West Valley Hospital
Rules and Regulations

Approved by the Board of Trustees on (Approval Date) for implementation beginning (Date).

ARTICLE I: DEFINITIONS

The following definitions shall apply to terms used in these Rules and Regulations: Words used in these Rules and Regulations shall be read as the masculine, feminine or neuter gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Rules and Regulations.

(a) **"Board"** means the Board of Trustees of West Valley Hospital, who has the overall responsibility for the operation of the hospital;

(b) **"Chief Executive Officer"** means the President/Chief Executive Officer of the hospital or designee;

(c) **"Dental Staff"** means all dentists, including oral and maxillofacial surgeons, who are privileged to attend patients in the hospital;

(d) **"Emergency"** means a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger;

(e) **"Medical Executive Committee"** means the Executive Committee of the Medical Staff

(f) **"Medical Staff"** means all physicians, dentists podiatrists and advanced practice providers who are granted privileges to treat patients in a Salem Health Hospital and/or clinic;

(g) **"Oral and maxillofacial surgeon"** means a dentist qualified by training or experience to practice oral and maxillofacial surgery;

(h) **"Patient"** or **"Patients"** means inpatients or out-patients;

(i) **"Physicians"** shall be interpreted to include both Doctors of Medicine and doctors of osteopathy;

(j) **"Podiatrists"** shall be interpreted to include doctors of podiatric medicine;

(k) **"Invasive Procedure"** means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

(l) **"Licensed Practitioner (LP)"** means Doctor of Medicine (MD) and doctors of osteopathy (DO), podiatrists (DPM), dentists (DMD or DDS), oral surgeons (DMD or DDS), Physician Associates (PA) and Advanced Practice Registered Nurses (APRN)who are currently licensed in the State of Oregon;

(m) **"Advanced Practice Clinician"** means a licensed or certified healthcare practitioner, other than a LPs, who is permitted to exercise limited clinical privileges and practices within the scope of their license with physician supervision, or on an independent basis without direct physician supervision if the practitioner has demonstrated experience and training in inpatient care and is permitted to do so by license and privileging. The following are deemed Advanced Practice Clinicians: clinical psychologists, radiology practitioner assistants, registered nurse first assistants, certified surgical technician first assistant and others identified by the Board of Trustees.

(n) **"Credentialed Provider"** means any Provider who has been credentialed and privileged to exercise clinical privileges, hereinafter referred to as a Provider

ARTICLE II: TREATMENT OF PATIENTS

Patients may be treated by Credentialed Providers who have submitted proper credentials and have been duly appointed to membership and/or granted privileges.

Self-Treatment or Treatment of Immediate Family Members: Consistent with the American Medical Association Code of Ethics, Opinion 8.19," Self-Treatment or Treatment of Immediate Family Members," Providers at West Valley Hospital generally should not treat themselves, members of their household, or any other first-degree relative of a household member.

First-degree relatives are defined as spouse, parents, brothers, sisters or children of the individual.

It would not always be inappropriate to undertake self-treatment or treatment of members of their household or first-degree relatives of a household member. In emergency settings or isolated settings where there is no other qualified provider available, provider should not hesitate to treat themselves or family members until another provider becomes available. In addition, while providers should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for providers to write prescriptions for controlled substances (schedule II, III, IV) for themselves, members of their household or any other first-degree relative of a household member.

If a provider is rendering care to a person with whom they have a significant social relationship, the situation will be referred for review by two members of the Medical Executive Committee (MEC). If the two MEC members find that, upon reviewing the medical record, it appears the care provider's relationship with the patient is in some way adversely affecting said care, the care provider may be required to step down and refer this case to another Provider.

ARTICLE III: ATTENDING, CONSULTING AND REFERRING PROVIDERS

ARTICLE III PART A: ATTENDING PHYSICIAN

At West Valley Hospital, every patient shall have a Licensed Provider who will be designated as the "Attending Provider" for that hospital admission. Providers manage the treatment of the patient. The attending Provider has the final authority on any matters of patient care and will be charged with the responsibility for release of the patient. Any other providers who are involved in patient care will be so designated through requests for consultation or referral.

