

RULES & REGULATIONS

CROUSE HOSPITAL MEDICAL STAFF

Approved June 2nd, 2025

1. ADMISSION AND DISCHARGE OF PATIENTS

- 1.1 A patient may be admitted to the Hospital only by a member of the Medical Staff. Admitting orders written by a designee on behalf of the attending practitioner require attending practitioner co-signature. All practitioners shall be governed by the official admitting policy of the Hospital.
- 1.2 A physician member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital. Non-physician members of the Medical Staff are responsible for the care and treatment of patients as it relates to their disciplines. Each member of the Staff is responsible for the prompt completeness and accuracy of the medical record, and for the necessary special instructions. Whenever these responsibilities are transferred to another Staff member for more than the usual coverage rotations, a note confirming the transfer of service and a transfer order shall be entered in the medical record.
- 1.3 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement will be recorded in the medical record within 24 hours.
- 1.4 In the case of emergent and/or non-emergent direct admission to the hospital wherein the patient will be under his care or service, the practitioner shall first contact the Crouse Transfer Center.
- 1.5 Each practitioner must assure timely, adequate, professional care for patients in the Hospital by being available or having available an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements may result in disciplinary action.
- 1.6 The attending practitioner or his/her designee is required to document the need for continued hospitalization.

1.7 Patients shall be transferred to another institution or provider only after adequate screening for emergent conditions, treatment sufficient to ensure a stable transfer (if within the capability of the institution), and appropriate information as to the risks and benefits of transfer.

1.8 Patients will be discharged only after a discharge order has been completed. The attending practitioner or designee shall complete a discharge summary together with a discharge medication reconciliation, and communicate the discharge plan to the patient and/or family.

Should a patient leave the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident will be made in the patient's medical record, and the attending practitioner or designee will complete a discharge order and AMA discharge summary.

1.9 In the event death takes place in the hospital, including the Emergency Department, the deceased shall be pronounced dead by the attending practitioner, advanced practice clinician or resident physician. The attending practitioner or advanced practice clinician shall complete and sign the death certificate. An entry must be made and signed in the medical record of the deceased before the body will be released.

A history and physical may be utilized in lieu of a death discharge summary in those instances when incontrovertible and irreversible terminal disease has been adequately documented in the admission history and physical and the patient has expired upon admission or within 24 hours of admission. A death pronouncement note is required. Policies with respect to the release of dead bodies will conform to local law.

1.10 It shall be the duty of all practitioners to secure meaningful autopsies whenever possible. An autopsy may be performed only with written consent, signed in accordance with State law. Autopsies completed by the Medical Examiner do not require consent. All autopsies, except medical examiner cases, shall be performed on site by the Hospital pathology department. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the final report issued within 60 days.

1.11 Medical Orders for Life Sustaining Treatment (MOLST)
Prior to discharge, the attending practitioner, advanced practice clinician or resident shall discuss post-discharge life sustaining treatment with the patient and complete and sign a Medical Orders for Life Sustaining Treatment (MOLST) form. MOLST forms completed by an advanced practice clinician do not require attending physician co-signature. MOLST forms completed by a resident require attending physician co-signature. The patient will receive the original document, and a copy of the form will be scanned into the permanent medical record.

MOLST forms completed on behalf of an individual with intellectual or developmental disability as identified on the MOLST form must be signed by a physician.

Code status must be addressed upon admission and the conversation must be documented in the medical record according to hospital policy.

For additional information, refer to hospital policy and procedure.

2. MEDICAL RECORDS

- 2.1 The attending member of the Medical Staff shall be responsible for the preparation of a complete, current and legible medical record for each inpatient. The contents of the medical record shall be sufficient to justify the diagnosis, and warrant the treatment and end results. All notes must include original and current information. Copy/paste is strongly discouraged. This record shall include identification data, chief complaint, history of present illness, past history, family history, social history, psychiatric history where appropriate, review of systems, physical examination, provisional diagnosis, reports of consultations, reports of laboratory and radiology services, reports of treatment, operative reports, pathology reports, progress notes, final diagnosis, discharge summary or note, autopsy findings and other reports as mandated by New York State Law.

- 2.2 A complete admission history and physical examination shall be completed and recorded upon admission by the attending practitioner, advanced practice clinician or resident physician. The attending practitioner must countersign the history and physical examination when it is completed by the resident physician or non-Hospital employed advanced practice clinician.

History and physicals completed by a podiatrist, Hospital-employed nurse practitioner or certified nurse midwife do not require attending practitioner countersignature.

In certain instances and only upon prior approval, infant history and physicals and/or discharge summaries completed by a nurse practitioner do not require attending practitioner countersignature.

History and physicals do not require countersignature when completed by a procedural advanced practice clinician, and the sole reason for admission is performance of that procedure.

If the attending practitioner wishes to use a complete history and physical that was completed within thirty days prior to an elective or scheduled surgical/procedural admission, a durable, signed, legible copy of the report shall be placed in the patient's hospital medical record upon or prior to admission. Upon admission, the attending practitioner shall document there has been no subsequent change or shall record any changes present at the time of admission.

In instances of a reoccurring IR procedure not coded as CMS as a surgery, wherein anesthesia services are not required (i.e. gastrostomy/nephrostomy tube exchange), an H&P or outpatient assessment must be completed every 6 months or sooner if

there are patient changes in status.

