaining 75% must be specific Addiction Medicine practice. Fellowship activity that is less than 12 months in duration or non-ACGME accredited may be applied toward the practice activity requirement. The actual training must be described for any fellowship activity. Documentation of Addiction Medicine teaching, research and administration activities, as well as clinical care or prevention of, or treatment of, individuals who are at risk for or have a substance use disorder may be considered.

Non-Accredited Fellowship Training: Credit for completion of training in a non-ACGME-accredited Addiction Medicine fellowship program may be substituted for the Time in Practice option in i) above. The applicant must have successfully completed an Addiction Medicine fellowship of at least 12 months that is acceptable to the American Board of Preventive Medicine. The fellowship training curriculum as well as a description of the actual training experience must also be submitted. Fellowship training of less than 12 months may be applied towards the Time in Practice hour requirements of the Practice Pathway. The nonACGME-accredited fellowships are those currently accredited through the American College of Academic Addiction Medicine (ACAAM), formerly known as The Addiction Medicine Foundation (TAMF).

ARTICLE X: CARDIOLOGY SPECIFIC R/R

10.1 Non-Invasive Cardiology Privilege Requirements

Non-Invasive			
Procedure	**Training Requirement**	**Initial Experience Requirement**	**Renewal Guidelines**
EKG	Must be Board Certified or Board eligible by the American Board of Internal Medicine in the subspecialty of Cardiovascular Disease	Must have read 500 EKGs in the past year unless Board Certified in Cardiovascular Disease or Clinical Cardiac Electrophysiology. First 50 EKGs must be over read.	Must interpret 100 per year unless Board Certified in Cardiovascular Disease or Clinical Cardiac Electrophysiology and Must maintain active Medical Staff status
Cardiac Ultrasound (Echocardiography)	Must be Board Certified or Board eligible by the American Board of Internal Medicine in the subspecialty of Cardiovascular Disease	Must have interprets 100 cases during fellowship or within past year. First 5 ultrasound procedures must be over read	Must interpret 50 per year unless Board Certified in Cardiovascular Disease or Clinical Cardiac Electrophysiology and Must maintain active Medical Staff status
Cardiac Stress Echo	Must be Board Certified or Board eligible by the American Board of Internal Medicine in the subspecialty of Cardiovascular Disease	Must have interpreted 100 cases during fellowship or within past year. First 20 stress echo procedures must be over read	Must interpret 5 per year unless Board Certified in Cardiovascular Disease or Clinical Cardiac Electrophysiology and Must maintain active Medical Staff status
Exercise Stress Test	Must be Board Certified or Board eligible by the American Board of Internal Medicine in the subspecialty of Cardiovascular Disease Must have interpreted 50 stress tests during fellowship or within past 2 years unless Board Certified in Cardiovascular Disease or Clinical Cardiac Electrophysiology	Must have interpreted 50 cases during fellowship or within past 2 years First 5 exercise stress tests must be over read	Must interpret 25 per year unless Board Certified in Cardiovascular Disease or Clinical Cardiac Electrophysiology and Must maintain active Medical Staff status

Nuclear Medicine (If applicable)	Any physician authorizing administration of radiopharmaceuticals must be an authorized user of radioisotopes according to NRC or state regulatory agency regulations. Must be Board Certified or Board eligible for certification in Nuclear Medicine or Cardiology Board certified (or Board eligible but within two years of finishing training) with at least four months of nuclear cardiology training.	Must have completed 300 procedures (including both exercise testing and pharmacological stress) within past 2 years. Completion of Radiation Safety Course	Perform and/or interpret 100 stress radionuchde cardiac imaging studies per year
	Board certified (or Board eligible but within two years of finishing training) and at least one year (full-time equivalent) of nuclear cardiology practice experience with independent interpretation of at least 800 nuclear cardiology studies. If training before 1995, 10 years of nuclear cardiology, nuclear medicine and/or PET practice with independent interpretation of at least 800 nuclear cardiology, nuclear medicine and/or PET studies within the past 10 years of which 200 cases must have been interpreted in the past two years.		
Cardiac CT (If applicable)	Must be Board Certified by the American Board of Internal Medicine and be	Must have conducted and interpreted 50 contrast cardiac CT	PerfOrm and interpret 12 cardiac CT exams annually with over reads

