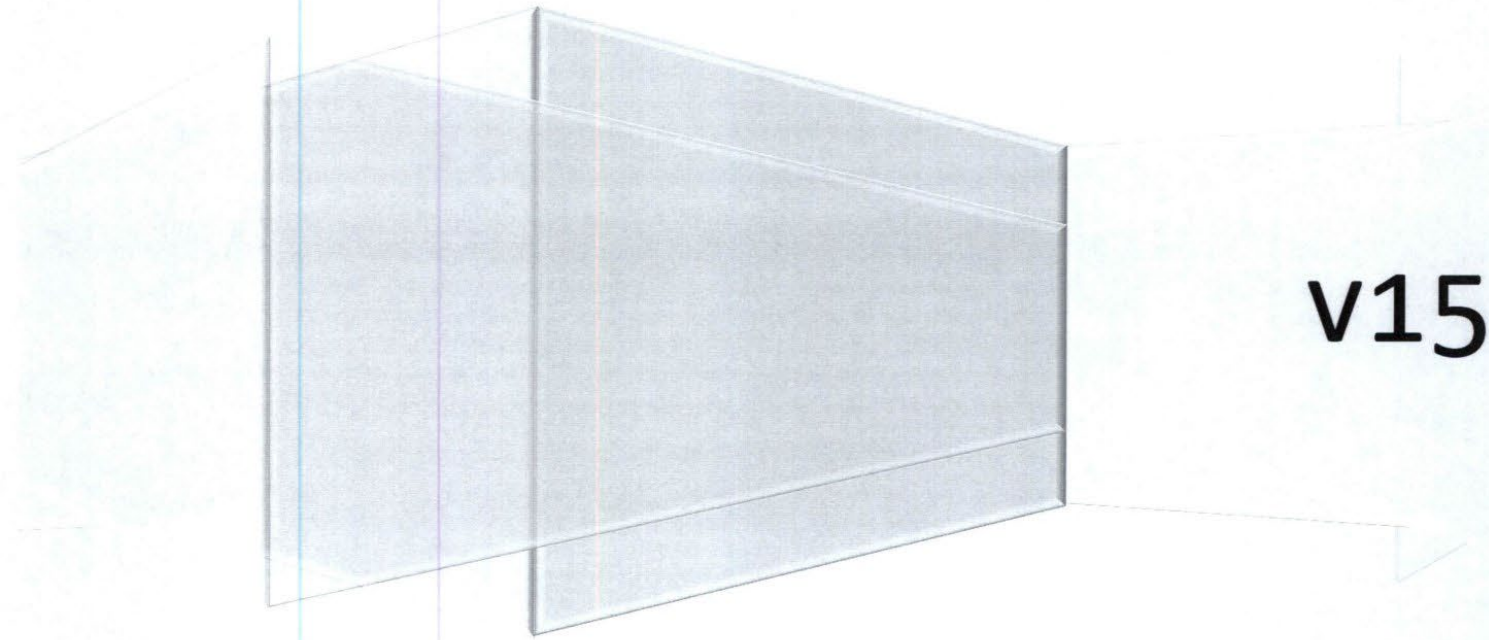
INTEGRATED HEALTH SYSTEMS, INC.
MEDICAL STAFF POLICIES AND PROCEDURES

Approved _____, 2016 by
The IHS Board of Directors



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GENERAL

All physicians and Allied Health Professionals who care for patients within the ambulatory clinics served by Integrated Health Systems, Inc. ("IHS") are responsible for providing such care within these rules and regulations as established by the IHS Board of Directors ("IHS Board of Directors").

The term "provider" or "practitioner" from this point forward in this document shall refer to any member of the IHS medical staff, whether M.D., D.O., C.A.M., D.P.M., P.A. or N.P.

REQUIREMENTS FOR PRIVILEGES AND APPLICATION PROCESS

I. PURPOSE

The purpose of this Policy is to describe the procedures by which Physicians and Allied Health Professionals ("AHP") are selected and governed within IHS.

A. DEFINITIONS. In addition to those set forth in the "Definitions and Interpretation" section of the IHS Medical Staff Bylaws which are incorporated by reference; the following definitions shall apply to this Policy:

"Allied Health Professionals" include nurse practitioners, physician assistants, certified mid-wives, clinical psychologists, audiologists, and CRNAs.

"Dependent AHP" means any AHP who is: employed by a Member, a practice entity of Members, or IHS. The dependent AHP will practice, if at all, in IHS only under the supervision of a Sponsoring Member; and entitled only to specified service authority.

"Independent AHP" means an AHP who is: licensed to practice independent of supervision by another health professional. If an applicant is a health care professional licensed under the Michigan Public Health Code, but is not in an area of practice which is currently credentialed and overseen through local Hospital employment mechanisms, they are eligible for consideration to obtain privileges as an Independent AHP.

"Medical Staff" means medical staff of IHS unless otherwise specified.

"Sponsoring Member" means a Member of the Medical Staff who is responsible for supervision of a Dependent AHP.

"Practice Assistants" are by virtue of their license not entitled to make independent medical decisions or write orders. As employees of a hospital system served by IHS, their education and

training will be verified, and their competency assured, through human resources channels, utilizing job descriptions and competency evaluations rather than privileges.

Examples of these fields would include, not limited to:

Medical Assistants
Nurses (RN, LPN)
Technicians (Laboratory, Research, Surgical)
Therapists (Occupational, Physical)
Professional Counselors
Surgical Assistants
Social Workers (Medical)
Orthotics
Pharmacists (Clinical)

II. POLICY

FULL PRIVILEGES OR SERVICE AUTHORITY

A. APPLICATION. Each provider seeking to be a member of the IHS Medical staff will complete and submit an initial application form for either ambulatory privileges or service authority to the administration manager of credentialing for the hospital(s) at which privileges or service authority is sought. Following verification of education, training, and receipt of required professional references by the manager of credentialing for the applicable hospital(s), assessment of the application and related documents will occur according to the policy and procedures of the IHS Bylaws.

For those providers for whom a privileges or service authority list has been developed, an applicant will be asked to indicate which privileges or service authority from that list he/she wishes. If the applicant wishes privileges or service authority not on the list, they will be considered individually by the IHS Credentialing Committee.

The full application shall then be reviewed by the IHS credentialing committee for ambulatory privilege or service authority consideration.

B. NON-VERIFICATION OF APPLICATION. If necessary, a follow-up deficiency letter shall be sent to the reference requesting additional information promptly after receipt of the application. If reference responses are still not received, another request for outstanding references will be generated with simultaneous involvement with the applicant to assist in promptly obtaining references. If 60 days after that request, the application is still not verified, a letter indicating the application is considered withdrawn is sent to the applicant and, if applicable, the Sponsoring Member.

C. EXCLUDED PROVIDER LIST. Each hospital served by IHS will screen all candidates for privileges or service authority at their hospital and ensure they have not been excluded from a Federal health care program. The OIG's List of Excluded Individuals and Entities ("LEIE"), is available at http://oig.hhs.gov/exclusions. The online database contains: (1) the name of the excluded person at the time of exclusion—meaning all names used by an individual (e.g. maiden names) should be searched; (2) the excluded person's provider type; (3) the authority under which the person was excluded; (4) the state where the excluded individual resided at the time of exclusion or the state

where the entity was doing business; and (5) a mechanism to verify search results, such as Social Security Number or Employer Identification Number.