ARTICLE III PART B: CONSULTING PROVIDER AND CONSULTATION REQUIREMENTS

Section 1. Consulting Provider and Consultation:

It is the duty of the Staff, through its, Departments, and Medical Executive Committee, to make certain that members of the Staff do not fail in the matter of calling consultants or responding to consultation requests as needed. A consultant must be qualified to give an opinion in the field in which his/her opinion is sought. See Article VII Consultations for documentation requirements.

(a) Once contacted for a consultation, the consulting physician may direct a Physician Associate or Nurse Practitioner as his or her representative to provide further assessment and stabilizing treatment.

(b) This determination should be based on the patient's medical needs.

(c) Although a Physician Associate or Nurse Practitioner may respond to the consultation request, the physician retains responsibility for providing the necessary services to the patient.

(d) If the Provider who requests the consultation disagrees with the decision to send a representative, he or she retains the right to request the actual appearance of the consulted physician.

(e) Consultants are required to timely respond to requests for consults.

Section 2. Definitions of Types of Consultation:

In the consultation process, it is important for both the Provider requesting consultation and the provider consulting to have a mutual understanding of the nature of the request. The types of consultation are listed below.

(a) Collegial discussion regarding the care of a condition or patient is encouraged. Such discussion is not considered a consultation unless the consultant makes a written entry into the patient record.

(b) Consultation for Opinion Only: a consultant's opinion on a specific problem is requested. There is no expectation that the consultant will provide continued care of the patient.

(c) Consultation for Co-Management of Patient: The consultant is requested to provide co-management of the patient for a defined period of time or until resolution of the particular problem.

(d) Consultation for Transfer of Care: A request is made to transfer care of the patient to the consultant on this issue.

Section 3. Required Consultations:

Except in an emergency, consultation with another qualified Provider is required in cases in which the Attending Provider does not have clinical expertise or possess specific clinical privileges required for the patient's condition or problem. Consultants are required to timely respond to requests for consults.

Section 4. Rapid Response Team Consultations:

When deemed to be necessary based on the clinical needs of the patient, a non-provider representative of the Rapid Response Team may initiate a consultation with a Provider on the behalf of the Attending Physician.

ARTICLE IV: STANDING ORDERS

The use of pre-printed and electronic standing orders, order sets, and protocols for patient orders are permitted and can be initiated by nurses or other clinicians without a specific order from the Provider only if the Hospital Representatives (including, as applicable, Nursing and Pharmacy Leadership) and Medical Staff:

(a) Establish that such orders and protocols have been reviewed and approved by the Medical Staff and Hospital's Nursing and Pharmacy leadership;

(b) Demonstrate that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(c) Periodically and regularly review (at least annually) such orders and protocols to determine the continuing usefulness and safety of the orders and protocols; and

(d) Require that such orders and protocols be dated, timed and authenticated as permitted by these Rules & Regulations, and by Hospital policies.

Providers retain the right to modify, cancel, void or refuse to authenticate standing orders as appropriate, considering medical necessity.

ARTICLE V: TREATMENT ORDERS

Patient Orders shall be electronic using the Salem Health EMR. Verbal and telephone orders shall be electronically signed by the ordering provider or another provider who is responsible for the care of the patient. Verbal telephone orders are co-signed or authenticated within 48 hours of transcription. Verbal and telephone orders are entered into the EMR by the person receiving the order.

(a) All verbal or telephone orders are accepted by licensed personnel only or other individuals authorized by law or their scope of practice to accept verbal orders, e.g., RNs, Physical Therapists, Occupational Therapists, Speech and Language Therapists, Respiratory Therapists, Dieticians, Pharmacists, and Radiological Technologists.

(b) The Provider must be called on admission of patient if no orders were given pre-admission.

(c) Medical student orders must be verified by the designated preceptor prior to implementation.

(d) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.

