RED BUD
REGIONAL HOSPITAL

Medical Staff Bylaws

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MEDICAL STAFF BYLAWS OF Red Bud Regional Hospital

P R E A M B L E

WHEREAS, Red Bud Regional Hospital (hereinafter referred to as "Hospital") is operated by Deaconess Illinois Corporation hereinafter referred to as "Corporation" (a non-profit corporation organized under the laws of the state of Illinois), Lawfully doing business in Illinois and is not an agency or instrumentality of any state, county or federal government; and

WHEREAS, no practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the medical staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to ultimate authority and direction of the Board of Trustees; and

WHEREAS, the cooperative efforts of the Medical Staff, management and Board of Trustees are necessary to fulfill these goals.

NOW, THEREFORE, the Practitioners practicing in Red Bud Regional Hospital hereby organize themselves into a Medical Staff conforming to these Bylaws.

D E F I N I T I O N S

1. "Allied Health Professional" or “AHP”: A credentialed individual other than a Practitioner who is qualified to render direct or indirect medical or surgical care under supervision of a Practitioner who has been afforded privileges within their scope of practice to provide such care in the Hospital. For purposes of these Medical Staff Bylaws, “AHP” shall be deemed to refer only to advance practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process. Such AHPs shall include, without limitation, physician assistants, certified nurse practitioners, certified nurse midwives, certified nurse specialists, anesthesiology assistants and certified registered nurse anesthetists and other such professionals. For purposes of these Bylaws, “Allied Health Professional” shall not be deemed to include those non-credentialed individuals (“Clinical Assistants” pursuant to the Hospital policy) whose appointment and competencies are handled outside the Medical Staff process. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.
2. "Board": The Board of Trustees of Deaconess Illinois,
3. "Board Certification":
    a. For Physicians, certification in a member board of the American Board of Medical Specialties, American Board of Osteopathic Specialists or an equivalent certifying board as determined by the MEC and Board.
    b. For non-Physicians, appropriate and applicable specialty boards as determined by the MEC and Board.
4. "Chief Executive Officer/ Chief Administrative Officer" or “CEO/ CAO”: The individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.
5. "Chief of Staff": The member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.
6. "Clinical Privileges": The Board's recognition of Practitioners' or AHPs’ competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.
7. "Corporation": Deaconess Illinois Corporation.
8. "Data Bank": National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, for purposes of reporting of adverse actions and Medical Staff malpractice information.
9. “Designee”: One selected by the CEO/ CAO, Chief of Staff, or other officer to act on his/her behalf regarding a particular responsibility or activity as permitted by these Bylaws.
10. "Ex-Officio": Service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.
11. "Fair Hearing Plan": The procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when privileges are adversely affected by a determination based on professional conduct or competence. The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix “A”.
12. “Hospital”: Red Bud Regional Hospital.
13. “Medical Executive Committee" or “MEC”: Executive Committee of the Medical Staff.
14. "Medical Staff": The formal organization of Practitioners who have been granted Medical Staff membership at the Hospital.

15. "Medical Staff Bylaws": The Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan and such other policies as may be adopted by the Medical Staff subject to the approval of the Board.
16. "Medical Staff Year": January 1-December 31.
17. "Member": Practitioner who has been granted Medical Staff membership pursuant to these Bylaws.
18. “Oral and Maxillofacial Surgeon”: An individual who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education. As determined by the Medical Staff, the individual must be currently competent to perform a complete history and physical examination to assess medical, surgical, and anesthetic risks of the proposed operative and other procedure(s).
19. “Peer Review Policy”: The policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all Practitioners with delineated clinical privileges, evaluate the competence of Practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix “D” hereto.
20. "Physician": An individual with D.O. or M.D. degree who is properly licensed to practice medicine in Illinois.
21. "Practitioner": A physician, dentist or podiatrist who has been granted clinical privileges and/or Medical Staff membership at the Hospital.
22. "Prerogative": The participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.
23. "Special Notice": Written notice sent with a return receipt.
24. “Telemedicine”: Use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

ARTICLE I - NAME

The name of this organization shall be the Medical Staff of Red Bud Regional Hospital.