D. COMMITTEE RECOMMENDATIONS AND ACTION.

The application for privileges or service authority shall only be processed upon receipt of all required credentialing documents by the IHS credentialing committee and the hospital administration of each hospital where privileges or service authority are sought.

If the Medical Staff appointment eligibility has been met and approved by the Medical Executive Committee of each hospital at which privileges or service authority is sought, the ambulatory practice application will be processed by the IHS.

The IHS credentialing committee shall review the material, may interview the applicant, and will forward the application along with a recommendation to the IHS Compensation Committee.

The IHS Compensation Committee will then develop and submit an employment compensation proposal for the applicant, along with the credentialing recommendation, to the applicable hospital board(s) for consideration.

The governing board of each hospital at which privileges or service authority is sought will then grant or deny final approval of privileges or service authority with a letter sent to the applicant and, if a Dependent AHP applicant, a copy to the Sponsoring Member. Notice to medical staff departments of newly appointed providers will also be issued. A period of thirty (30) days is reasonably expected at each step of the review process once the application has been verified.

E. UNAPPROVED FIELD. When an applicant seeks appointment in a field of practice that is not already an approved field of practice, the applicant shall have the burden of including with his/her application a request that his/her field be approved and the best support for that position he/she can provide. Such support may include: a narrative description of the types of services provided by the applicant; medical or professional literature describing the field, including the kinds of services its provider offer (in contrast to services already available authorized for an IHS provider); information relevant to quality and cost-effectiveness data; and/or verifiable experience with other health care institutions (e.g., signed statements). The Credentialing Committee shall have discretion to decide whether consideration of such field approval will precede or be contemporaneous with consideration of the applicant as an individual.

TEMPORARY/ PROVISIONAL PRIVILEGES OR SERVICE AUTHORITY

Temporary privileges or service authority are an extraordinary measure utilized to provide skills needed by or in the hospital on an expedited basis. They shall not be granted solely for the convenience of an AHP or a Member.

A. CIRCUMSTANCES. Upon the concurrence of the IHS President, the IHS Board of Directors, may grant temporary privileges or service authority in the following circumstances:

1. LOCUM TENEMS. When the service of a provider in the joint judgment of the IHS President and the IHS Board of Directors is necessary to continue appropriate operation of the clinic or a service line, a provider qualified to provide such services may be granted temporary privileges or service authority as were granted to others he/she is temporarily replacing or of whom he/she is working as peer. Each Department where locum tenens practice is authorized shall establish its own requirements in the Department rules.
2. COMMUNITY DISASTER. In the event of a disaster in the community that requires additional services, a provider may, pursuant to Paragraphs C through D below, be granted temporary privileges limited to treatment of patients at the request of and under the supervision of a sponsoring appointee of the Medical Staff. Unless terminated earlier for reasons related to competency or conduct, the temporary privileges shall terminate at the point the need for services subsides, as determined by the IHS president, IHS Board of Directors, or their designee.

B. CREDENTIALING REVIEW. A provider seeking temporary privileges or service authority may be interviewed by the IHS President, the IHS Board of Directors, or their designee. A provider must submit adequate evidence of his/her identity and qualifications, which at minimum shall include a copy of his/her driver's license with photo, a copy of current license, a copy of his/her authority to prescribe restricted drugs if applicable, and a favorable reference from a physician from a reputable healthcare facility concerning his/her capabilities. The reference requirement may be waived by the IHS President or the IHS Board of Directors when temporary privileges or service authority are granted solely for the care of specific patients at the request of the attending Member.

Before temporary privileges or service authority are granted, a provider must acknowledge in writing that he/she has received and read those sections of these policies and procedures and any department rules which would govern his/her temporary activities within the IHS service community.

C. SUPERVISION AND TERMINATION. Providers who are performing services for IHS pursuant to temporary privileges orservice authority granted in accord with this section shall be under the supervision of a Sponsoring Member. Special requirements such as mandatory consultation may be imposed by the IHS staff member responsible for supervision of the provider granted temporary privileges or service authority. The IHS President or the IHS Board of Directors shall be entitled to suspend or revoke such temporary privileges or service authority when the conduct of the provider holding such temporary privileges or service authority so indicates. In the event of any such termination, the Physician responsible for supervising that provider shall assign any of his/her patients to another AHP or Member. The wishes of the patient shall be considered where feasible in choosing a substitute.

D. MONITORING. When an applicant is granted provisional privileges or service authority, his/her clinical competency will be evaluated by a monitoring process. Unless the IHS Credentialing Committee believes for good reason more or fewer cases should be monitored, ten (10) cases of substance shall be monitored to include evidence of competency for privileges requested. Monitoring forms will be forwarded to the applicant along with the name of the assigned monitor. The assigned monitor will be the Sponsoring Member, a Member from the specialty department closely related to the specialty of the applicant, or designated member. The monitor shall submit in writing to the IHS Credentialing Committee, the information which pertains to the monitored cases.

The monitoring evaluation will recommend:

1. Removal from monitoring with privileges or service authority requested;
2. Reason for continued monitoring;
3. Exception(s) and limitation(s); or
4. Complete denial of privileges or service authority in a specific category.

When there is a pre-defined privileges or service authority list for the field, the applicant will be monitored according to criteria included in the list. If requested privileges or service authority are not included in a pre-defined list, the specific monitoring requirements will be set at the time and to the extent that privileges or service authority are provisionally granted.

E. APPOINTMENT DECISION The IHS Credentialing Committee will review and report an appointment decision in writing to the IHS Board of Directors. The IHS Credentialing Committee will give notice to the MEC of each hospital at which privileges or service authority is sought of their determination, and the recommendation of both bodies shall be forwarded to the governing boards of any hospital at which privileges or service authority is sought. The IHS Board of Directors will communicate to the applicant, and his/her Sponsoring Member, if applicable, in writing, the final decision. Dependent AHPs, granted Service Authority regardless of monitoring completion, will continue to perform under the supervision of the Sponsoring Member.

SERVICE AUTHORITY TIE TO SPONSORING MEMBER

In the event a Dependent AHP is no longer employed by his/her Sponsoring Member or the AHPs Sponsoring Member will no longer be able to provide supervision of the Dependent AHP for any reason, all service authority of the Dependent AHP shall cease. Further activity for IHS, thereafter, shall be conditioned upon the AHP either arranging for another approved Sponsoring Member or meeting other criteria established by the IHS Board of Directors on a general or case-by-case basis.

RESPONDING TO INQUIRIES FROM OFFICIAL AGENCIES REGARDING MEDICAL STAFF FILES

CONTENT OF MEDICAL STAFF QUALITY ASSESSMENT FILE

I. PURPOSE

To describe the separate file, named the Quality Assessment ("QA") File, that is maintained in the Medical Staff Office on each member of the IHS Medical staff. The file shall be secured within the Medical Staff Office, and access to the file will be limited to individuals specifically authorized to review the file by the policies and procedures below. The Medical Office Staff shall supervise the review of a QA File by any non- Medical Staff Office personnel.

Material may be placed into the file only by the IHS President, the IHS Board of Directors, or by one of their designees.