ARTICLE VI: MEDICAL RECORDS

ARTICLE VI PART A: CONTENT OF MEDICAL RECORD

All medical record entries must be legible and complete, and must be authenticated, and dated and timed promptly by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished.

While it is acceptable to copy and paste from a source document into the Salem Health EMR, the provider must adhere to the following:

A provider may not copy another provider's document verbatim and use it as if it were their own work. If a document is copied and pasted, it must be stated as such and credit given to the author of the document. It cannot replace the provider's own documentation for that encounter.

A provider may not copy forward or clone their own document unless the document is updated/edited to reflect the unique patient encounter for that given day.

If a copied and pasted or cloned document is unchanged/unedited so that it cannot be used for billing purposes, the document will be considered 'incomplete' by the provider and a deficiency will be created in the medical record for that encounter.

The Attending Provider shall be responsible for the completion of the medical record.

All records are the property of the Hospital and may not be removed except pursuant to a court order, subpoena or statute.

HISTORY AND PHYSICAL EXAMINATION

(See Bylaws, Part 1, Appendix A, as required by the Joint Commission and CMS.)

ARTICLE VI PART B: PROTOCOL FOR OUTPATIENT INVASIVE PROCEDURES

A provider's legible note indicating significant history and physical findings must be present on the chart prior to the procedure. This note must be written by the practitioner performing the procedure and must meet the standards required in Bylaws Part 1, Appendix A. The Provider ordering the procedure will provide the H&P, and the provider performing the procedure will complete the Focused H&P.

(1) If the patient is kept only for the invasive procedure and then post-procedure for observation in the outpatient areas, the physician performing the procedure (i.e., radiologist or anesthesiologist) will remain the Attending Physician.

(2) If the patient is admitted to West Valley Hospital for an overnight stay, the Attending Physician shall be the physician performing the procedure regardless of the indication for the admission. If the physician performing the procedure does not have admitting privileges, it is the responsibility of the physician performing the procedure to find an accepting admitting physician. The physician performing the procedure shall remain involved in the case as a consultant to deal with complications directly related to the procedure.

(3) In the event a patient referred by a non-Staff member requires admission, the Provider performing the invasive procedure will make arrangements for an Attending Provider to care for the patient as described in (2) above.

(4) If the outpatient invasive procedure does not require use of moderate or deep sedation or general anesthesia, an assessment, as recommended by the Department Chair, and approved by the Medical Executive Committee, is sufficient. (NOTE: The "assessment" noted above is a pre-procedure assessment consisting of vital signs, allergies, assessment of site, and pertinent history of contraindications for those procedures that require only local anesthesia, or minimal sedation/anxiolysis.)

ARTICLE VI PART C: POST INVASIVE PROCEDURE REPORTS

All invasive procedures performed shall be fully described by the Provider performing the procedure, and an operative report shall be dictated, or self-entered into the electronic medical record upon completion of procedure, before the patient is transferred to the next level of care. An immediate post invasive procedure note is to be entered into the medical record immediately after the procedure to provide pertinent information for any individual required to attend to the patient. This is not required if self-entered complete operative note is entered into the Salem Health EMR. The immediate post invasive procedure note is to be dated and timed.

Fulfillment of the requirements of a post-invasive procedure note can be accomplished by the following methods:

(1) Place an immediate post-invasive procedure note into the electronic medical record using the following required elements:

- Name of the specific procedure(s) performed;
- Pre-op diagnosis
- Post-op diagnosis;
- Name of the surgeon(s) and assistants or other Providers who performed surgical tasks (defined as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Complications, if any;
- Estimated/qualitative blood loss;

AND WITHIN 24 HOURS

(2) Dictate a post-invasive procedure report including the following required elements:

- Name of the specific procedure(s) performed;
- Brief history/indications for surgery

- Pre-operative diagnosis
- Post-operative diagnosis;
- Name of the surgeon(s) and assistants or other Providers who performed surgical tasks (defined as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Description of techniques, findings, and tissues removed or altered;
- Prosthetic devices, grafts, transplants, or devices implanted, if any;
- Condition after surgery;
- Estimated/qualitative blood loss;