ARTICLE II - PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation, and professional support) may be obtained and obligations of membership fulfilled.

2.1(b) To foster cooperation with administration and the Board while allowing Medical Staff members to function with relative freedom in the care and treatment of their patients.

2.1(c) To provide a mechanism to ensure all patients admitted to/treated in any facilities of the Hospital shall receive a uniform level of appropriate quality care, treatment, and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other performance improvement activities in accordance with the Hospital's performance improvement program.

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all Practitioners and AHPs authorized to practice in the Hospital through delineation of clinical privileges, on-going review, and evaluation of each Practitioner's performance in the Hospital and supervision, review, evaluation and delineation of duties and prerogative of AHPs.

2.1(e) To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirement.

2.1(f) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill.

2.1(g) To promulgate, maintain and enforce bylaws and rules and regulations for the proper functioning of the Medical Staff.

2.1(h) To provide a means by which issues concerning the Medical Staff and Hospital may be discussed with the Board or CEO/ CAO.

2.1(i) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available.

2.1(j) To assist the Board in identifying changing community health needs/preferences and implement programs to meet those needs/preferences; and

2.1(k) To accomplish its goals through appropriate committees.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Ensuring Practitioners and AHPs cooperate with each other in caring for patients in the Hospital.

2.2(b) Accounting for quality, appropriateness and cost effectiveness of patient care rendered by all Practitioners and AHPs authorized to practice in the Hospital, by acting to:

(1) Assist the Board and CEO/ CAO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements.
(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted.
(3) Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the Hospital; and require documentation of individual participation in such programs by all individuals with clinical privileges.
(4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan.
(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPs.
(6) Initiate and pursue corrective action with respect to Practitioners and AHPs, when warranted.
(7) Develop, administer, and enforce these Bylaws, Rules & Regulations of the Medical Staff and other Hospital policies related to medical care.
(8) Review and evaluate quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment.
(9) Ensure functions delineated in Section 11.3(b) of these Bylaws are performed by appropriate standing or ad hoc committee of the Medical Staff; and
(10) Implement a process to identify/manage matters of individual physician health separate from Medical Staff disciplinary function in accordance with the Practitioner Wellness Policy (Appendix "B").

2.2(c) Assisting the Board in maintaining the accreditation status of the Hospital.

2.2(d) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

2.2(e) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so privacy and confidentiality are preserved. The Hospital and all health care providers will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. The OHCA allows the Hospital and providers to share information for purposes of treatment, payment, and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the OHCA.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital and is not a right of any person. Membership on the Medical Staff shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the Practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she has been granted appropriate privileges to do so.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF MEDICAL STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those Practitioners legally licensed in Illinois, who:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital.

(2) Are determined, based on documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of Medical Staff responsibilities.

(3) Comply and have complied with federal, state, and local requirements, if any, for their medical practice; and are not or have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital as determined by the MEC and Board.

(4) Have professional liability insurance that meets the requirements of Section 13.2.

(5) Are graduates of an approved college holding appropriate degrees.

(6) Have successfully completed an approved internship program or the equivalent where applicable.

(7) Maintain a good reputation in his/ her professional community; can work successfully with other professionals and have physical and mental health to adequately practice the profession.

(8) Meet one of the following requirements, in addition to those listed above:

(i) Board Certification, as defined in the Definitions Section of these Bylaws, in a specialty consistent with the scope of clinical privileges requested and maintained at Hospital; or

(ii) adequate progress toward Board Certification, as defined in the Definitions Section of these Bylaws, in a specialty consistent with the scope of clinical privileges requested and maintained at Hospital. The determination of adequacy shall be made by the MEC and must be approved by the Board of Trustees; or

(iii) demonstration to the satisfaction of the MEC and the Board of Trustees, competency and training equal or equivalent to that required for Board Certification, as defined in the Definitions Section of these Bylaws, in a

specialty consistent with the scope of clinical privileges requested and maintained at Hospital.

The above requirement shall not apply to any Practitioner already a member of the Medical Staff as of 12/5/2001.