A patient who requires recurrent outpatient infusion services will require an H&P or completed outpatient assessment every 6 months or sooner if there are patient changes in status.

Obstetrical records must include all prenatal information. A durable, legible, signed clinic prenatal record is acceptable.

When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record.

A history and physical examination must be recorded prior to the performance of an elective surgery. In an emergency, the attending surgeon must write a pre-op note prior to surgery and the attending surgeon or designee must complete a full history and physical within 24 hours upon conclusion of the surgery.

- 23 A patient will be seen by a physician, advanced practice clinician or resident at least once each day, except for 23-hr post-procedural patients discharged per protocol. Progress notes shall be recorded at the time of observation and provide a pertinent chronological report of the patient's course in the Hospital and should reflect any change in condition and the results of treatment. Progress notes shall be written once daily by the attending practitioner or his designee on all patients in the Hospital who do not meet the qualifications for ALC (Alternate Level of Care).

For patients who meet ALC qualifications, progress notes shall be written by the attending practitioner or advanced practice clinician every 72 hours at a minimum or at any time there is a change in diagnosis and/or in the plan of care.

24 MEDICAL RECORD COMPLETION DATES

Operative Reports and Discharge Summaries must be authenticated within three (3) days of discharge date.

Coding Queries must be completed within seven (7) days of assignment.

Clinical Documentation Clarification Inquiries (CDI) must be completed within 24-hours of assignment.

Consultation Notes must be completed within twenty-four (24) hours of consultation.

All Other Medical Records must be completed within 7 days of discharge date or date of assignment.

- 2.4.1 All operative and procedural notes are to be entered in the electronic medical record within twenty-four (24) hours of the operation or procedure and authenticated within three (3) days of the discharge date.
- 2.4.2 Immediate brief post-operative/procedural notes are required when the full operative note has not yet been completed and must be completed within one (1) hour of operation/procedure completion and contain a pre- operative/procedural and a post-operative/procedural diagnosis, a description of the findings, the technical procedures used, the specimens removed, and the name of the primary surgeon and any assistants. Procedure/Operative Date as well as the actual date of note are required. The immediate post-operative/procedural note shall be signed by the surgeon. Immediate post-operative/procedural notes written by a resident physician/designee require attending practitioner co- signature.
- 2.4.3 Non-operative procedures performed by the attending practitioner, advanced practice clinician or resident physician require a non-operative procedure note to be completed and entered into the medical record.
- 2.4.4 Consultation notes shall record pertinent findings on the examination of the patient with the consultant's opinions and recommendations. When operative procedures are involved, the consultant's notes shall, except in emergency situations so verified on the record, be recorded prior to the operation. If the consultant assumes the management of a patient, a transfer of service order must be completed.

Consultation notes shall be completed by the consulting practitioner, advanced practice clinician or resident physician. The consulting practitioner must countersign the initial consultation note completed by the resident physician, physician assistant, or non-Hospital employed advanced practice clinician within 24 hours.

- 2.4.5 A discharge summary shall be completed at the time of discharge. Discharge summaries completed by a resident physician, physician assistant or non-Hospital employed advanced practice clinician must be countersigned by the attending practitioner. The discharge summary shall include the reason for hospitalization, significant findings, procedures performed and treatment rendered, the final diagnosis, condition of the patient upon discharge, and any specific instructions given to the patient and/or family. Discharge instructions shall be given to the patient and/or family member present.
- 2.4.6 A progress note, including an order for discharge, written prior to discharge by the attending practitioner, advanced practice clinician or resident physician, is considered the discharge summary in the case of patients with minor conditions who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetrical deliveries discharged within 72 hours of admission. A discharge note completed by a resident physician requires attending practitioner countersignature.

2.5 BIRTH/DEATH CERTIFICATES

Birth certificates must be completed within 5 business days of initial creation.

Death certificates must be completed within at least 24 hours and no later than 48 hours of pronouncement of the patient's death. Resident physicians, nurse practitioners and physician assistants may complete electronic death certificates at the discretion of the attending physician.

2.3 PENALTY FOR INCOMPLETE MEDICAL RECORDS

Practitioners who do not complete medical records within the time limits stated herein will be administratively suspended from the Medical Staff until such time as the medical records have been completed. Practitioners incurring 3 such suspensions in a rolling 12-month period will be required to appear before the Medical Executive Committee.

A practitioner who has been required to appear before the Medical Staff Executive Committee and who, within 12 months thereafter is suspended for failure to complete an operative or procedural report, will be deemed to have resigned from the Medical Staff. Any Medical Staff member who resigns under these circumstances shall not be entitled to a hearing or appellate review under Article XI or Article XII of the Medical Staff Bylaws. If such individual wishes to have his/her Medical Staff membership and clinical privileges reinstated, he/she must submit a new application for membership and clinical privileges. That application shall be processed in the manner required by Article V of the Medical Staff Bylaws.

2.4 Written informed consent of the patient is required for the release of medical information to persons not otherwise authorized to review or receive this information.

2.5 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, statute, and hospital policy. All records are the property of the Hospital and are maintained for the benefit of the patient, the Medical Staff, and Hospital. In the case of a readmission of a patient, all previous records shall be made available for the use of the attending physician.