Documents and material to be included in the QA File shall include the following provider-specific documents or information:

1. Periodic general reports of provider performance such as the "Provider Report Card".
2. Special reports of provider performance which may from time to time be generated by Medical Staff or IHS Committees.
3. Reports, summaries, or minutes of general or special Peer review activities concerning the provider.
4. Letters of concern, complaint, criticism, or praise, which have been evaluated by the IHS Board of Directors, and judged to be appropriate for the QA File. The physician shall be afforded a 30 day opportunity to review such documents and append additional information or comment.
5. Copies of any special awards or certificates of commendation.
6. Memoranda of Understanding.
7. Reports of adverse action taken against the provider's privileges, or summaries of restrictions placed thereupon.
8. Copies of formal or file notes taken by a IHS Board of Directors' designee in the course of the discharge of his/her duties regarding special investigations.

9. Copies of documents received from external sources which pertain to the provider's performance at other hospitals or healthcare organizations which would not ordinarily be included in the provider's hospital credentials file.

10. Copies of documents from the external sources which pertain to restrictions, limitations, or sanctions placed on the provider's license or eligibility to practice or exercise clinical privileges.

11. Summary documents of actions taken as a result of a fair hearing.

12. Re-appointment worksheets prepared by the Medical Staff Office which summarize the contents of the file to assist authorized reviewers at the time of provider's re-appointment.

Additionally, the Manager of Credentialing may, at his/her discretion, include other documents or information not specifically described above, if:

- The document is accompanied by a note from the IHS Board of Directors which explains the rationale for inclusion of the document and the provider has been provided with a copy of the material to be included; and
- The provider shall be notified in writing of any material to be placed within the file, and be offered an opportunity to append additional information or comment.

DOCUMENT RETENTION IN MEDICAL STAFF CREDENTIALS AND QA FILES

It is the policy of IHS that documents placed in a Medical Staff member's Quality Assessment File remain on file in perpetuity unless the individual document itself specifies the duration of retention or a condition under which the document is to be expunged. In that case, the document will be removed and destroyed on the specified date or after the specified conditions have been met.

CONFIDENTIALITY OF PROVIDER SPECIFIC QUALITY ASSESSMENT FILES

CONFIDENTIALITY

I. PURPOSE

To describe the mechanisms whereby the confidentiality of the QA files are maintained.

II. POLICY

QA files are maintained for each provider. These files shall not be made available to anyone other than stated in this policy.

A. Definition. An "Official Agency" is an agency of the federal or state government, or a private agency which by law has been authorized to act for and on behalf of government, which, acting under color

of law, seeks information regarding a provider's credentials, practice, or other comparable provider information.

III. PROCEDURE

A. A QA file will be maintained for each provider.
B. The files will be secured in the Medical Staff Office in association with the Hospital Credentials file.
C. The following will have access to the QA files at request:
    1. The Attending Physician or Mid-Level Provider (and their Supervising Physician);
    2. IHS President;
    3. IHS Board of Directors Chairperson ;
    4. Risk Manager; and
    5. Manager of Credentialing.

D. All other requests will be directed through the IHS President or the IHS Board of Directors.
E. Upon receipt of an inquiry from an Official Agency regarding a Medical Provider's status (which contains no signed physician's authorization to release and report), and following verification of the legitimacy of the request, the following processes will be used for responding:

    1. The recipient of the request will inform the medical provider for whom the inquiry was made and the IHS President or the IHS Board of Directors Chairperson.

    2. The necessary information in the provider's credentials file will be reviewed by the IHS President, IHS Board of Directors Chairperson, or their designee.

    3. The Manager of Credentialing will draft a response, which is accurate, concise, and limited to the legitimate request made. If necessary, legal advice will be obtained to verify the legitimacy of the request.

    4. Upon completion of a response, the Manager of Credentialing will send a response to the requesting agency. Copies of the response will be placed in the physician's credentials file and sent to the provider via certified mail.

    5. No information from a physician's file, nor any other peer review information or data, which are protected from disclosure pursuant to the provisions of MCL 331.531 or MCL 331.533, and other state and federal laws, will be released, whether in response to informal or formal requests from agencies of other organizations, or in response to subpoenas.

       For purposes of this policy, peer review information shall mean records, data, and knowledge collected by, or for, individuals or committees of IHS performing a function of professional review, peer review, review of morbidity and mortality, preventability of deaths and complications, quality and necessity of care, and improvement of care. It may include, but is not

necessarily limited to, performance improvement information, credentialing information, morbidity and mortality reports, peer review committee records and minutes.

6. When an inquiry from an Official Agency is made, the IHS President, or their designee, will be notified immediately.

NOTIFICATION OF QUERY

If the QA file is queried for any other reason than general administrative functions, the attending provider will be immediately notified of the details of the query, prior to release of information.

MAINTENANCE OF FILES

The files will be maintained by the Medical Staff Office.

CONFIDENTIALITY OF PEER PROFESSIONAL REVIEW INFORMATION

I. PURPOSE

To describe the mechanisms whereby documents prepared for or generated by peer/professional review activities are confidentially maintained.

II. POLICY

Peer/professional review committee minutes, reports, worksheets, and other data are CONFIDENTIAL documents prepared solely for the peer/professional IHS Staff Policies & Procedures Manual review function. These documents shall not be duplicated nor made available to anyone without the authority of the peer/professional review committee which generated the document or for which the document was prepared.

III. PROCEDURE

A. Information collected for committees related to the review and analysis of professional practice shall be subject to control measures to ensure confidentiality. Those documents include, but are not limited to memoranda, statistical and other reports, and additional tools used to gather data such as worksheets.

Safeguards to ensure confidentiality of documents include:

1. Documents reproduced and circulated at meetings are for use only during the meeting and shall be collected at the end of each session and destroyed. No electronic data shall be shared, forwarded, copied, or sent without committee approval.
2. Original documents shall be maintained in a secure location in the Medical Staff Office.

3. Access shall be limited to the review process and shall be for committee/department use only.
4. Documents shall be marked "Confidential – For Peer Review Purposes Only" or some similar designation, and shall be stored separate and apart from employment files.

B. Persons with access to the Minutes at request:

1. IHS President
2. IHS Board of Directors
3. Manager of Credentialing
4. IHS Peer Review Committee
5. Risk Manager

All other request for review of minutes will need to be approved by the IHS Board of Directors.

INTERNAL AND EXTERNAL REPORTING OF CHANGES IN PRIVILEGES

I. PURPOSE

To describe the mechanisms whereby internal and external reporting of any changes in IHS Medical Staff privileges or service authorities are consistent and follow requirements of governing agencies.

II. POLICY

Written guidelines shall direct the communication of changes in a provider's Medical Staff privileges or service authority internally as well as externally.

III. PROCEDURE

A. INTERNAL

1. When all or part of a provider's privileges are voluntarily relinquished, suspended temporarily, or revoked permanently the following will be notified in writing:

    a) The Physician or Allied Health Professional (and Supervising Physician)
    b) The governing boards of any hospital at which the provider has privileges
    c) IHS President
    d) IHS Board of Directors
    e) Medical Executive Committee of any hospital at which the provider has privileges
    f) Health Information Management
    g) Nursing Administration
    h) Pharmacies

B. EXTERNAL

1. External reporting will occur to the Quality Improvement Committee of any hospital at which the provider has privileges.

NATIONAL PRACTITIONER DATA BANK

QUERYING THE DATA BANK

I. PURPOSE

To assure compliance with the requirements of the Health Care Quality Improvement Act of 1986 ("HCQIA") related to facility communications with the National Practitioner Data Bank (the "Data Bank").