(9) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and

(10) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other Practitioners within the Hospital.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise particular clinical privileges merely because he /she is licensed to practice in this or any other state, or because he/ she is a member of any professional organization, or because he /she is certified by any clinical board, or because he/ she had, or presently has, Medical Staff membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of race, color, sex, national origin, religion, gender identity, sexual orientation, or disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his/ her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

The burden shall be on the applicant to establish he/ she is professionally competent and worthy in character, professional ethics, and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification he/ she has in the past and agrees that he/ she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

3.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff shall:

3.3(a) Provide patients with continuous care at the generally recognized professional level of quality.

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies regarding utilization.

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies (including Practitioner Wellness and Behavior that Undermines a Culture of Safety policies, Appendices “B” and “C”), and Rules & Regulations of the Medical Staff.

3.3(d) Discharge the Medical Staff, committee, and Hospital functions for which he/ she is responsible by Medical Staff category assignment, appointment, election or otherwise.

3.3(e) Cooperate with other members of the Medical Staff, management, Board of Trustees, and employees of the Hospital.

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/ she admits or, in any way provides care to, in the Hospital.

3.3(g) Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these Bylaws.

3.3(h) Attest he/ she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise privileges requested prior to initial exercise of privileges and participate in the Hospital drug testing program.

3.3(i) Abide by the ethical principles of the profession and specialty.

3.3(j) Refuse to engage in improper inducements for patient referral.

3.3(k) Refrain from engaging in business practices which are predatory or harmful to the Hospital/ community.

3.3(l) Notify the CEO/ CAO and Chief of Staff within seven (7) days if:

(1) Professional licensure in any state is suspended or revoked, or of any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license.

(2) Professional liability insurance is modified or terminated.

(3) Named as defendant, or is subject to final judgment or settlement, in any court proceeding alleging professional negligence or fraud.

(4) Any criminal charges, other than minor traffic violations are brought/ initiated against and any guilty or no contest pleas or convictions entered.

(5) Excluded debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension, or ineligibility from such programs, or is under investigation by any such program.

(6) Currently voluntarily or involuntarily participating in rehabilitation or impairment program or has ceased participation in such a program without successful completion; or has been diagnosed with any condition resulting in a material change in health status from the time member submitted application.

(7) There has been voluntary or involuntary limitation, reduction or loss of clinical privileges on any medical staff (including relinquishment of such Medical Staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body; or agreement to refrain from practice while under investigation or to avoid such investigation).

(8) DEA registration number/ controlled substance certificate or equivalent state credential is revoked, suspended, or relinquished, or subject to any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/ her certificate/ credential.

(9) Subject to terms of a valid agreement that would prevent practicing at the Hospital (e.g., a non-compete agreement).

(10) Subject to any pending or successful challenges to membership/ fellowship in local, state, or national professional organizations; and/ or

(11) Subject to any pending or successful challenges to, or voluntary relinquishment of specialty board certification.

Failure to provide any such notice, as required above (except as to professional negligence actions not resulting in judgment or settlement), shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

3.3(m) Comply with state and federal requirements for maintaining confidentiality of patient identifying medical information, including Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

3.3(n) Admission History & Physicals and Initial Assessments

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician (or AHP who has been credentialed and granted privileges to perform a history and physical examination) within twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/ maxillofacial surgeons may be granted privileges to perform part or all the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document circumstances surrounding the need for additional acute care. Should the physician fail to ensure the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia, the record shall be considered delinquent and the Chief of Staff or designee or CEO/ CAO or designee may take appropriate steps to enforce compliance. If the history and physical is completed by an AHP who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

At minimum, the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that establishes medical necessity in concise manner based upon the patient's own words; (b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system; (i) diagnostic data available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and (k) the plan outlining the

evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

A history and physical performed within thirty (30) days prior to Hospital admission may be used if the medical record contains durable, legible Practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. This updated H&P review and examination information must be documented within twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia.

Each department or service will determine for its members which outpatient procedures require a history and physical examination as a prerequisite and, if required, the scope of such history and physical. Notwithstanding the foregoing, a history and physical examination shall be required for all invasive operative procedures performed in the outpatient setting. Where required, a history and physical must be completed and documented in accordance with the timeframes described above.