2.6 Access to all medical records shall be afforded to members of the Medical Staff or other authorized individuals for bona fide study and research investigation consistent with Institutional Review Board and Hospital policies.

The entire medical record shall be complete within 30 days of patient discharge.

2.11 ATTRIBUTION

Attribution of patient cases shall be assigned by the discharging practitioner to the attending physician or the physician most involved in the care of the patient. If the discharging practitioner is unable to determine attribution, attribution will default to the discharging physician.

3 GENERAL CONDUCT OF CARE

- 3.3 Medical Staff members, resident physicians, and all individuals involved in the delivery of patient care are required to wear their Hospital-issued, photo identification badge above the waist when on Hospital property, including off-site surgery centers and patient care facilities. The front of the ID badge should be clearly visible at all times.

ID badges are not transferrable and may not be used by unauthorized individuals under any circumstances. Inappropriate use of ID badges may result in revocation of coded access to Hospital property and/or disciplinary action. Replacement ID badges may be obtained in Human Resources for a fee.

- 3.4 A consent form and treatment authorization form signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission.

- 3.5 Consent for specific procedures must be obtained by the attending practitioner, resident physician or advanced practice clinician. The indication(s), all pertinent clinical information, and/or the reason(s) for the procedure must be included in the medical record. The responsibility for informing the patient as to the risks and benefits remains with the attending practitioner. Consents obtained by a resident physician or advanced practice clinician must be co-signed by the attending practitioner.

- 3.6 All orders for drugs and biologicals shall be entered in the electronic medical record. A telephone order for drugs or biologicals, other than chemotherapeutic agents as defined by Hospital policy, is considered valid when dictated to a health care professional functioning within his or her scope of practice and signed by the ordering practitioner within 24 hours. All “stat” orders must be so indicated.

- 3.7 Paper orders and documentation are allowed during Hospital downtime procedures.

EXCEPTIONS:

Unless requested by the patient, do not resuscitate orders and limited resuscitation orders are not inactivated when a patient goes to surgery and do not have to be rewritten post operatively. Such orders may be temporarily rescinded during surgical and other invasive procedures per the Hospital policy on "Do Not Resuscitate Orders". In this instance, the order is automatically reinstated post discharge from the recovery area. No order for reinstitution is required.

- 3.8 All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These drugs will be used in full accordance with the statement of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration. The Pharmacy and Therapeutics Committee Approved Manual of Procedures is incorporated into these Rules and Regulations for the use of clinical investigative drugs.

3.9 Investigational drugs or procedures are approved only through the Institutional Review Board of the Hospital. Patients admitted on an emergency basis who are on an investigational protocol requiring the use of drugs not approved at this institution will be continued on that protocol, provided the attending practitioner files in the chart upon admission a signed copy of the investigational study consent and protocol as submitted to the approving institution.

3.10 All inpatients and outpatients shall have identified an attending practitioner. The attending practitioner or medical staff designee is responsible for requesting consultation when indicated from a qualified consultant who is a member of the Hospital Medical Staff. Special privileges for non-medical staff members may be granted in accordance with the Bylaws.

3.11 Qualified practitioners with clinical privileges in this Hospital may be called for consultation within the practitioner's area of expertise.

Except in an emergency, consultation is required according to the rules governing consultations in the Department Manual of each clinical department.

3.12 Consultants shall be required to immediately notify the attending practitioner with regard to time-sensitive orders.

3.13 If a nurse or clinical staff has any reason to doubt or question the care provided to any patient or believe that appropriate consultation is needed and has not been obtained, that individual is obligated to notify the attending physician and/or their supervisor. The report, whether correct or in error, shall be regarded as justified by the Medical Staff. The supervisor, in turn, may refer the matter to the appropriate service Director. If warranted, the report shall be brought to the attention of Senior Leadership, Medical Staff Leadership and/or Physician Quality Leadership Committee for review. See hospital Chain of Command policy for further reference.

3.14 The Hospital Internet Acceptable Use Policy is incorporated into these Rules and Regulations.

3.15 Whenever the primary responsibility for the care of a patient transfers from the service of one Medical Staff member to another, that change in service shall be documented in the medical record. The practitioners involved shall communicate relative to the current diagnoses, treatment and patient expectations. It is the responsibility of the transferring physician to notify the patient of the transfer of care. When a change in service occurs, the transferring physician should complete a to-date interim summary. Should a transfer of service become necessary due to conflicting personal values or religious beliefs, no breach in the continuous care of the patient may occur.

3.16 The attending surgeon of record is personally responsible for the patient's welfare throughout a surgical operation. The attending surgeon must be physically

present in the operating room at all times during critical portions of the procedure and, and thereafter remain immediately available in the operating suite or surgical waiting/consultation area until such time as the patient has been transported to the post-anesthesia care unit.

- 3.17 At the discretion of the Chief Medical Officer, a medical staff member who experiences an event that requires medical attention while on hospital property must obtain medical clearance from a licensed practitioner prior to returning to patient care.

4 TEACHING

Reflecting the longstanding policy of this Hospital with respect to medical education, every effort is made to conduct clinical services in a manner consistent with that of a Teaching Facility. All physicians are asked to consider their private patients as part of the teaching service. The attending physician maintains the responsibility for the care of the patient, including writing orders.