	Board Certified or Board qualified for certification in Nuclear Medicine Completion of an ACGME approved fellowship in Cardiovascular Disease in which cardiac CT cases were interpreted and supervised, or Level 2 training and completed preceptorship involving interpretation of at least 150 studies (in which 50 where the candidate is physically present, involved in the acquisition and interpretation of the case) attendance in at least 20 h of devoted CCT classes and attendance in at least 20 h of devoted CCT classes	exams annually with over reads of 10% of cases	of 10% cases

Note: Initial requirements and maintenance of competency has been determined by ACC/AHA Clinical Competence statements published by Journal of the American College of Cardiology. Any deviations can be determined by Director of Cardiology or Executive Board of Medicine based on patient volume and applicant qualifications.

References:

ACCF 2008 Training Statement on Multimodality Noninvasive Cardiovascular Imaging
A Report of the American College of Cardiology Foundation/American Heart Association/American College of Physicians Task Force on Clinical Competence and Training Developed in Collaboration with the American Society of Echocardiography, the American Society of Nuclear Cardiology, the Society of Cardiovascular Computed Tomography, the Society for Cardiovascular Magnetic Resonance, and the Society for Vascular Medicine. Journal of the American College of Cardiology, Volume 53, No. 1, 2008.

ACCF/AHA Clinical Competence Statement on Cardiac Imaging with Computed Tomography and Magnetic Resonance A Report of the American College of Cardiology Foundation/ American Heart Association/American College of Physicians Task Force on Clinical Competence and Training. Journal of the American College of Cardiology, Vol. 46, No. 2, 2005

ACC/AHA Clinical Competence Statement ACC/AHA Clinical Competence Statement on Echocardiography A Report of the American College of Cardiology/American Heart Association/American College of Physicians—American Society of Internal Medicine Task Force on Clinical Competence. Journal of the American College of Cardiology, Vol. 41, No. 4, 2003.

ACC/AHA Clinical Competence Statement on Electrocardiography and Ambulatory Electrocardiography A Report of the ACC/AHAIACP—ASIM Task Force on Clinical Competence (ACC/AHA Committee to
Develop a Clinical Competence Statement on Electrocardiography and Ambulatory Electrocardiography) American College of Cardiology/American Heart Association Clinical Competence Statement on Stress Testing A Report of the American College of Cardiology/American Heart Association/American College of Physicians—American Society of Internal Medicine Task Force on Clinical Competence.
Journal of the American College of Cardiology, Vol. 38, No. 7, 2001.

American College of Cardiology/American Heart Association Clinical Competence Statement on Stress Testing A Report of the American College of Cardiology/American Heart Association/American College of Physicians—American Society of Internal Medicine Task Force on Clinical Competence. Journal of the American College of Cardiology, Vol. 102, No. 14, 2000.

10.2 Invasive Cardiology Privilege Requirements

Invasive			
Procedure	**Training Requirement**	**Initial Credentialing Requirement**	**Renewal Guidelines**
Diagnostic Catheterization	Board Certified in Cardiovascular Services	200 cases in the past year, plus 3 Proctored cases Submit procedure log	50 cases in the past year Procedure log
Implantable Loop Recorder	Board Certified in Cardiovascular Services	1 Proctored case and ILR company training	Procedure log
Temporary Pacing Wires	Board Certified in Cardiovascular Services	2 Proctored cases	Procedure log
Permanent Pacemaker Implants	Board Certified in Cardiovascular Services	Completion of fellowship and documentation of competency and experience. 50 pacemaker implants in the 2 years prior to application 3 Proctored cases	3 cases in the past year in HMH system Procedure Lou
Right Heart Catheterization	Board Certified Cardiovascular Services	1 1 Proctored case	Procedure Log
Intra-Aortic Balloon Pump Insertion	Board Certified in Cardiovascular Services	2 Proctored cases	Procedure log
Must have Performed Interventional	Board Certified in in Interventional Cardiology	75 cases in the past per or as dictated by **NJDOH** volume	75 cases in the past year or as dictated by