An initial assessment of all patients must be performed by the responsible Medical Staff member within twenty-four (24) hours of admission.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed three (3) years. Appointment may be granted for a period less than three (3) years with the imposition of any condition the MEC and Board deem necessary to monitor the applicant's practice. Conditional appointment for a period of less than three (3) years does not in and of itself entitle an applicant to fair hearing rights. In no case shall the Board act on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.4(b) Declaration of Moratorium

The Board may declare moratoriums in granting and exercising of clinical privileges when the Board, in its discretion, deems it in the best interest of this Hospital and the health/ patient care capable of being provided by the Hospital and Medical Staff. The moratoriums may apply to individual medical specialty groups or any combination thereof. Prior to declaring a moratorium, the Board will seek input of the Medical Staff regarding the needs of the Hospital and patient community.

3.4(c) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed three (3) years. Reappointment may be granted for a period less than three (3) years with imposition of any condition the MEC and Board deem necessary to monitor the applicant's practice. Conditional reappointment for a period of less than three (3) years does not in and of itself entitle an applicant to fair hearing rights.

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

A Medical Staff member may request a voluntary leave of absence from Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time of the leave, which may not exceed one (1) year unless approved by the MEC and Board. If the leave is granted, the Medical Staff member shall not be entitled to exercise any clinical privileges or rights/ prerogatives of membership commencing on the date the leave is granted until granted reinstatement. If the staff member's appointment ends while the member is on leave, the member must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

3.5(b) Termination of Leave

(1) At least sixty (60) days prior to the expiration of the leave period, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to the CEO/ CAO or designee for transmittal to the MEC. The Medical Staff member shall submit a written summary of relevant activities during the leave. The MEC may require proof of competency by further education, such as a refresher course or appropriate monitoring for a period, or both, to insure continuing competence prior to any recommendation for reinstatement. The MEC shall make a recommendation to the Board concerning the reinstatement of the Medical Staff member's privileges.

(2) Failure to request reinstatement in a timely manner shall result in automatic termination of Medical Staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges, and prerogatives pursuant to this section shall not be considered an adverse action.

(3) If Medical Staff member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning Medical Staff member. Any new privileges requested will be acted upon and monitored in similar fashion as if the Medical Staff member were a new applicant.

(4) Reinstatement will ordinarily be automatic if a leave of absence is for an armed services commitment. If such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period, or both, to insure continuing competence.

3.6 RESIGNATION

A resignation of membership or privileges must be submitted to the CEO/ CAO in writing and signed by the Practitioner or AHP. The Practitioner or AHP shall make a good faith effort to provide at least thirty (30) days' notice of the resignation, if possible. The CEO/ CAO shall forward the notice to the MEC. A resignation is effective upon the date designated in the written notice. If no date is indicated, the resignation will become effective immediately upon delivery to the CEO/ CAO.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall include Active, Courtesy, Consulting and Honorary categories. Qualifications, prerogatives, and responsibilities are outlined below. Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Medical Staff membership.

For purposes of determining whether a Practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission/ referral of a patient for inpatient care. When a patient has more than one procedure or diagnostic test performed or interpreted by the same Practitioner during a single Hospital stay, the multiple tests shall count as one patient contact.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

(1) Meet the basic qualifications set forth in these bylaws; and

(2) Have a practice and/ or residence located within 30 miles of the Hospital to be continuously available for provision of care to patients, as determined by the Board; or

(3) Are regularly involved in the care of at least 25 patients in the Hospital in a calendar year as defined in Section 4.1.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) Admit patients to the Hospital consistent with granted clinical privileges and Section 4.2(a).

(2) To exercise only such delineated clinical privileges as are granted pursuant to Article VII.

(3) To vote on all matters presented at general and special meetings of the Medical Staff.

(4) To vote and hold office in the Medical Staff organization and on committees to which appointed; and

(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3.

(2) Within area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom providing services, or arrange a suitable alternative for such care and supervision.