4.3 RESIDENT PHYSICIAN HOUSE STAFF

- 4.3.1 Resident physician staff participate in other area hospital approved Graduate Medical Education programs as provided by 10 NYCRR 405.4(f). It is encouraged that resident physicians be given as much responsibility for care and management of patients as is commensurate with their level of education, experience, and personal maturity.
- 4.3.2 The sponsoring program is responsible for maintaining resident physician online records to perform specific procedures appropriate to each discipline. The attending physician will cooperate in this effort by instructing, supervising and signing off on procedures.
- 4.3.3 Resident physician patient care activities shall be monitored by the attending staff to ensure resident physicians carry out only those independent activities for which they are credentialed. Other procedures will be done under direct supervision. Supervision shall be conducted and documented according to sponsoring program protocols.
- 4.3.4 Resident physicians are responsible for the care of patients under the supervision of an attending physician including the admission, work up, writing orders, continuing management and operating room experience, if as appropriate to the discipline, under the supervision of an attending physician, employing progressively greater responsibility consistent with his/her individual growth in clinical experience, knowledge and skill.
- 4.3.5 Except for an admission order or specific hematology/oncology order, orders written by a resident physician do not require attending physician countersignature.

- 4.3.6 Residents are responsible for their professional growth and development, relying on learning acquired during the process of providing patient care. As the resident physician demonstrates increasing competence, s/he will be granted increasing independence of practice and judgment. All decisions made by a resident physician at all levels of training are subject to the supervision and review of the attending physician, faculty and program director.
- 4.3.7 Resident physicians are responsible for conduct consistent with the Policies and Procedures of the Hospital at all times.
- 4.3.8 The number of hours of on-duty assignment, including on-call duty in the Hospital during night shift hours, shall be subject to the limitations defined in applicable New York State regulations (See 10 NYCRR 405.4(b)(6)).

Residents may moonlight as stated in the sponsoring program's Resident Handbook.

Attending physicians shall be alert to signs of resident fatigue and provide for appropriate relief. Disciplinary action, as appropriate, will be determined by the Program.

- 4.3.9 The Hospital retains the right to refuse acceptance of or immediately remove a resident physician from patient care activities should the resident physician exhibit behavior deemed to compromise patient safety, interfere with peer/staff relations, or disrupt in any way the environment of care within the Hospital.
- 4.3.10 Prior to providing clinical patient care, all residents are required to complete the Hospital's New Resident Orientation as specified by Medical Staff Administration.

5 MEDICAL AND ADVANCED PRACTICE CLINICIAN STUDENTS

Students may be assigned as clinical clerks or participate in elective externships. Students shall be identified during all patient care activities. The attending practitioner is urged to spend as much time with students as possible.

- 5.3 With the approval of the attending physician, students may take patient histories, perform complete physical examinations and enter findings in the patient medical record. All student documentation must be countersigned by the attending physician within 24 hours.

Orders written by a student must be countersigned by the attending physician prior to enactment of the order.

Students may perform the following procedures as provided by Hospital policy, under the direct, in-person supervision of the attending physician, resident (R-2 and up), or other supervising physician approved by the attending physician:

1. Establishing an I.V. line.
2. Obtaining sample of peripheral venous blood.
3. Taking ABG sample from established arterial line.
4. Discontinuing arterial or venous lines.
5. Passing or removing naso-gastric tube.
6. Performing soft catheterization of bladder in male or female patient.
7. Reinsertion of tracheostomy tube, in emergency situations for patients who are not less than one week post-tracheostomy.
8. Obtaining blood samples from pre-existing central venous line.
9. Obtaining mixed venous blood gases from a pulmonary artery catheter.

Concerns and issues regarding student demeanor and conduct shall be referred to the attending physician.

6. CLINICAL SERVICES

The Department Manuals of Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Pathology, Medical Imaging, Neurology, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pediatrics, Psychiatry, Surgery, and Urology are considered to be a part of these Rules and Regulations.

Special Care Unit manuals or Service Line protocols supplement Department Manuals.

7. EMERGENCY SERVICES

- 7.1 As a condition of Medical Staff membership, all members of the active Medical Staff must be available for coverage of the Emergency Department, in their particular area of expertise, on a rotation basis assigned by the Department Chiefs. Surgical and subspecialty physicians are expected to attend their private patients admitted through the Emergency Department. In the event they are not available, private group, solo and/or Senior physicians not participating in the department on-call rotation are expected to have an alternative coverage arrangement with another physician currently on staff in the same department with similar privileges. An exception may be granted by Department Chiefs in accordance with hospital and/or written department policy and authorized by the Chief Medical Officer.
- 7.2 Physicians on call for the Emergency Department must respond to Emergency Department staff calls or texts with 30 minutes of initial contact and must be available to be on-site within one hour when requested by the Emergency Services practitioner. A physician who refuses to respond to ED calls/texts or refuses to come on site as requested by the ED provider will be referred to the Physician Quality Leadership committee in contemplation of remediation or referral to the Peer Review Committee for disciplinary action.

A resident physician or advanced practice clinician acting on the behalf of the attending physician may satisfy this obligation under the direction of the on-call physician, unless attending physician presence is demanded by the ED attending physician. However, the on-call physician must be immediately available to assist the resident, be responsible for all resident patient care activities, and must countersign resident physician consult notes.