OR

(3) Self-enter a post-invasive procedure report into the electronic medical record including the following required elements:

- Name of the specific procedure(s) performed;
- Brief history/indications for surgery
- Pre-operative diagnosis
- Post-operative diagnosis;
- Name of the surgeon(s) and assistants or other Providers who performed surgical tasks (defined as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Description of techniques, findings, and tissues removed or altered;
- Prosthetic devices, grafts, transplants, or devices implanted, if any;
- Condition after surgery;
- Estimated/qualitative blood loss.

ARTICLE VI PART D: FOREIGN MATERIAL AND TISSUES REMOVED

Specimens removed during a surgical procedure shall be routinely sent for Pathological review, except those specimens defined in the Care and Handling of Surgical or Procedural Specimens policy which has been approved by the Medical Executive Committee.

ARTICLE VI PART E: PROGRESS NOTES

The Attending Provider of record or the covering Provider shall be required to make daily face-to-face rounds on their hospitalized patients, followed by the documentation of their observation in a progress note.

Progress notes must be documented no less than daily, and must be documented on the day of the encounter, with the following limited exceptions:

(1) Patients who meet discharge criteria, who remain in the hospital other than due to medical necessity, when progress notes and face-to-face visits must be documented at least every other day.

(2) Patients in the Discharge Ready Unit who are awaiting discharge must have documented progress notes and face-to-face visits at least every seven days.

(3) Patients in the Physical Medicine and Rehabilitation unit (PMR) also known as the Inpatient Rehabilitation Facility (IRF) by CMS and in accordance with CMS guidelines, the rehabilitation physician must conduct face-to-face visits with the patient and have documented progress notes at least three days per week throughout the patient's stay in the PMR/IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

Regardless of exception, an additional progress note is required for any immediate change in patient status, defined as:

(1) Any change in condition of the patient that requires the provider to perform a bedside evaluation,

(2) ICU-to-floor transfer, or if there is a change in provider,

(3) Floor-to-ICU transfer.

Daily Progress notes shall be self-entered into the EMR and give a pertinent report of the patient's course in the hospital over the past 24 hours and reflect any changes in the patient's condition, the results of treatment, and any changes in plan of care.

ARTICLE VI PART F: CONSULTATION

A consultation shall include appropriate examination of the patient and the record. A written opinion authenticated by the consultant will be made a part of the record. The following elements are strongly recommended for inclusion:

- Chief complaint;
- Details of the present illness;
- A medical history which includes information from the patient and/or family, prior medical testing, and results of prior medical treatment;
- Detailed past, psychosocial/social, and family history;
- Presence of significant allergies or documentation of none;
- Current medications which are pertinent to the reason for admission or procedure;
- Review of systems;

- Vital signs;
- Physical examination;
- Mental status exam if indicated or pertinent to the admission or procedure;
- Impression, Differential Diagnoses, Conclusion;
- Treatment; and
- Plan.

Fulfillment of this requirement is accomplished by:

(1) Dictation plus brief consultation note in electronic medical record; or

(2) Self-entry of full consultation in electronic medical record.

ARTICLE VI PART G: DISCHARGE DIAGNOSES/SUMMARIES

The discharge summary will be assigned to the Provider who is identified in the discharge order. If no designation exists, the Attending Provider will be responsible for the discharge summary. The discharge summary shall be dictated or documented no later than 7 days following patient's discharge.

A discharge summary contains the following elements, some of which are required as noted below:

REQUIRED:

- Final diagnoses, including principal and all secondary diagnoses.
- Treatment rendered.
- Disposition: Discharge to home, discharge to skilled nursing facility, expired, etc.
- Any instruction given to the patient or family relating to physical activity, medication, diet, and follow-up care.

RECOMMENDED:

- Reason for hospitalization.
- Significant findings.
- Principal and secondary procedures performed.
- The condition of the patient on discharge.