Cardiology Procedures		Requirements 3 Proctored cases	NJDOH volume requirements Procedure log

Intravascular Ultrasound (IVUS). (if applicable) **Fractional Flow reserve (FFR)**	Board Certified in in Interventional Cardiology	Completion of ACGME accredited Interventional Cardiology Fellowship 5 in the past 2 years Submit Procedure Log	Procedure Log
Radial Artery PCI	Board Certified in in Interventional Cardiology	Reviewed by Cath Lab Medical Director	Procedure log
STEMI	Board Certified in in Interventional Cardiology	24 in the past two years **1** (Can be based on performance at JSUMC)	Procedure log
Impella (If applicable)	Board Certified in in Interventional Cardiology	1 Proctored case	Procedure log
Rotational Coronary Atherectomy (Rotablator)	N/A		
Balloon Valvuloplasty	N/A		
Mitral	N/A		
Aortic	N/A		
Chronic Total Occlusion	N/A		
Retrograde Approach	N/A		

Antegrade Approach	N/A		

Note: Initial requirements and maintenance of competency has been determined by ACCF/AHA/SCAI 2013

Update of the Clinical Competence on Coronary Artery Interventional Procedures published by Journal of the American College of Cardiology. Any deviations can be determined by Director of Cardiology or Executive Board of Medicine based on patient volume and applicant qualifications.

Ocean University Medical Center

Medical Staff Guideline for Institutional Minimal Procedural Volumes

Introduction/Purpose:

Accumulating evidence has linked institutional and surgeon volume to outcomes for certain surgical and invasive procedures. To insure the highest level of care for patients treated at OMC, the medical staff will insure that accepted minimal volume standards are maintained wherever relevant.

Scope:

Procedures for which there is evidence linking minimum volumes to

Outcomes. Guideline:

- **Departments will select procedures to be tracked. At a minimum the procedures listed in Appendix 1 shall be tracked.**
- **Minimum volumes required shall be consistent with leapfrog standards.**

  Absent leapfrog recommendations minimum volume requirements shall be recommended by the relevant department based on the best current evidence
- **Volumes will be tracked annually by the Outcomes Department and reported to QI & 0 Committee.**
- **If a new procedure is introduced, a two-year period shall be allowed to achieve the minimum required volume.**
- **Should volume for a particular procedure fall below the minimum required**

  volume and outcomes are excellent, an additional 12-24 months may be allowed to achieve adequate volumes.

APPENDIX 1

PROCEDURE	MINIMUM ANNUAL VOLUME
1. Carotid Endarterectomy	20
2. Lung Resection	40
3. Esophageal Resection	20
4. Pancreatic Resection	20
5. Rectal Cancer Surgery	16
6. Bariatric Surgery	50

Ocean University Medical Center
Medical Staff Policy for Surgical Necessity/Appropriateness

Purpose:

To insure appropriate use and prevent overuse of surgical and other invasive procedures.

Scope:

For all departments performing invasive procedures. Each department will select the most appropriate procedures for monitoring but shall include, at a minimum, those procedures listed in Appendix 1.

Policy:

1. Surgical and other invasive procedures will be performed based on necessity and appropriateness for the patient as determined by the following conditions:

- **Procedure is determined to be appropriate based on specialty criteria which shall be reviewed annually and which will be informed by:**
  - **Latest evidence and guidelines**
  - **Input of members of the relevant Department or Section**
- **Procedure will be beneficial for the patient in keeping with their goals for treatment**
- ***Patient has been actively engaged in shared decision making, and consents to procedure after being fully informed of the risks and benefits and alternative treatment options***

2. All members of the Medical Staff who perform procedures are expected to engage their patients and/or families in shared decision-making around the benefits and risks of the proposed procedure and ensure that the patient and/or family is informed about the range of treatment alternatives to the procedure.