(3) Actively participate in:
   (i) performance improvement program/ patient care evaluation/ monitoring activities required of the Medical Staff and possess the requisite skill and training for oversight of care, treatment, and services in the Hospital.
   (ii) supervision of other appointees where appropriate.
   (iii) promoting effective utilization of resources consistent with delivery of quality patient care; and
   (v) discharging such other Medical Staff functions as may be required.

(4) Serve on at least one (1) Medical Staff committee if appointed by the Chief of Staff; and

(5) Satisfy requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of committees of which a member.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of Practitioners, who:

(1) Meet the basic qualifications set forth in these Bylaws.

(2) Have a practice and/ or residence located within 50 miles of the Hospital to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the Medical Staff with privileges appropriate to the treatment provided.

(3) Are not regularly involved in the care of more than 25 patients in the Hospital in a calendar year as defined in Section 4.1 (the limitation on patient contacts shall not apply to contracted emergency department physicians who reside outside the community); and

(4) Are members of the Active Staff of another hospital where he/she actively participates in the performance improvement program.

Courtesy Staff membership may also be granted to Practitioners whose primary practice is located outside the community, which shall be defined as a 100-mile radius of the Hospital, when the MEC and Board determine applicant will provide services to meet an otherwise unfulfilled community need. A determination by the MEC and Board that a community need does not exist shall not entitle the applicant to fair hearing rights under these Bylaws. Such Courtesy Staff members are granted exemption from requirements of subsections 4.3(a) (2) and (3) herein and are permitted to be regularly involved in an unlimited number of cases in the Hospital in a calendar year as defined in Section 4.1.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a).

(2) Exercise such clinical privileges as are granted pursuant to Article VII.

(3) Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, except *shall not* vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3.
(2) Retain responsibility within area of professional competence for care and supervision of each patient in the Hospital for whom providing service.
(4) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which a member.

4.4 CONSULTING STAFF

4.4(a) Qualifications

Any Practitioner may be requested to provide a consultation within the scope of the Practitioner's license and designated clinical privileges. Consulting Staff shall consist of a special category of physicians each of whom is because of board certification, training, and experience, recognized by the medical community as an authority within the specialty.

4.4(b) Prerogatives

(1) Prerogatives of a Consulting Staff member shall be to:
    (i) provide an unlimited number of consultation recommendations and reports; and
    (ii) attend all meetings of the Medical Staff may wish to attend as a non-voting visitor.
(2) Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.
(3) Other than providing consultation, Consulting Staff members shall not otherwise be regularly involved in the care of any patient within the Hospital as defined in Section 4.1.

4.4(c) Responsibilities

Each member of Consulting Staff shall assume responsibility for consultation, treatment, and appropriate documentation.

4.5 HONORARY STAFF

4.5(a) Qualifications

The Honorary Staff shall consist of physicians who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active Hospital services, but continue to demonstrate a genuine concern for the Hospital; or
(2) Physicians of outstanding reputation in a particular specialty whether a resident in the community.

Honorary Staff members shall not be required to meet qualifications set forth in Section 3.2(a).

4.5(b) Prerogatives

The prerogatives of an Honorary Staff member shall be:

(1) Attending by invitation any such meetings he/ she may wish to attend as a non-voting visitor.

(2) Honorary Staff members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility or otherwise be regularly involved in care of any patient within the Hospital as defined in Section 4.1. Honorary Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.5(c) Termination

Appointment and reappointment to the Honorary Staff is a courtesy which may be terminated by the Board of Trustees upon recommendation of the Medical Executive Committee without affording the right to fair hearing proceedings.

4.6 REFER & FOLLOW STAFF – MEMBERSHIP WITHOUT CLINICAL PRIVILEGES

4.6(a) Qualifications

Refer & Follow Staff shall consist of physicians who desire to be associated with the Hospital for purposes of continuity of care and promoting educational opportunities but who do not intend to treat patients at the Hospital.