All patients regardless of type, request a discharge summary with the following exceptions.

Final progress note may be substituted for a discharge summary if:

- The patient was hospitalized less than 48 hours for a minor problem (does not include deaths), must contain the same required elements listed above, **OR**
- The patient had an uncomplicated obstetrical stay, **OR**
- The patient was a normal newborn infant

ARTICLE VI PART H: PROBLEM LIST

(1) Purpose of the Problem List: The purpose of the problem list is to communicate to other members of the health care team the relevant problem(s) the patient is experiencing for the current episode of care, specifically rationale for why treatment is chosen and may be used for the purpose of coding.

(2) Management of the Problem List: The management of the problem list falls to all Provider(s) taking care of the patient, each Provider managing their problem(s) on the list. All Providers will manage the problem list, specifically any Provider may edit, remove, or make inactive any other Provider's problem(s). Non-credentialed providers (nursing staff, certified nurse assistants, medical assistants, unit clerks, pharmacists, ancillary staff – RT, PT, OT) will not be expected or allowed to manage the problem list. The exception to this is for nursing and ancillary staff that have patient encounters without credentialed providers present (i.e., Infusion and Wound Care).

(3) Entering the Problems: The problem list should continue all problems actively managed or monitored during that hospital stay. If no problem is entered, a deficiency will be created for the attending provider.

ARTICLE VI PART I: REQUIREMENTS FOR PRE-SEDATION/PRE-ANESTHESIA

A pre-sedation/anesthesia examination assessing those aspects of the patient's physical condition that might affect decisions regarding intra-procedure risk and management will be completed by the appropriately credentialed Provider. This includes:

(1) ASA Classification System;

(2) Previous history of adverse reactions to sedatives/anesthesia;

(3) Heart, lungs, airway and treatment site;

(4) Plan for sedation/anesthesia.

Procedure, Alternatives, Risks and Questions (PARQ) discussion for both planned procedure and sedation/anesthesia will be documented.

ARTICLE VI PART J: PROCEDURE FOR DELINQUENT RECORDS

Section 1. Delinquent Charts:

Hospital charts will become delinquent the date assigned for completion by the HIM Department. Completed charts will include all required documentation and signatures.

Section 2. Health Information Management Department Procedure for Impending Administrative Suspension:

(a) The Health Information Management Department shall send a notification to each Provider having such delinquent charts, approximately five (5) working days before consideration is given by the Medical Staff Office to initiate the action provided in Section 3 below.

(b) If all delinquent records are not completed (including all required documentation and signatures) by noon on the effective date of suspension, the Provider will be subject to the penalties outlined in Section 3 below.

(c) The Medical Staff President, President Elect or his/her designee shall have the discretion to provide an extension in the case of unique circumstances to complete delinquent records.

Section 3. Penalties for Non-Completion of Delinquent Medical Records by Noon on the Effective Date of Suspension:

(a) First Non-Completion of Delinquent Medical Records:

(1) A disciplinary fine of $250 will be imposed, to be paid within 2 weeks of notification of the missed noon deadline for completion of delinquent medical records.
(2) A personal telephone call to the practitioner from the Section Chief or Department Chair.
(3) All outstanding medical records must be completed.
(4) Fines not paid within 2 weeks will result in an administrative suspension of privileges until the fine is paid and all records are completed.

(b) Second Non-Completion of Delinquent Medical Records:

(1) Administrative Suspension of Privileges will be invoked.
(2) Disciplinary fine of $250, to be collected prior to privileges being reinstated.
(3) All outstanding medical records must be completed.

(c) Third Non-Completion of Delinquent Medical Records:

(1) Administrative Suspension of Privileges will be invoked.
(2) Disciplinary fine of $500, to be collected prior to privileges being reinstated.
(3) All outstanding medical records must be completed.
(4) Mandatory one-week disciplinary suspension.

(d) Fourth Non-Completion of Delinquent Medical Records:

(1) Administrative Suspension of Privileges will be invoked.
(2) Disciplinary fine of $1,000, to be collected prior to privileges being reinstated.
(3) Mandatory two-week disciplinary suspension.
(4) Mandatory meeting with the MEC to provide an explanation for repeated non-compliance.