When an on-call consultation has been completed, the responding physician or clinical designee acting on his behalf must inform the Emergency Services provider of the consultation disposition prior to leaving the Emergency Department, and/or advise the Emergency Services provider in the event the patient is to be admitted to his service.

When an on-call consultation is requested at the change of shift, the on-call physician or clinical designee is responsible for accepting the consultation at the time of the request and transitioning patient care to the next on-call physician or clinical designee. The Emergency Services provider is not responsible for nor will he assume communication continuity between on-call physicians and clinical designees.

The on-call physician is responsible for the follow-up of patients seen by himself or his clinical designee unless other appropriate outpatient follow-up arrangements acceptable to the patient are made.

- 7.3 In the event the on-call physician determines consultation with another service is necessary, he is required to personally contact the secondary service on-call physician within 30 minutes to discuss the patient's condition. The secondary service on-call physician is required to respond to the on-call physician's call or text within 30 minutes. Should the on-call physician request the presence of the secondary service on-call physician, the secondary service on-call physician is required to be on site within one hour. Thereafter, the two on-call physicians will mutually determine under which service the patient will be admitted.

When assignment of admitting physician is disputed between the on-call and secondary on-call physicians or between admitting physicians within the same service, the ED practitioner shall designate the admitting physician. All instances of assignment disagreement will be reviewed by Physician Quality Leadership.

If the patient must be transferred to another facility, the on-call physician and/or secondary service on-call physician will discuss the case with the ED provider and engage in the transfer process. Both the on-call physician and secondary service on-call physician will be immediately available in person to communicate with the receiving facility upon request.

Services as specifically stated in Department Manuals and physicians for which Emergency Department on-call coverage does not apply are not subject to this standard.

- 7.4 On-call physicians and their designees are required to provide emergency medical care as promulgated by the Emergency Medical Treatment & Labor Act (EMTALA) of 1986.

Patients may only be sent to physician's offices or other facilities for evaluation or treatment when stabilized. If the hospital does not have resources available for proper evaluation and/or treatment, or if the patient requests, a medically-appropriate transfer should be implemented.

- 7.5 The physician listed as on-call for the Emergency Department as specified in AmION (or electronic equivalent) is responsible for assigned coverage dates.

The on-call physician is responsible for making suitable alternate arrangements for coverage if unavailable. If the physician is not readily available or if alternate coverage is not readily available, the on-call physician will be subject to disciplinary action including but not limited to Peer Review and/or formal corrective action. The appropriate service Department Chief must be informed when a lapse or delay in ED on-call coverage occurs.

- 7.6 Physicians on call for the Emergency Department may not delay or refuse care to any patient due to the patient's financial status.

8. SPECIALTY SECTIONS

Specialty sections including Radiation Oncology and Interventional Radiology are assigned to the Department of Medical Imaging.

Specialty sections including Non-invasive Cardiology, Electrophysiology, Cardiology and Cardiac Catheterization, Endoscopy and Gastroenterology, Nephrology, Physical Medicine and Rehabilitative Services, and Pulmonology are assigned to the Department of Medicine.

The specialty section Podiatry is assigned to the Department of Orthopedics.

Specialty sections including Bariatric, Cardio-Thoracic, Dental, and Plastic Surgeries are assigned to the Department of Surgery.

The specialty section Robotics is assigned to the Departments of Surgery, OB/Gyn, and Urology.

Practitioners requesting privileges or specialty section privileges not assigned to their primary department must obtain approval from the appropriate Department Chief and/or Section Chief.

9. COMMITTEES

In addition to the Standing Committees listed in the Bylaws, other Standing Committees of the Medical Staff shall be:

9.1 PHYSICIAN QUALITY LEADERSHIP COMMITTEE

The Committee shall consist of the Chief Medical Officer, President of the Medical Staff, Past President of the Medical Staff, Chair of the Peer Review Committee and Chair of the Credentials Committee, with other members appointed at the discretion of the Chief Medical Officer and President of the Medical Staff.

The Committee shall review behavioral and clinical issues of care and treatment provided by Medical Staff members related to mortalities, patient complaints, critical events and occurrence reports. Determinations are made as to whether the Chief of the Department needs to complete a full review of the case or if tracking and trending is sufficient. The Committee may determine that a collegial conversation should occur with the Medical Staff member and collaborate with the Department Chief to ensure follow through. The “Just Culture Algorithm v3.0” is used as a resource when determining whether care provided meets generally accepted medical standards. Cases deemed to have not met the generally accepted medical standards are forwarded to the Peer Review Committee for further action. The Quality Improvement Department shall maintain a spreadsheet for tracking and trending of cases.

The Committee shall meet weekly and report to the Peer Review Committee. An annual report shall be provided to the Medical Executive Committee.

9.2 PEER REVIEW COMMITTEE

The Committee shall be chaired by a physician and shall consist of the President of the Medical Staff, Chief Medical Officer, a physician member of the Board of Directors, and at least five (5) clinically-experienced members of the Active Medical Staff. All Committee members shall be appointed by the President of the Medical Staff.

The Quality Improvement Director, the Medical Staff Administration Director, and the Risk Management Director shall also be invited.

Department Chiefs and/or any other member of the Medical Staff shall be invited at the discretion of the Committee.