II. POLICY

The National Practitioner Data Bank shall be queried for physicians, dentists, and other health care professionals for disclosure of professional competence or conduct deficiencies. Query is intended to assist the Medical Staff with privileging decisions through querying of the National Practitioner Data Bank.

III. PROCEDURE

A. The Data Bank will be queried for the following instances:
   1. Screening all initial physician applicants to the IHS Medical Staff and such categories of Allied Health Professional who are to be credentialed by IHS and granted clinical privileges;
   2. Reappointment every two years for all physician members of the IHS Medical Staff and those designated Allied Health Professionals who have been granted privileges; or
   3. At other times as the IHS Board of Directors deems necessary. (See reporting to the Data Bank)

B. Assignment of Responsibility for Querying the Bank. The Manager of Credentialing will be the official authorized to query the Data Bank. The IHS credentialing committee shall be responsible for completing and forwarding appropriate forms and for receiving and securing Data Bank reports.

C. Confidentiality and Access. Reports to/from the Data Bank will become part of the physician's QA file, shall be considered confidential and shall be subject to IHS Confidentiality Policy.

D. Administration. The IHS President, the IHS Board of Directors or their designee(s), shall be responsible for administering this policy.

REPORTING TO THE DATA BANK

I. PURPOSE

To provide a mechanism for reporting adverse peer review actions against IHS Medical Staff membership/clinical privileges to the National Practitioner Data Bank.
To assure compliance with the requirements of the HCQIA related to facility communications with the Data Bank.

II. POLICY

IHS is required to report any professional review action taken by IHS committees based on reasons related to competence or professional conduct which adversely affects a practitioner's clinical privileges for a period longer than thirty (30) days. IHS must also report the voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation relating to questions of competence or professional conduct. For purposes of this Reporting Policy, a "practitioner" shall mean physicians and Allied Health Professionals, in accordance with the Act; provided however that if the HCQIA is amended to require reporting of additional or other health care practitioners, the definition of practitioner under this policy shall be deemed to be automatically amended to conform to the statutory amendment:

REPORTABLE ADVERSE ACTION

Adverse actions which are reportable to the Data Bank are those affecting a practitioner's clinical privileges for greater than thirty (30) days, and which are based on competence or professional conduct. Examples of reportable adverse actions include but are not limited to the following, where such actions are based upon review of the practitioner's competence or professional conduct:

A. Denial of request for clinical privileges as a result of assessment/evaluation of professional competence and/or conduct;
B. Revocation, suspension or restriction of appointment or reappointment and/or clinical privileges due to review of practitioner while under observation status;
C. Reduction, restriction, denial, suspension, non-renewal or revocation of clinical privileges for greater than thirty (30) days;
D. Peer review actions resulting in monitoring requirements that require co-management and/or approval of a proctor before medical care is rendered or specified procedures performed;
E. Voluntary restriction or withdrawal of clinical privileges in return for the IHS Board of Directors not taking adverse action, or during investigation relating to circumstances stated above; or
F. Non-renewal of clinical privileges for failure to meet reappointment/renewal criteria relating to specific privileges when the criteria are established to assure an expected level of current competence.

NON-REPORTABLE ACTIONS

Adverse actions affecting the clinical privileges of an IHS Member and/or initial applicant which are process/technical in nature and which are not based upon the practitioner's competence or professional

conduct shall not be reportable to the Data Bank. These include but are not necessarily limited to the following:

A. Denial, revocation or suspension of clinical privileges and/or non-reappointment to the Medical Staff for failure to provide adequate proof of professional liability insurance;
B. Failure to provide additional documentation as requested in support of initial/renewal request(s) for clinical privileges;
C. Suspension, restriction and/or revocation of clinical privileges for failure to timely complete medical records;
D. Change to IHS Medical Staff status due to failure to comply with meeting attendance or other administrative requirements, which do not reflect upon competence or professional conduct, as determined by the IHS President, the IHS Board of Directors, or their designee;
E. Voluntary restriction and/or surrender of clinical privileges and/or withdrawal of request for privileges for personal reasons while not under investigation;
F. Denial of clinical privileges because of IHS's inability to support such practice (e.g. lack of facilities, technical support etc.).

DETERMINATION OF REPORTABILITY

The determination whether an adverse action which has been taken or recommended is reportable to the National Practitioner Data Bank shall be made by the IHS President, the IHS Board of Directors, or their designee, following consultation with the affected Medical Staff member.

SUBMISSION OF ADVERSE ACTION REPORTS

Following the occurrence of an adverse action, the determination that such action is reportable and the preparation of an "Adverse Action Report," the IHS Medical Staff Member will be provided a copy of the proposed report and notified that he/she may have five (5) days in which to submit any suggested revisions to the proposed report prior to filing. The IHS President (or his/her designee) shall consider any suggested revisions timely submitted by the practitioner and may, but is not obligated to, make revisions to the Adverse Action Report which the IHS President (or designee) deems appropriate. IHS shall submit "Adverse Action Reports" to the applicable state of Michigan licensing board within fifteen (15) days of the action being taken.

REPORTING OF REVISION TO ACTION

The IHS President (or designee) shall report substantive revisions of an adverse action initially reported. Such revisions include reversal of a professional review action or reinstatement of clinical privileges or professional society membership.

REPORTING ERRORS OR DISPUTES

The IHS President (or designee) may submit to the Data Bank information correcting a previously submitted Adverse Action Report of information concerning a dispute with respect to a previously submitted Adverse Action Report.

REPORTING TO STATE

Where a report to the State is required under the Michigan Public Health Code but not the Data Bank, the report shall be made by the IHS President (or designee). Typically such reports may be required for short periods of discipline (15 to 29 days) or other changes in status. Such reports shall be made in a form which meets legal requirements.

ARTICLE II - MEDICAL RECORD POLICIES

I. PURPOSE

To provide guidelines for documentation and completion of ambulatory patient visit records. All portions of the patient's medical record must be prepared within the time frames provided in these rules and regulations. A medical record shall not be permanently filed until the responsible Medical Staff member completes the required content of the record or it is ordered filed by the Director of Health Information Management.

II. POLICY

PHYSICIAN IDENTIFIER POLICY

When physicians log in to the electronic medical records ("EMR") system, their electronic signature is automatically placed in the system whenever they mark an item as reviewed, accepted or signed. All EMR users must log in only using their own individual EMR ID and password (or other authentication method such as an ID smartcard). This ensures that all of their documentation, orders and other actions are appropriately attributed to the correct caregiver. Under no circumstances is it permissible for a physician to share his or her EMR password or allow another individual to log in or document care using the provider's own ID and password (or other authentication method); doing so shall constitute grounds for disciplinary action.

REQUIRED CONTENT

The attending physician, other Medical Staff members, clinical staff and Allied Health Professionals involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for all patients, including a billable claim when applicable. All entries in the medical record should be dated, timed and authenticated. The record's content shall be pertinent i.e. facilitate continuity of care, support treatment provided, provide appropriate documentation for performance improvement purposes, and be accurate, legible, timely and current. The specific requirements for a complete medical record are specified within accreditation standards and Medicare guidelines for conditions of participation.