(e) Fifth Non-Completion of Delinquent Medical Records:

(1) Deemed to constitute voluntary resignation from the Medical Staff.

Penalties will be imposed for non-completion of delinquent medical records by the noon deadline on the effective date of suspension that occur within a rolling 24-month period as follows. Any practitioner fines imposed are expected to be paid immediately but must be paid within 2 weeks or prior to privileges being reinstated if privileges have been administratively suspended.

Section 4. Notification of Suspension:

On the effective date of administrative suspension from the Medical Staff for delinquent medical records, the Medical Staff Office will notify the Staff member of the suspension by telephone and by letter. In addition, relevant areas of the Hospital may be notified.

Section 5. Completion of Delinquent Charts:

So long as the staff member is not subject to Section 3(e) above, then upon completion of all charts, payment of any disciplinary fine and completion of any other requirements, Staff members will be reinstated upon notification by the Medical Staff Office and approval of the Medical Executive Committee, Medical Staff President, Medical Staff President Elect or his/her designee. The Medical Staff Office staff shall also immediately notify relevant areas of the Hospital notified under Section 4 above.

Section 6. Notification of Unavailability:

Any Staff member notifying the Health Information Management Department or the Medical Staff Office of absence from the city or unavailability for one week or longer will not be considered delinquent for that period of time. Unavailability means that the

Staff member will not be performing other functions in the hospital. The Staff member shall complete all available records before a planned absence.

Section 7. Suspension Process:

The Medical Executive Committee may modify the suspension process to impose some lesser penalty on a uniform basis to be applied to all members of the Medical Staff. In the situation of an urgent patient care need and a practitioner that is administratively suspended for delinquent medical records, the Administrator on Call, together with the Medical Executive Committee (MEC) Member on Call, can reinstate privileges for no greater than a 24-hour period. All such reinstatements will be subsequently reviewed by the MEC at the next meeting.

ARTICLE VII: AVAILABILITY TO SEE HOSPITAL PATIENTS

All Active Staff members shall be available to see their hospital patients every day or to make arrangements with a member of the Active Staff who has comparable privileges to see their hospital patients in case of their unavailability. Hospital patients shall be defined as both inpatients and outpatients.

In case of failure of the Staff member to make such arrangements, the Medical Staff President or his delegate, shall select a Staff member to take the necessary action. A Staff member called by the Medical Staff President shall give appropriate treatment and shall leave a report of such treatment for inclusion in the record.

Timely response to phone, beeper and/or answering service is expected of all Active Staff members, defined as within 15 minutes of the initial contact. If there is no response within 15 minutes, a second attempt at contacting the Staff member will be made. If there is no response within 15 minutes of the second attempt, the Section Chief (or Department Chair if no Section) and the Medical Executive Committee Member On Call will be contacted to handle the patient care issue.

ARTICLE VIII: EDUCATION OF HOSPITAL PERSONNEL

Medical Staff members shall cooperate with Administration in education of Hospital personnel by giving such personal supervision and lectures as required.

ARTICLE IX: EMERGENCY DEPARTMENT

ARTICLE IX – PART A: DEFINITIONS

(1) Unassigned Patient: Patients who have no assigned Primary Care Provider.

(2) Primary Care Provider: A Provider from the West Valley Hospital Medical Staff whom the patient has an ongoing relationship with and provides primary care services.

(3) Emergency Department: The West Valley Hospital department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life threatening, requiring immediate attention.

(4) Emergency Department Backup: This is the process whereby the West Valley Hospital back-up Provider is requested to:

(a) Come to the Emergency Department to provide care, as determined by the Emergency Department Provider.

(b) Admit and provide inpatient services, as determined by the Emergency Department Provider, in collaboration with the back-up Provider; and

(c) Provide outpatient follow up of the patient's evaluation in the Emergency Department in cases where the patient is deemed to have an acute medical problem that requires follow up. This excludes Urgent Care.