The Committee shall review all behavioral and clinical issues of care and treatment brought forward by the Physician Quality Leadership Committee and make recommendations for practitioner remediation, education, corrective action, and/or regulatory agency reporting.

The Committee shall meet as frequently as necessary and report to the Medical Executive Committee at least once annually.

9.3 PRACTITIONER HEALTH COMMITTEE

The Committee shall be chaired by a physician appointed by the Medical Executive Committee. The Committee shall consist of at least three (3) members appointed

by the Medical Executive Committee, at least one of whom shall be a psychiatrist.

No Medical Staff member concurrently having a Medical Staff disciplinary role shall serve on the Committee. No member shall concurrently serve on the Medical Executive Committee or Credentials Committee. If a member is the subject of an investigation by the Committee, such person shall not participate in the investigation or determination of the matter and a substitute member will be appointed by the Medical Executive Committee.

The Committee shall meet as necessary to perform its responsibilities, but not less than annually, and shall maintain a record of its proceedings. The meeting records shall be submitted to the Chief Medical Officer within fifteen (15) days of the meeting.

The Committee shall develop and implement general guidelines for dealing with Medical Staff members who may be suffering from a physical, psychiatric, emotional behavioral impairment or substance abuse problem such that the impairment or problem may affect the member's ability to practice his profession and/or otherwise appropriately function in a hospital setting.

The guidelines developed by the Committee shall be for the purpose of helping an affected member recover from his impairment, protecting the patients of the members, protecting the integrity and credibility of the Hospital, and assisting the Hospital in meeting its obligations to patients, other members of the Medical Staff, and Hospital personnel.

The Committee shall provide education about member health and impairment recognition; facilitate diagnosis, treatment, and rehabilitation of members who may be suffering from potentially impairing conditions; and enhance prevention of physical, psychiatric and emotional illness of members.

The Committee shall serve as a resource to members on the Medical Staff who, because of physical, psychiatric or emotional illness, or substance abuse issues, may be in need of assistance and/or monitoring to regain optimal functioning and to provide competent patient care.

The Committee shall act as an advisor to the Medical Executive Committee, Hospital Administration and individual Department Chairs regarding impairment concerns about particular members and general issues of member health maintenance and illness/impairment recognition and prevention.

The Committee shall serve as a resource in educating the Hospital community and Medical Staff members about prompt and appropriate treatment of illness and problems associated with illness and impairment in members and health maintenance of members.

The Committee shall determine the credibility of each referral, complaint, allegation, or concern expressed regarding a Medical Staff member. The individual who suspects a member of being impaired must give an oral or, preferably, a written

report to the Chief Medical Officer or the Chair of the PHC. The report must be factual and shall include a description of the incident(s) that led the individual to the belief that a member may be impaired. The individual making the report does not need to have proof of the impairment, but must state the basis that led to the suspicion of impairment.

Upon notification of suspected impairment of a Medical Staff member, the Committee Chair shall promptly advise the Medical Executive Committee, Chief Medical Officer and Department Chief in instances when the Medical Staff member presents clear or likely jeopardy to safe patient care. The Committee shall advise the Medical Executive Committee, Chief Medical Officer, and Department Chief when the Medical Staff member fails to cooperate with the Committee recommendations.

The Committee shall report as necessary, but not less than annually, to the Medical Executive Committee.

10. DISRUPTIVE BEHAVIOR

It is the objective of the Hospital to ensure the best in patient care by providing a safe, cooperative and professional healthcare environment absent of conduct which disrupts the operation of the Hospital, affects the ability of others to appropriately do their jobs, creates a hostile or compromised work environment for Hospital employees, Medical Staff members, and other health care practitioners or interferes with an individual's ability to practice competently.

- 10.1 It is the practice of the Medical Staff that all individuals are to be treated with respect, honor, and dignity.

All Medical Staff members, Residents and Allied Health Staff members are required to conduct themselves in a professional and cooperative manner within the Hospital and its facilities and refrain from demonstrating intimidating, abusive, negative or otherwise inappropriate behavior toward patients, employees, visitors, or other healthcare practitioners.

- 10.2 Disruptive behavior is negative personal interaction with patients, employees, visitors or other healthcare practitioners which interferes with patient care or the operation of the Hospital as demonstrated by but not limited to:

1. Physical attack or assault upon another person, destroying or defacing Hospital property
2. Verbal exchange containing inappropriate, foul or discriminatory language.
3. Lying, cheating, stealing, fraud.
4. Sexual harassment.
5. Physical or verbal intimidation.
6. Unsavory personal habits including cleanliness, hygiene, mannerisms.
7. Deliberate disclosure of HIPAA-protected information or ePHI to unauthorized persons.

8. Inappropriate or impertinent comments made in patient medical records or official documents impugning the quality of care provided in the Hospital or attacking other healthcare practitioners, clinical staff or Hospital policies.
9. Failure to appropriately and timely respond verbally or in person to Hospital or other healthcare practitioner requests for consultation to facilitate the delivery of patient care.
10. Failure to comply with administrative and/or clinical Hospital and/or Departmental policies and procedures, including timely completion of medical records.