Each attending provider is responsible within his/her power for appropriate and meaningful use of the EMR, the official medical record of the ambulatory care centers served by IHS. Such responsibilities include the overall content, accuracy, completeness, appropriate placement and timeliness of documentation of care in the patient's electronic medical record. The provider or his/her agent in

overall charge of the patient is responsible for documenting the office visit in EMR within the first three (3) business days of the date of service. The provider is responsible for completion of any and all elements required to meet criteria for meaningful EHR use. In the event that the EMR is unavailable, providers will follow established down-time procedures to ensure that appropriate documentation is completed.

LABORATORY REPORTS/PRESCRIPTIONS/FORMS

All labs, imaging studies, or other diagnostic reports should be reviewed and follow up instructions, if any, provided to the nursing staff within five (5)business days of receiving the final report. It is the responsibility of the provider to ensure that any urgent instructions given to the staff regarding abnormal results, such as generating alerts, scheduling follow up appointments, or repeat lab draws, are completed as directed.

All prescription refill requests should be responded to within five (5) business days. Any prescription requests receiving no response after seven ( )7 business days will be considered delinquent.

Any forms requiring completion should be filled out, signed, transferred digitally into EMR, and returned to the appropriate person or agency within fourteen (14) days of arrival at the office.

DELINQUENT MEDICAL RECORD POLICY

A. Providers are encouraged to complete all available medical records as they become available in the Clinical inbox.
B. The provider is responsible for medical record completion. Failure of a resident, student, or clinic staff member to complete additions to the medical record does not change the provider's responsibility.
C. Providers will receive daily notification of deficiencies via their EMR Clinical inbox as they occur.
D. A medical record should be completed, including the billing claim created, within three (3) business days from the date of service.
E. A DEFICIENT medical record is defined as any state of incompleteness after five (5) business days from the date of service.
F. Providers will then receive another notification in their inbox from IHS when the record becomes deficient at five (5) days.
G. A DELIQUENT medical record is defined as any state of incompleteness that has aged to seven (7) business days from the date of service or more. Any record that is delinquent 7 business days or more should prompt a personal letter to the provider from the IHS Board of Directors requesting that all delinquencies be completed.
    1. As patients are priority, maintaining continuity of care during the recertification process is important. Therefore, the provider will continue with a normal clinic schedule, but for every day

(in full or in part) that the record remains incomplete past ten (10) business days, the provider will forfeit an eight (8) hour PTO day from his or her remaining vacation schedule.

2. If the provider's contract year ends in less than ninety (90) days, or no PTO days remain, and any medical record delinquencies remain at ten (10) business days from the day of service, the dollar equivalency of a PTO day will be forfeited from the provider's next paycheck using the guidelines stated above. The provider will continue a normal clinic schedule during this corrective action period.

H. If a provider identifies a medical record deficiency that was inaccurately assigned, the provider should send notice to IT for reassignment of the record.

I. A physician with a record forty five (45) days old will experience automatic relinquishment of all ambulatory clinical privileges, and receive notification thereof.

1. The physician will have fifteen (15) days from the notice of the forty five (45) day old record, to resolve all medical record delinquencies. Automatic Resignation from the IHS Medical Staff will occur if the delinquencies are not completed within fifteen (15) days.
2. As outlined in the bylaws, no procedural hearing rights will be provided. After Automatic Resignation, the physician will be required to complete the initial application process, pay all associated applications fees and meet all threshold eligibility criteria in order to be considered for appointment to the IHS Medical Staff.

Providers who meet suspension criteria will be informed via telephone and in writing. Notification will also be sent to the: IHS President, as well as the Chief of Staff, Department Chairs, Director of Admissions, Director of Emergency Services, Patient Care Services, Quality and Resource Management and the Medical Staff Office of each hospital at which the provider has privileges. A record of each suspension imposed shall be made part of the provider's credentials file after verification with the Director of Health Information Management.

It is understood that from time to time unexpected circumstances may result in a few delinquent medical records occurring outside the provider's control, such as emergent medical leave, IT issues, natural disasters, etc. Exceptions to all corrective action will be reviewed and determined by the IHS Board of Directors or IHS President on a case by case basis.

RECURRING SUSPENSION

When a provider remains on the suspension list for the same delinquencies for greater than 30 days from the initial date of suspension, this shall be considered an additional suspension. If during the time of a suspension, new records become delinquent and now meet suspension criteria, a new suspension will be issued.

EFFECT OF SUSPENSION

Except as otherwise specified in these rules, the sanctions for failure to complete a patient record in a timely fashion are suspension of the provider's right to examine ambulatory patients, provide ancillary department services, and of voting and office-holding prerogatives until all of his/her outstanding records are completed or until such later time as provided in this Section.

If an "emergency", defined as 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 treatment would add to that harm or danger, exists requiring the suspended provider to immediately treat the patient, then the suspension may be temporarily lifted for treatment of that specific patient by the Chairman of the Board or President of IHS.

The ambulatory clinics and other notified departments are expected to enforce the suspension. The provider will remain on enforced suspension until completion of all overdue medical records.

Any physician who appears on the suspension list two (2) times within a calendar year must appear before the IHS Board of Directors to explain the recurring suspensions. If the provider fails to appear or the IHS Board of Directors does not find the reasons provided satisfactory, the IHS Board of Directors may institute a corrective action plan that may include the imposition of a fixed period of suspension of clinical privileges whenever a pattern of non-compliance with this section exists.

USE OF SYMBOLS AND ABBREVIATIONS

The use of unapproved symbols and abbreviations is prohibited in the medical record. Final diagnoses and complications shall always be recorded without the use of prohibited symbols and abbreviations.

FILING OF INCOMPLETE RECORDS

In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible provider to complete the record, the Director of Health Information Management shall consider the circumstances and may enter such reasons in the record and order it filed.

No Medical Staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him/her, regardless of the status of the provider who is responsible for completing the record. Any provider who is removed per the Bylaws and these rules and regulations for delinquent records or who resigns from the Medical Staff without adequately completing all medical records will not be allowed to reapply for staff membership until such records are satisfactorily completed.

OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including x-ray films, pathological specimens and slides, are the property of the facility where the patient is treated and the information contained therein is the property of the patient. Medical records and the information contained therein may be removed only in accordance with applicable hospital policy. Unauthorized removal of a medical record or any portion thereof from the clinic is grounds for disciplinary action, including immediate and permanent revocation of Staff appointment and clinical privileges, as determined by the IHS Board of Directors and the governing board of hospitals served by IHS.

ACCESS TO RECORDS

Patients, hospital personnel, and Medical Staff members may have access to information contained in the medical record pursuant to the policies and procedures of the applicable hospital. Requests for access by persons other than the patient or his or her legal representative shall be addressed through the IHS bylaws.

BILLING AND CLAIM GENERATION

Providers should create a billable claim through the EMR system for the correct E/M level and/or office procedure performed on each patient. The policy for creating each claim in a timely manner is the same as the delinquent medical record policy stated above.

Under no circumstances shall a provider change the billing fee schedule, waive a patient's contracted co-payment or co-insurance, give discounts on an individual basis, or make any exceptions in the billing policy established by the facility at which the provider provides services.

All providers have the responsibility to attend, and successfully complete, an annual medical coding and billing in-service program. The in-service will be provided locally by IHS or will be made available via another CME format. Any alternate program chosen by the provider must be pre-approved by the IHS Committee in order to meet this requirement.