4.6(b) Prerogatives

Refer & Follow Staff members:

1) may refer patients for outpatient diagnostic testing and specialty services provided by the Hospital.
2) may refer patients to other appointees of Medical Staff for admission, evaluation, and/or care and treatment.
3) may visit patients in the Hospital, review patient medical records and receive information concerning medical condition and treatment, so long as the admitting/ attending physician agrees and grants permission.
4) shall not be eligible for clinical privileges and under no circumstances participate in any treatment or procedure, make any entries in the medical record, admit a patient to the Hospital, or otherwise be regularly involved in patient care in the Hospital as defined in Section 4.1.
5) shall not be subject to the requirements for ongoing professional practice evaluation or focused professional practice evaluation; and
6) Shall not vote on staff matters, hold office, or serve on committees.

4.6(c) Responsibilities

Individuals requesting Refer & Follow Staff appointment shall be required to submit an application for initial appointment or reappointment as prescribed by Article VI of these Bylaws with the exception of the requirement to provide information regarding the demonstration of current competency and other exceptions approved by the MEC and Board.

4.6(d) Termination

Appointment and reappointment to the Refer & Follow Staff is a courtesy which may be terminated by the Board of Trustees, upon recommendation of the Medical Executive Committee, without affording the right to fair hearing proceedings.

ARTICLE V - ALLIED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

An Allied Health Professional ("AHP") shall be identified as an individual other than a Practitioner who is qualified to render direct or indirect medical or surgical care under supervision of a Practitioner who has been afforded privileges within their scope of practice to provide such care in the Hospital. Clinical Assistants who are not AHPs and who are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital. AHPs may be employed by physicians on the Medical Staff. Whether or not employed, the AHP must be under the supervision and direction of a Medical Staff physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules & Regulations) and not exceed the limitations of practice set forth by the AHP's respective licensure.

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

5.2(a) AHPs must:

(1) Document professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and are qualified to provide needed services within the Hospital.

(2) Establish based on documented references they adhere strictly to the ethics of their respective profession, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities.

(3) Have professional liability insurance in the amount required by these Bylaws.

(4) Provide a needed service within the Hospital; and

(5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

Upon establishing experience, training, and current competence, AHPs, as identified in Section 5.1, shall:

5.3(a) Exercise judgment within the area of competence providing a physician of the Medical Staff has ultimate responsibility for patient care.

5.3(b) Participate directly, including writing orders to the extent permitted by law, in management of patients under supervision/ direction of a member of Medical Staff; and

5.3(c) Participate in patient care evaluation and other quality assessment and monitoring activities required of the Medical Staff, and to discharge Medical Staff functions as may be required.

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of Practitioners. The Board in consultation with the MEC shall determine the scope of activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

5.4(b) Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO/ CAO. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. The affected AHP shall have the right to request to be heard before the MEC with an opportunity to rebut the basis for termination. Upon receipt of a written request, the MEC shall afford the AHP an opportunity to be heard by the MEC concerning the AHP's grievance. Before appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action and the AHP may present information relevant thereto. A record of the appearance shall be made. The MEC shall, after conclusion of the investigation, submit a written decision simultaneously to the Board and the AHP.

5.4(c) The AHP shall have a right to appeal to the Board any decision rendered by the MEC. Any request for appeal shall be required to be made within fifteen (15) days after date of receipt of the MEC decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall become final and effective immediately upon affirmation by the MEC and Board. If appellate review is requested the Board shall, within fifteen (15) days after receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for appellate review. The appeal shall be in writing only and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall decide the matter by a majority vote of Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

5.4(d) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member unless another qualified physician indicates willingness to supervise the AHP and complies with all requirements for undertaking such supervision. In the event an AHP's supervising physician member's privileges are significantly reduced or restricted the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

5.4(e) If the supervising Practitioner employs or directly contracts with the AHP for services, the Practitioner shall indemnify the Hospital and hold harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of

patients, or any action by such AHP beyond the scope of license or clinical privileges. If the supervising Practitioner does not employ or directly contract with the AHP, the Practitioner shall indemnify the Hospital and hold harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the Practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

5.5(a) Provide patients with continuous care at the generally recognized professional level of quality.

5.5(b) Abide by Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable.

5.5(c) Discharge any committee functions for which responsible.

5.5(d) Cooperate with members of the Medical Staff and AHPs, administration, Board of Trustees, and employees of the Hospital.

5.5(e) Adequately prepare and timely complete medical and other required records for which responsible.