ARTICLE IX PART B: EMERGENCY DEPARTMENT BACKUP REQUIREMENTS

(1) In order to meet community need, sections which include four or more active staff members are responsible for providing continuous coverage for their emergency call roster.

(2) The Active Staff shall be responsible for maintenance of their Emergency call roster. In the event of a schedule dispute, the Section Chief has the authority to resolve the dispute; if unable to do so, the dispute will be referred to the Department Chair. If the dispute cannot be resolved by the Section Chief and/or Department Chair, it shall be referred to the Medical Executive Committee.

(3) Family Medicine Providers shall participate on a backup list commensurate with their Hospital privileges.

(4) Exceptions to the above requirements are as follows:

(a) Those members who are 60 years of age or more, on approval of Section.
(b) Sections may be granted a variation in required coverage based upon good cause shown by the section and with approval by the Medical Executive Committee.

(5) Upon written request, and upon the receipt of a recommendation by the Department Chair approving such request, the Medical Executive Committee may relieve any Staff member from duties under this section for such time and under such circumstances and conditions as the Medical Executive Committee shall consider appropriate and in the best interest of the hospital. All actions

concerning privileges and/or responsibilities of medical staff members are under the auspices of the Board of Trustees and therefore such action by the MEC under this article may in the discretion of the Hospital President/CEO be forwarded to the Board of Trustees for approval and/or modification.

ARTICLE IX – PART C: DUTIES OF MEDICAL STAFF MEMBERS RESPONSIBLE FOR EMERGENCY DEPARTMENT BACK UP AND EMERGENCY DEPARTMENT REFERRAL

(1) The duties of the backup member shall be:

- (a) To respond promptly to the Emergency Department Credentialed Provider, as listed in Sections 3, 4 and 5 below, and assume responsibility for Emergency Department emergencies referred by the Emergency Provider for unassigned patients.
- (b) Once contacted by the Emergency Department Credentialed Provider, the backup or on-call Provider may direct a Physician Associate or Nurse practitioner as his or her representative to provide further assessment and stabilizing treatment.
- (c) This determination should be based on the patient's medical needs.
- (d) The backup or on-call physician retains responsibility for providing the necessary services to the patient.
- (e) If the Emergency Department physician disagrees with the decision to send a representative, he or she retains the right to request an in-persona consultation of the on-call physician.
- (f) If the patient is transferred to another acute care facility, the Credentialed Provider arranging the transfer must certify the risks and benefits discussion.
- (g) In the case of patients who have a Primary Care Provider, it shall be the responsibility of that Credentialed Provider, or his/her designated substitute, to admit or to obtain consultation.
- (h) To provide subsequent outpatient follow-up care for a particular problem referred by the Emergency Department Credentialed Provider, as listed in Section 6 below.

(2) Telephone or Arrival: Timely response to the Emergency Department Credentialed Provider request is defined as responding by telephone or arrival in person within 15 minutes.

(3) Arrival: Request by Emergency Department Credentialed Provider or other member of the Medical Staff to come to the Emergency Department.

- (a) Credentialed Provider Request for Urgent Arrival: Medical Staff member shall arrive in person within 30 minutes. *
- (b) Credentialed Provider Request for Non-Urgent Arrival: Medical Staff member shall arrive in person within 1 hour. *

(4) Level II Trauma: Trauma Surgeon response time is within 15 minutes.

(5) Outpatient Follow-up Care of Emergency Department Referral Patients:

(a) Patient Responsibilities:

(1) The patient must request follow-up care within a two-week period of time Otherwise the Emergency Department Referred provider may refer the patient back to the Emergency Department or Urgent Care.
(2) If the patient does not accept the offered appointment, the patient may be referred to the Emergency Department or Urgent Care.