CO-SIGNATURES OF ENTRIES BY STUDENTS, RESIDENTS, AND ALLIED HEALTH PROFESSIONALS

ISH Medical Staff members shall be in compliance with CMS Documentation Guidelines for Supervising Physicians, including but not limited to elements of E/M service documentation, and supervising physician attestation statements when required for students.

USE OF THE MEDICAL RECORD FOR MEDICAL STAFF RESEARCH/QUALITY IMPROVEMENT

Medical Records must be kept confidential and may be released with prior approval of the overseeing IHS Committee for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. Unauthorized release or removal of medical records from the clinic or EMR is grounds for corrective action.

ENFORCEMENT OF IHS MEDICAL STAFF RESPONSIBILITIES

The IHS President or the IHS Board of Directors Chairman may at his/her discretion, following a request by the IHS Board of Directors, invoke the current Delinquent Medical Record Policies and Notifications Systems for a member of the IHS Medical Staff who has been determined to be in violation of the IHS rules and regulations. Invoking such policies shall be deemed to be appropriate only if the Medical Staff Member has failed to appropriately respond in a timely manner to a written request from the IHS Board of Directors.

A record of the use of this policy for individual provider's corrective action shall be available for review and consideration by any hospital at which the provider has privileges at the time of a provider's reappointment to said hospital's medical staff.

ARTICLE II - PROFESSIONAL CONDUCT
RESPONSIBILITIES WHEN THE PHYSICIAN RESPONSIBLE FOR PATIENT(S) MANAGEMENT IS AVAILABLE

I. PURPOSE

To provide guidelines for obtaining necessary care for a patient when the responsible provider is available.

II. POLICY

ATTENDANCE

The IHS Medical Staff recognizes its responsibility to provide professional medical service to the ambulatory community in the clinic assigned each week as follows:

Each provider has a weekly schedule of patient appointments and is expected to arrive prior to the time of the first appointment for each day.

Each provider should personally evaluate every patient on their daily schedule, unless another medical emergency takes precedence by default. It is understood by the Medical Staff that it is the nature of healthcare to, from time to time, have a patient with unexpected needs that may require staff to miss a lunch break or stay longer than anticipated at the days end. The provider is encouraged to remain prepared for such delays a at all times. No additional compensation in time or money shall be requested by or allocated to the IHS Medical Staff for these occurrences.

APPOINTMENTS

Each provider will have a schedule of appointments with a maximum number of time slots consistent with the current median metrics for their given specialty and level of expertise. A provider may choose to place additional patients on their schedule during their clinic hours, but should not remove patients, block time slots, or "down schedule" appointments on a regular basis without prior approval of the Practice Administrator. Understanding that "walk-in" care, phone call triage, and office staff supervision are ongoing throughout the day, a provider should not leave the facility until business hours have concluded.

LATE ARRIVALS

Surgeons, OB/GYN's, and/or other specialists that require correction for being chronically late to the OR, labor/delivery, or any other department, will be reviewed by the appropriate hospital committee with authority over those departments affected.

RESPONSIBILITIES WHEN THE PHYSICIAN RESPONSIBLE FOR PATIENT(S) MANAGEMENT IS NOT AVAILABLE

I. PURPOSE

To provide guidelines for obtaining necessary care for a patient when the responsible physician is not available, does not respond to a request for assistance, or the quality/appropriateness of care is being questioned.

II. POLICY

The Medical Staff recognizes its responsibility to provide timely intervention when an attending or responsible provider is not available or does not respond to nursing or staff concerns. The Medical Staff also recognizes the need to respond when the quality or appropriateness of care being provided to a particular patient is questioned. The purpose of Medical Staff intervention is to assure that necessary care is provided and that preventable adverse patient outcomes are avoided.

A. PROFESSIONAL LIABILITY. Members of the IHS Medical Staff are provided professional liability protection when serving in the capacity of a consultant or covering a colleague.

III. PROCEDURE:

A. The Medical Staff member notified of a care need will either personally evaluate the case or direct another provider to evaluate and provide care to the patient.
B. Once a Medical Staff member has accepted responsibility to respond to requests for assistance, they shall be expected to respond in a timely manner. The responding provider has the authority and responsibility to review relevant patient information and provide care.
C. The IHS Committee will review any report regarding situations where a patient did not receive care when an available opportunity existed to do so by the provider and take an appropriate action. Such an action may be:

    1. To determine that the concern did not constitute a valid issue regarding either a refusal to see a patient or a quality of care issue.

    2. To request additional information through a personal appearance of the involved member at the IHS Peer Review Committee meeting reviewing the issue.

    3. To issue to the provider a written statement of warning, admonition, or reprimand.

    4. To refer the issue to the IHS Board of Directors.

The IHS Peer Review Committee (if not the IHS Board of Directors) will keep a written record of the actions taken, and will provide to the provider and the IHS Board of Directors a written summary of both the complaint and the actions taken.

ALTERNATE COVERAGE

Each attending physician must assure timely, adequate professional care for his/her patients in the clinic, as well as, provide supervision to any AHP under their delegated authority, by being personally available or by arranging for a member of the IHS Medical Staff to cover. A similarly qualified physician who has appropriate temporary privileges and is available for coverage could also be assigned. If the alternate is unavailable when needed, the applicable IHS officer or the IHS President has the authority to assign any qualified member of the staff to provide the needed coverage.

The Medical Staff member accepting responsibility for coverage should respond to all urgent/emergent care needs from any department, agency, or individual the attending physician provides professional services to on behalf of IHS (i.e.: pharmacies, hospice, Healogics, Summer camps, etc.).

TRANSFER OF PATIENTS TO ANOTHER ATTENDING PROVIDER

Transfer of a patient's care to another provider or service, will be documented in the chart after timely, interactive and effective provider-to-provider communication and consent.

A formal transfer from one service to another is not required for diagnostic procedures, such as endoscopy procedures, biopsies, etc. but documentation is required.

All hand-offs of patient care, for either "on-call coverage" or transfer of care, should include communication points of: diagnosis and current condition, recent changes in condition or treatment plans and potential clinical concerns. All hand-offs should include the opportunity to clarify issues prior to transfer.

SELF-ADMINISTRATION OF MEDICATIONS

No patient may self-administer medications unless so ordered by the patient's attending physician or, when appropriate, by a consultant involved in the direct management of the patient.

PATIENT DEPARTURE AGAINST MEDICAL ADVICE

A. Notification and reporting. Should a patient threaten to leave or leave the clinic against advice of a provider or nurse or without usual discharge, a notation of the event shall be made in the chart. The patient's attending provider shall also be notified as soon as practical of the patient's anticipated or actual leaving the clinic.

B. Release form. A patient leaving the clinic against the advice of a provider or nurse shall be requested to sign the proper release form to be placed in the patient's medical record. A patient's failure or refusal to sign the proper release form shall be recorded within the patient's medical record.

SUICIDAL OR DANGEROUS PATIENTS

Each provider shall throughout a patient's care be responsible for recording documentation which may be necessary to ensure the protection of the patient from self-harm and to ensure the protection of others whenever the patient might be a source of danger.

The provider is responsible in such cases for obtaining appropriate mental health consultation and for notifying any outside agencies, such as CMH, police, or Adult/Child protective services, when indicated.