0. **All members of the Medical Staff are expected to be aware of their specialty society's clinical practice guidelines and employ them in their decision making.**
1. **Indications for surgery shall be documented in the dictated procedure note or, if available, a specific form designated for the purpose of documentation of indication/appropriateness**
2. **Each department that performs procedures shall monitor the necessity/appropriateness of procedures selected for monitoring on a quarterly basis and report the results to the QII3t0 committee.**
3. **The Department Chair (or designee) will counsel individual practitioners if determined to be performing outside of recommended guidelines.**
4. **Physicians who repeatedly or egregiously perform outside of recommended guidelines for surgeries shall be referred to the MEC for corrective action.**

Ocean University Medical Center
Medical Staff Guideline for Incorporating Surgeon-Specific Volumes in the Credentialing/Re-credentialing Process

Introduction/Purpose:

Accumulating evidence has linked Institutional and surgeon volume to outcomes for certain surgical and invasive procedures. To insure the highest level of care for patients treated at OMC for surgeon-specific volumes should be taken Into account during the credentialing and re-credentlaling process.

Scope:

All departments performing invasive procedures. Each department will select the most appropriate procedures for which minimum volume standards shall be applied but shall include, at a minimum, those procedures listed in Appendix 1.

Guideline:

Surgeons/procedurlsts must meet minimum annual volume guidelines as delineated In Appendix 1. Volumes may be calculated annually or be averaged over 24 months.

- **Volumes may Include cases done at other Institutions but at least 10% of the cases must be performed OMC to insure familiarity with equipment and team processes.**
- **New members of the medical staff or members of the medical staff taking on a new procedure who have been deemed competent by their training program director or other reliable source in one or more of these procedures may be granted privileges for those procedures and shall have two year to achieve minimum volume requirements.**
- **Should a practitioner not meet the necessary volume requirements, the Chair may allow the practitioner an additional 12-24 months to meet these requirements providing outcomes have been excellent.**
- **In rare case, where a member of the medical staff falls short of the specified volume but has had consistently stellar outcomes, the volume requirement may be waived**
- **Each department that performs procedures shall monitor the procedurist-speciifc volumes for the selected procedures and annually report the results to the QI&O Committee.**
- **If the procedures is not performed at the institution and the surgeon can demonstrate adequate qualification, volume, and results at other institutions,**

the volume requirements can be waived at the discretion of the Chair of the Department.

Department of Surgery

Procedure: Bariatric Surgery

Indications Any patient with BMI >40
Patients with BMI between 35-40 and with a medical comorbility
Contraindicated Patients < 18 years old or > 75 years old
Treatment Expert Anil Pahuja MI) FACS FASMBS
Guideline ASMBS
Monitored by Bariatric Committee

Procedure: Open Abdominal Aortic Aneurysm Repair

Indications: Symptomatic AAA
Asymptomatic Large Fusiform AAA>5.4cm
Saccular AAA
Women with Aymptomatic AAA Fusiform 5.0-5.4cm Rapid expansion of small AAA

Not indicated if: Overall Medical condition prohibitively high risk of mortality **Department Expert:** Frank Sharp, MD
Source: Updated SVS Guidelines on the care of patients with AAA
Monitored by: Section of Vascular Surgery

Procedure: Carotid Endarterectomy

Indications: Carotid Artery Stenosis of 60% or more - Neurologically asymptomatic Carotid Artery Stenosis of 50% or more- Neurologically symptomatic

Department Expert: Frank Sharp, MD
Source: Updated SVS guidelines for management of extracranial carotid disease
Monitored by: Section of Vascular Surgery
Vascular Quality Initiative