(b) Medical Staff Members Responsibilities:

(1) Active and Associate Staff members and Refer & Follow staff status shall participate in outpatient follow-up care on a rotational basis as determined by their section and department and approved by the Medical Executive Committee.
(2) The Medical Staff member must agree to see the patient within two weeks of the patient's initial follow-up call, or sooner at the discretion of the Providers involved and based on the nature of the medical condition, providing that the patient met the responsibilities outlined in 6.a. above. The Provider must provide at least one follow-up option in the two-week time frame.
(3) Outpatient follow-up care shall be limited to only the particular problem referred by the Emergency Credentialed Provider. It is not the responsibility of the back-up Provider to accept the patient as a full-time patient to his/her practice; however, they may do so at their discretion.

(6) Violation of Medical Staff Regulations: Violations will be dealt with by the Section Chief, Department Chair and/or MEC.

*Unless the on-call credentialed Provider is preoccupied in a procedure or care of an unstable patient. In this case, an estimate should be obtained from the on-call credentialed provider as to when they are likely to become available. If the patient's condition requires more prompt evaluation and treatment, then the patient should be stabilized and transferred to a facility with available resources. This is to be coordinated with the assistance of the house supervisor.

ARTICLE IX – PART D: EMERGENCY MEDICAL SERVICES

(1) Emergency services and care shall be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and

qualified personnel available to provide such services or care. Such emergency services and care shall be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, gender, gender identity, sexual orientation, , pre-existing medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

(2) Medical Screening Examinations, within the capability of the Hospital, will be performed on all individuals who come to the hospital requesting examination or treatment to determine the presence of an emergent medical condition. Qualified medical personnel who can perform Medical Screening Examinations within applicable Hospital policies and procedures are defined as:

(a) Emergency Section:

(1) Members of the Medical Staff with clinical privileges in Emergency Medicine.

(2) Registered Nurses who have completed Sexual Assault Nurse Examiner (SANE) certification and maintain competency may perform medical screening examinations on adolescent and adult alleged sexual assault victims in accordance with Emergency Department policies and procedures.

(b) Labor and Delivery:

(1) Members of the Medical Staff with OB privileges.

(2) Registered Nurses who have completed a Labor and Delivery departmental orientation/competency program may perform the initial medical screening in accordance with Labor and Delivery Policies and Procedures.

ARTICLE X: REPORTABLE DEATH AND AUTOPSIES

ARTICLE IX PART A: REPORTABLE DEATHS

(a) When deaths occur in the following categories, they are reportable to the Marion County Medical Examiner. The Medical Examiner must be notified in all cases in which death occurs in any of the below categories. In these cases, the Medical Examiner must give consent prior to requesting organ donation.:

(1) All cases "Dead on Arrival" not attended by a Provider.

(2) Deaths subsequent to violence (homicide, suicide or accident);

(3) Death was assumed to be due to a communicable disease that might be hazardous to the public health;

(4) Death occurred where the individual was not under the care of a Provider;

(5) Death was apparently the result of the individual's employment (including accidents);

(6) Sudden unexplained death;

(7) Death occurred in a public or private hospital less than 24 hours after admission;

(8) The death certificate had been signed but circumstances suggest that further investigation is indicated; and/or

(9) Death occurred under suspicious circumstances.

ARTICLE IX PART B: AUTOPSY

(b) An autopsy should be performed in all neonatal deaths, maternal deaths, pediatric (age <18) deaths, and deaths occurring intra-operatively or within 24 hours following surgery. The attending Provider or designee will be responsible for requesting permission for the autopsy. If in the opinion of the attending Provider the request for an autopsy would be uninformative or would be unduly distressing to the family, or would likely be rejected by the family, the request may be deferred.

In cases falling under the jurisdiction of the Marion County Medical Examiner, the Medical Examiner determines if a Medical-Legal Autopsy is performed. (ORS 146.045)

If the Medical Examiner waives Medical-Legal Autopsy, permission for hospital autopsy may be requested from next-of-kin.

(c) Use of autopsy in Quality Assessment and Improvement activities:

Autopsy reports are included in the review of death peer review indicators as part of the quality assessment and improvement activities by the Medical Staff.