ETHICS CONSULTATION

A. Introduction. One of the functions of a hospital ethics committee is to provide consultative services on specific ethical dilemmas to physicians, associates, patients and families. The ethical issues may involve either cases or specific hospital policies.
B. Request for Consultation. Any provider directly involved with a particular case, or affected by a particular hospital or clinic policy may request that the Ethics Committee consider the ethical aspects of the case or policy. The applicable hospital policy and procedures must be followed in each instance. .
C. Consultation. The IHS Committees provides supportive consultation, but do not make final decisions on care management. Ultimately, decisions rest with the patient, family and physician.

GUIDELINES FOR WITHHOLDING AND WITHDRAWAL OF TREATMENT

I. PURPOSE

A. To provide guidelines for healthcare professionals in formulating, documenting, and communicating decisions to withhold or withdraw medical treatment.
B. To support the attending physician or attending physician's designee to withhold or withdraw medical treatment.
C. To provide mentally capable patients or the authorized representative of an incapacitated or a minor patient with the autonomy to refuse medical treatment which conflicts with the patient's values and life goals.

II. POLICY

GENERAL PRINCIPLES

A. Autonomy and Decision Making

1. Competent patients have the right to self-determination, including the right to accept or refuse medical treatment. Autonomous choice implies the opportunity to make informed choices, which are consistent with the life goals and values of the patient.

2. Medical treatment decisions should be considered in the context of the overall objective(s) of the care plan for the patient rather than in isolation.

3. In order to exercise self-determination, the patient is entitled to all information necessary to make an informed decision, including diagnosis, prognosis, the range of alternatives and the risks and benefits associated with each.

4. A patient with decision-making capacity has the right to refuse care, even care that is considered medically beneficial.

5. The patient's right of self-determination survives incapacity. This right may be effectuated by an appropriate surrogate as he/she is guided by:

   a. the patient's explicit advance directive;

   b. the surrogate's judgment about what the patient would have wanted; and

   c. in the absence of a. and b., the patient's best interests.

B. Withholding/Withdrawing Medical Treatment

1. Decisions to withhold medical treatment are not fundamentally distinct from decisions to withdraw medical treatment. The distinction between foregoing and discontinuing therapy is not itself of moral importance. A justification that is adequate for not commencing a medical treatment is also sufficient for ceasing it.

2. When comfort and dignity are maintained, respecting a patient's (or surrogate's) decision to forgo treatment of any kind, does not constitute an abandonment of the patient, symbolic or otherwise.

3. Under all circumstances, the "minimum care" any person requires is that necessary to achieve:

   a. Minimization of anguish, pain and suffering; and
   b. Maintenance of the patient's dignity as a person.

   No other care is ethically required. Moreover, there may be situations that are so burdensome that the care required to achieve these minimum objectives is all that it is ethically permissible to provide.

4. IHS Medical Staff covering an attending physician must not withhold care or medication from a patient if it has been validated in the EMR to be part of the patient's current care plan. The current care plan can only be adjusted by the covering provider after a personal examination and new assessment of the patient.

5. IHS Health care professionals must not perform euthanasia or participate in assisted suicide.

6. Risk Management for the applicable hospital should be consulted before altering or withholding medical treatment that could result in the death of any patient.

7. If concurrence cannot be obtained among both parents or guardian, the minor (as appropriate) and the attending physician or his/her designee, then, in this case, consultation with Social Services, the Ethics Committee, or the IHS legal counsel is advisable.

III. PROCEDURE

DOCUMENTATION

A. The discussion of the plan of care and the agreement of the patient/surrogate should be documented in the medical record and include the following:

   1. Who participated in the discussion;

   2. The medical condition and prognosis of the patient;

   3. A description of the patient's decision making capacity;

   4. A description of the circumstances relevant to the decision, including the objective(s) of the patient or surrogate;

   5. The medical care options presented; and

   6. A detailed description of and rationale for the plan of care agreed to by the patient/surrogate, including (to the extent that can be anticipated) what specific medical treatment will be provided, withheld, and/or withdrawn. If death is an anticipated and accepted outcome of the care plan, this should be specified.

DISPUTE RESOLUTION

A. Whenever a patient or surrogate decision maker requests the withdrawal of a treatment(s), the attending physician or designee must review this decision with the patient or surrogate decision maker and:

   1. Implement the decision; or

   2. Promptly make his/her objection and the reasons for same known to all interested parties and, if the objection or disagreement cannot be resolved, either:

      a. Promptly request an Ethics Consultation, or

      b. Make all reasonable efforts to arrange for the transfer of the patient to the care of another physician.

ARTICLE IV - PERSONAL CONDUCT SECTION

I. PURPOSE

Professional medical care is an endeavor built on collegiality and the mutual respect of all those involved in patient care. The principal objective is to ensure high standards and delivery of patient care, promote a professional practice, and safe work environment. The importance of respect among all health professionals as a means of ensuring good patient care is at the very foundation of professional ethics. As a member of this profession, a physician must recognize his/her ethical responsibility not only to patients, but also to society and to other health professionals. This creates the obligation to make relevant information available to colleagues, to interact with other health professionals in a collaborative and respectful manner, and to obtain consultation and use the expertise of other health professionals when indicated.

II. POLICY

CITIZENSHIP

A. Definition. Responsible, professional behavior is defined by appropriate, timely, and continuous care of patients and may include, but is not limited to:
   1. Arranging for professional coverage and on call coverage for his/her patients during time away from the community and providing that coverage information to the hospital;
   2. Participation with quality and performance improvement activities of the IHS Medical Staff and each applicable hospital;
   3. Assisting in monitoring activity for new Medical Staff appointees;
   4. Participating in coverage of other coverage programs as required by an IHS Committee; and
   5. Thorough, complete and timely medical record documentation, including adoption and meaningful use of the Electronic Medical Record (EMR) and creating billable claims.

Compliments to providers may be filed using the "Physician Compliments and Complaints" form located on the TRH Intranet or other written form. Completed forms describing the scenario or circumstance will be sent to the Practice Administrator or the appropriate IHS officer.

Review of the compliment will be performed by the Practice Administrator or IHS Office as a verification process. The physician named by the compliment will be notified by letter or personal contact from the Medical Staff office.

A copy of the notification letter of good citizenship will be placed in the provider's Quality Assessment file.

DISRUPTIVE BEHAVIOR

A. Definition. Disruptive behavior is any behavior which endangers patient, Medical Staff or employee safety and may include, but is not limited to:
   1. Verbal attacks, intimidation, using foul or threatening language;

2. Physical attacks or threats of physical attack;
3. Behavior or remarks which are inconsistent with the policy on sexual harassment;
4. Modeling inappropriate behaviors for students and residents, thereby impairing their ability to achieve clinical skills;
5. Abusive, non-constructive criticism;
6. Willful damage to or theft of organization property;
7. Unauthorized use, possession, or ingestion of mood altering substances on organization property, or when caring for patients in the Hospital; or
8. Retaliations or retribution to reporting individuals.

However, constructive criticism offered in good faith and in a spirit of collaboration, openness and mutual respect with the aim of improving patient care should not be construed as disruptive behavior.

Reports of disruptive behavior should be sent to the IHS Practice Administrator or an appropriate IHS Board of Directors Officer.

Review of the complaint will be performed by the IHS President or the appropriate IHS Board of Directors Officer as a verification process. Behavior complaints will then be presented to the appropriate IHS committee for review, action and notification of the involved Medical Staff member. While a single incident may not be sufficient for action, a history of verified complaints may be an indication for IHS Board of Directors action.