6.1 Disruptive practitioner behavior may be reported confidentially by any individual who observes or is the recipient of such behavior by using any of the following mechanisms:

1. Verbal/written/email report to immediate supervisor, or Nurse Manager or Nursing Supervisor;
2. Verbal/written/email report to Chief Medical Officer or Director of Medical Staff Administration;
3. Occurrence Report submitted through CNN homepage;
4. (Anonymous) telephone call to Physician Hotline - 315-470-8881;
5. (Anonymous) telephone call to Corporate Compliance - 315-470-7555; or
6. Report or telephone call to Administrator On Call - Call operator (O) for contact information.

6.2 Documentation of the incident should be *factual* only and include:

1. Date/time of incident;
2. Name(s) of patient, employee or other person(s) involved;
3. Description of the incident and circumstances that resulted in disruptive behavior;
4. Remedial action taken at the time of the incident, if any and by whom;
5. Name and signature of person reporting the incident;
6. Date and time of report.

6.3 All reports of disruptive behavior shall be forwarded to the Physician Quality Leadership Committee for review and investigation. Substantiated reports shall be forwarded to the Department Chief, Chief Medical Officer, or the Peer Review Committee for further action as appropriate. Such action may include: informal counseling; letters of reprimand; referrals to third party resources offering psychological, stress or anger management counseling or similar programs; and corrective action under the Medical Staff Bylaws. Any action taken shall be fully documented as appropriate.

6.4 The Board of Directors maintains responsibility for the environment of care within the Hospital and its facilities and may supersede any of the foregoing procedures or actions at its sole discretion. This policy shall be not be construed as precluding formal corrective action pursuant to Article XI of the Medical Staff Bylaws at any time such action is deemed necessary due to the circumstances and any history of previous disruptive behavior. Should such behavior threaten the immediate safety of any individual or clinical care of any patient, such behavior shall be immediately reported to the Department Chief and/or Chief Medical Officer for potential

summary suspension or restriction of the practitioner's medical staff privileges as described in Article XI of the Medical Staff Bylaws.

7. CONTINUING MEDICAL EDUCATION

Each physician Medical Staff member will attest in writing to completing 37 Category I Continuing Medical Education Credits during the three years prior to reappointment. Continuing Medical Education shall include education specific to the Member's specialty or sub-specialty as may be required by certification boards, associations or regulatory agencies.

Affiliate Medical Staff members will complete Continuing Medical Education Credits or Continuing Education Units appropriate to their scope of practice.

8. PROFESSIONAL LIABILITY INSURANCE LIMIT REQUIREMENTS

Active, Courtesy, Consulting and Senior Physician Medical Staff members are required to maintain professional liability insurance coverage in the amount of \$1.3 million per claim and \$3.9 million aggregate. Affiliate Medical Staff members are required to maintain professional liability insurance coverage in the amount of \$1 million per claim and \$3 million aggregate. Exceptions to coverage requirements must be approved by the Chief Medical Officer and/or Director of Risk Management.

9. PRIVILEGE AND EDUCATION CERTIFICATION PROGRAMS

At the discretion of the Hospital, Medical Executive Committee and/or regulatory agencies, certain privilege and/or education certification programs are required to support practitioner competence and patient safety. Education resources are available in the Medical Staff Administration Department, and such certification programs may include but are not limited to:

- A. **Annual Education:** Required upon initial appointment and prior to participating in, observing or providing patient care at any Crouse Hospital location and annually thereafter.
- B. **Laser Safety Education:** Required prior to granting of specific laser privilege(s) upon initial appointment and thereafter every 2-years upon reappointment of specific privilege. Proof of competency as demonstrated by resident/fellowship training or current education/privilege at other area hospital(s) may be considered at the discretion of the Department Chief.
- C. **Moderate Sedation Privilege:** Initial appointment of privilege requires current ACLS/PALS/NRP certification per hospital policy appropriate to the department, completion of a hospital-approved moderate sedation education program (including video, written content, post-test passing grade of 80%), and documentation of 3 proctored cases. At the discretion of the Department Chief, completion of the moderate sedation education program and/or documentation of 3 proctored cases may be waived for practitioners

who demonstrate current competence. Proof of current competence shall include: documentation of recent residency/fellowship training in administration of moderate sedation (letter of competency from Residency Program Director and/or case logs) and/or documentation of moderate sedation privilege currently held at another area hospital (letter of competence from Department Chief and/or case logs).

Reappointment of privilege requires current ACLS/PALS/NRP certification and case log of 10 moderate sedation procedures performed without incident in the prior two-year period. The case log may include moderate sedation procedures performed at another area hospital. At the discretion of the Department Chief, repeat completion of the moderate sedation education written content/post-test program within the previous 12 months and/or completion of 3 proctored cases may be substituted in lieu of the case log.

By virtue of specialty certification and training, physicians currently American Board certified in Emergency Medicine, Critical Care, and Anesthesia are exempt from initial/reappointment current ACLS/PALS certification, moderate sedation education, and reappointment case log requirements. Physicians currently American Board certified in Neonatology must maintain current NRP certification at initial appointment and reappointment, but are exempt from moderate sedation education and reappointment case log requirements.

- D. Fetal Monitoring: Required prior to granting of specific privilege upon initial appointment only. Proof of completion of department-approved education program must be submitted.
- E. Provider Performed Microscopy: Annual certification required of all practitioners performing microscopy in labor and delivery service.
- F. Fluoroscopy Education: Required prior to granting of specific privilege upon initial appointment only.

Other privileging/certification criteria as determined by the appropriate oversight committee and/or Department Chief may also be required.