1. Provider may be subject to "Provider Health & Impairment Policy", General Policy & Procedure Manual, Personal Conduct Policies section.

2. Corrective actions will be consistent with the applicable hospital Medical Staff Bylaws and be commensurate with the behavior and will be monitored.

3. Peer review protection and confidentiality will be appropriately provided for both the provider and the source of the report.

4. Interventions will be guided by the welfare and best interest of patients, rather than based on personal friendships and dislikes, antagonisms, jurisdictional disagreements or competitiveness among members of the staff.

5. Interventions will allow for self-correction, as well as structured rehabilitation.

6. Suspension of responsibilities or privileges may be a mechanism of final resort if the behavior persists despite attempts to intervene.

7. The existence of this Disruptive Behavior Policy shall not in any way limit the right of IHS to take any actions pursuant to its employment agreement with a disruptive physician, including termination.

PROVIDER HEALTH & IMPAIRMENT POLICY

I. PURPOSE

The purpose of the policy is to provide guidelines for the identification and management of providers who are unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness or injury, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.

II. POLICY

REPORTING IMPAIRMENT

A. BY OTHERS: If an individual working at the clinic, including a Medical Staff member, has a reasonable belief that a provider is impaired with regard to the provider's ability to provide patient care services, that individual may make a written report to the IHS Board of Directors. The report shall include a description of the incident(s) that led to the belief that the provider may be impaired.

B. SELF REPORTING: Any provider who believes that he/she may be impaired or who is subject to a recovery contract through the Michigan Health Professional Recovery Program or has had his/her privileges or employment duties limited by any healthcare organization shall report that circumstance to the IHS President or the IHS Board of Directors.

ACTION ON REPORT

A. SUMMARY ACTION: The IHS President or the IHS Board of Directors (or a designee of either) shall discuss the circumstances reported with the individual who submitted the report. If the report appears to be reliable and would justify immediate summary action (e.g., summary suspension) under the IHS Bylaws or applicable Medical Staff Bylaws and a continuing threat to safety exists as long as the provider continues to practice, the IHS Board of Directors and the IHS President may, acting jointly, immediately take such summary action or if they are unsure whether there is a continuing risk to safety, they may defer a decision on summary action pending an investigation.

B. INVESTIGATION: The IHS Board of Directors may consult with the provider and require independent examinations of the provider. The investigation results and the IHS Board of Directors's recommendation shall be shared with the provider, the Chief of Staff at any hospital where the provider has privileges, and the IHS President. Action shall be taken on the recommendation in the following manner:

1. If the IHS Board of Directors finds that there is *no impairment*, the matter will be referred back to the IHS President and/or MEC for their determination as to whether the circumstances giving rise to the report justify institution of summary action or corrective action under the applicable Medical Staff Bylaws or, if an employee, IHS employment policies.

2. If the determination is made that there is *potential or probable* impairment but the provider would not benefit from or does not agree to participate in a rehabilitation process acceptable to the IHS Board of Directors, the matter will be referred back to the IHS President and/or the applicable hospital MEC for their determination as to whether the circumstances giving rise to the report justify summary action or corrective action under the applicable Medical Staff Bylaws or IHS employment policies.

3. If a finding is made by the IHS Board of Directors that the provider is or may be *legally* impaired, and the provider has not already self-reported his/her impairment status to the State of Michigan Health Professional Recovery Program he/she shall be requested to do so. Thereafter, if the subject provider fails to provide evidence to the IHS Board of Directors that he/she has self-reported, the IHS Board of Directors may make that report.

4. If a finding is made by the IHS Board of Directors that the provider is or may be, impaired and would benefit from rehabilitation, and the provider agrees that he/she has a probable impairment and is willing to participate in good faith in a rehabilitation process defined by the IHS Board of Directors, the provider shall enter into a memorandum of understanding to ensure compliance with rehabilitation and patient quality of care and safety.

REHABILITATION PLAN

A. PLAN DEVELOPMENT: If the provider agrees to participate in a rehabilitation process, the provider shall authorize all health professionals providing his/her care to disclose to the IHS Board of Directors the precise nature of the provider's condition, the current course of treatment that the provider is receiving, if any, and mental, physical and emotional assessments of the provider's ability to safely exercise privileges. Recognizing that patient quality of care and safety are paramount, the plan may provide for, among other things, a leave of absence, imposition of a course of therapy, imposition of periodic mental or physical health examinations by a health care professional selected by the IHS committee, and restrictions or limitations on practice and/or clinical privileges at the hospital and/or other practice settings, including a consultation or preceptor requirement.

B. PATIENT CARE: The provider should identify at least one other provider on the IHS Medical Staff who is willing and able to assume responsibility for the care of the provider's patients in the event of his/her inability or unavailability to render appropriate and safe care and treatment to the patients.

C. EXAMINATION AND TESTING: If applicable, the provider shall agree to immediately submit himself/herself to a physical examination, including blood, breath, saliva, urine and other testing, in order to rule out the presence of drugs or alcohol any time a request is made by the IHS President, the IHS Board of Directors, or the IHS Practice Administrator when there is reasonable suspicion that the provider is impaired while at the Clinic or while treating or offering treatment advice for an IHS ambulatory care patient.

D. REPORTING: The provider shall be required to obtain periodic and other reports necessary and appropriate for the IHS Board of Directors to monitor the provider's rehabilitation status and continued ability to safely exercise privileges.

NONCOMPLIANCE

If the provider fails to comply with the provisions of the memorandum of understanding, a report of non-compliance shall be submitted by the IHS President, or IHS Board of Directors Chairperson, and to the Governing Board of any hospital at which the to be considered a request for corrective action.

INTERPRETATIONS AND DEFINITIONS

A. CONTROLLING PROVISIONS. In the event of any apparent or actual conflict between this Policy and a hospital's Medical Staff Bylaws, including the incorporated policy manuals, the provisions of this policy shall control. However, nothing in this policy shall interfere with the right of the governing board of a hospital served by IHS to impose summary action or institute corrective action when warranted. Further, nothing in this policy shall interfere with the obligation of health care professionals to make a report of another health care professional's suspected impairment, when warranted.

B. IMPAIRED. For purposes of this policy, the term "impaired" means the diminished capacity of an individual to perform one's duties while acting in the scope of one's employment or professional responsibilities while treating or offering treatment advice for a patient, and whose diminished capacity has resulted from aging, physical illness, mental illness, alcohol abuse, drug use, or other conditions causing impairment. A person who is impaired for this purpose may not be "legally impaired".

C. LEGALLY IMPAIRED. For the purposes of this policy, the term "legally impaired" means the inability or immediately impending inability of a health professional to practice his or her profession in a manner which conforms to minimum standards of acceptable and prevailing practice of that health profession due to the health professional's substance abuse, chemical dependency, or mental illness, or the health professional's use of drugs or alcohol that does not constitute substance abuse or chemical dependency.

CONFIDENTIALITY

A. PEER/PROFESSIONAL REVIEW. Inasmuch as the IHS Board of Director's function is peer/professional review, the records, data and knowledge collected by the council in any form shall be maintained at all times in a confidential manner, consistent with the provisions of state and federal statutes.

B. DISCLOSURE: The peer review records, data and knowledge of IHS may be disclosed as permitted or required by law.

The existence of this Provider Health & Impairment Policy shall not in any way limit the right of IHS to take any actions pursuant to its employment agreement with an impaired physician, including termination.