Failure to comply with the requirements for any privilege or education certification program will result in suspension and/or termination of the specific privilege or revocation of operating suite access.

10. PARKING FACILITIES

- 10.1 Courtesy parking in the Crouse Hospital parking garage is reserved for authorized physician Medical Staff members who do not have access to parking at other adjacent or area medical facilities. Requests for access to the Marley Education Center lot shall be forwarded to Medical Staff Administration prior to approval by the Hospital Parking Committee.

- 10.2 Reserved emergency on-call parking in the Crouse Garage is available free of charge to authorized on-call practitioners as prescribed in the Hospital's Parking Control System policy. Reserved emergency on-call parking is not available for routine rounding. Unauthorized use of reserved emergency on-call parking will result in disciplinary action.

Unauthorized use of any Hospital parking facility will result in disciplinary action.

The authorized physician's Hospital-issued photo ID badge is required to gain access to Hospital parking facilities. Unauthorized use of a physician ID badge by persons other than the authorized physician to gain access to Hospital parking facilities shall result in revocation of the parking privilege and/or disciplinary action.

11. AMION (Or Electronic Equivalent)

To support timely and effective communication between practitioners, Emergency Department medical staff members and on-call physicians/groups are required to participate in AMION, the Hospital's online resource for on-call schedules and practitioner contact information.

Answering service contact numbers may be substituted for personal beeper or cell phone numbers. Maintaining accurate, up-to-date on-call schedules and contact information is the responsibility of the practitioner/group.

IMMUNIZATIONS

Upon initial appointment and prior to providing patient care, all practitioners are required to submit proof of immunizations and current PPD or other approved TB test as required by NYS Department of Health and Crouse Hospital Employee Health. Thereafter, an annual TB screen or other approved TB test may be required as determined by NYSDOH and/or hospital policy. At the discretion of the hospital, proof of mumps is also required. All immunization costs incurred are the responsibility of the Medical Staff member.

Per NYS DOH policy, all practitioners are encouraged to receive an annual flu immunization per NYSDOH policy. In the absence of flu immunization, face masks must be worn at all times in all patient care areas.

12. Respirator Fit Test

All on-site practitioners are required to complete an OSHA-approved respirator fit test prior to initial appointment and annually thereafter. OSHA-approved respirator fit tests completed at other facilities will be accepted.

13. REQUIRED DOCUMENTATION SUBMISSION FOR REAPPOINTMENTS:

All practitioners are required to submit documentation within 90 days of initial request. Failure to submit documentation within 90 days of initial request will result in administrative suspension of medical staff appointment.

Required documentation subject to immediate administrative suspension includes but is not limited to: proof of current malpractice insurance, current hospital-approved ACLS/PALS/NRP certification cards, and proof of current licensure.

Failure to provide privilege or education-specific documentation will result in suspension of the specific privilege(s) only.

14. ADMINISTRATIVE SUSPENSION

Except as provided for in the Bylaws at reappointment, practitioners who fail to comply with Hospital or regulatory agency documentation requirements and medical records completion dates shall be administratively suspended until such time as the required documentation has been received by Medical Staff Administration or medical records have been completed. Administrative suspension is applicable to the practitioner's medical staff appointment or specific privileges.

Medical staff appointments or privilege(s) may be administratively suspended for a period not to exceed 90 days. Thereafter, the practitioner shall be deemed to have voluntarily resigned from the Medical Staff or deemed to have voluntarily resigned a specific privilege.

Practitioners shall be required to pay an administrative reinstatement fee as indicated: 1st suspension - \$100.00; 2nd suspension - \$250.00; 3rd suspension - \$500.00. Reinstatement fees may be waived one time for acceptable cause at the discretion of the Director of Medical Staff Administration and/or the Chief Medical Officer.

Practitioners who voluntarily resign their medical staff appointment or specific privilege(s) under these circumstances shall not be entitled to a hearing or appellate review under Article XI or Article XII of the Medical Staff Bylaws.

Should the practitioner wish to regain his/her Medical Staff appointment or specific privilege, a new application for medical staff membership or privilege must be submitted, and that application shall be processed in the manner required by Article V of the Medical Staff Bylaws.

15. CREDENTIALING CRITERIA FOR NEW PRIVILEGE REQUESTS

When requesting a new privilege, or when new technology or medical advancements result in the establishment of a new clinical or surgical procedure, the practitioner shall be required to request the privilege as stated in the Bylaws. Proof of competency and/or credentialing criteria shall be determined by the appropriate oversight committee, Department Chief and/or as stated in the Department Manual. The burden of proof lies with the applicant.

At the direction of the Department Chief, proof of competency may include but is not limited to: Case logs from a residency program, cadaver training, completion of manufacturer training/education, a minimum of proctored cases as defined by

the Department Chief in tandem with a practitioner who currently holds the privilege or a manufacturer representative specially trained in the privilege, or a letter of competency from a residency Program Director or former CMO/Department Chief at another hospital.

16. ADOPTION; AMENDMENTS

Document in entirety adopted by the Medical Executive Committee and approved by the Board of Directors

Date:

Maria Ciciarelli - President Crouse
Health Hospital Medical Staff

Approved by the Board of Directors:

Date:

Seth Kronenberg, MD – President & CEO
Crouse Health Hospital