5.5(f) Participate in performance improvement activities and in continuing professional education.

5.5(g) Abide by the ethical principles of his/ her profession and specialty.

5.5(h) Notify the CEO/ CAO and the Chief of Staff within seven (7) days if:

(1) Professional license or certification in any state is suspended or revoked, or if any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/ her license or certification.

(2) Professional liability insurance is modified or terminated.

(3) Named as a defendant, is subject to a final judgment or settlement, in any court proceeding alleging professional negligence or fraud.

(4) Criminal charges, other than minor traffic violations, are brought/ initiated and any guilty pleas or convictions entered.

(5) Excluded, debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets criteria for mandatory exclusion, debarment, suspension, or ineligibility, or is under investigation by any such program.

(6) Currently voluntarily or involuntarily participating in any rehabilitation or impairment program or has ceased participation in such a program without successful completion or has been diagnosed with a condition resulting in material change in health status from the time the AHP submitted application.

(7) There has been a voluntary or involuntary limitation, reduction or loss of clinical privileges on any medical staff (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of sanction or notice of intent to sanction from any peer review or professional review body; or agreement to refrain from practice while under investigation or to avoid such investigation).

(8) DEA registration number/ controlled substance certificate or equivalent state credential is revoked, suspended, or relinquished, or subject to any investigation,

sanction or notice of intent to sanction or to revoke, suspend or modify certificate /credential; and/ or

(9) Subject to a valid agreement that would prevent from practicing at the Hospital (e.g., a non-compete agreement).

Failure to provide such notice as required (except professional negligence actions not resulting in judgment or settlement) shall result in immediate loss of Allied Health membership and clinical privileges without grievance or appeal rights.

5.5(i) Comply with state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and associated regulations and execute a health information confidentiality agreement with the Hospital.

5.5(j) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies about utilization.

5.5(k) Attest suffers from no health problems which could affect ability to perform functions of Allied Health membership and exercise privileges requested prior to initial exercise of privileges and participate in the Hospital drug testing program.

5.5(l) Refuse to engage in improper inducements for patient referral; and

5.5(m) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community.

ARTICLE VI - PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

6.1(a) Review and Determination

Medical Staff, through its designated committees, shall investigate and consider each application for appointment or reappointment to Medical Staff, each request for modification of Medical Staff membership status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating, or reducing Medical Staff membership or clinical privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each requesting Medical Staff membership or clinical privileges.

6.1(b) Credentials Verification Organization

In accordance with applicable laws and accreditation standards, the Hospital may enter into an agreement to allow a credentials verification organization (CVO) to collect, receive and verify information necessary to credential applicants. The CVO shall be responsible for obtaining a complete application within the time frame established by the Hospital and provide a report to the Medical Staff summarizing the verified information. Medical Staff and Board shall utilize its independent judgment and have sole discretion in determining whether an applicant will be granted Medical Staff membership and/ or clinical privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. The Hospital shall verify all active state licenses and current DEA registration/ controlled substance certificate (for all Practitioners except pathologists and any other Practitioner whose scope of practice does not require DEA registration/ controlled substance certificate as determined by the MEC and Board). A signed Medicare penalty statement and a certificate of insurance must be submitted with the application. Any application fee or Medical Staff dues shall be approved by the MEC and Board and addressed in Medical Staff policy. Applicants shall supply the Hospital with all information requested on the application. The application form shall include, at a minimum, the following:

(a) Acknowledgment & Agreement: A statement the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of Medical Staff and agrees:
   (i) to be bound by the terms if granted membership and/ or clinical privileges; and
   (ii) to be bound by the terms relating to consideration of application without regard to whether granted membership and/ or clinical privileges.

(b) Administrative Remedies: A statement indicating the applicant agrees to exhaust administrative remedies afforded by the Bylaws before resorting to formal legal action should an adverse ruling be made with respect to Medical Staff membership, Medical Staff status and/ or clinical privileges.

(c) Criminal Charges: Any current criminal charges except minor traffic violations pending against the applicant and any past convictions or pleas. The Practitioner shall acknowledge the Hospital's right to perform a background check at appointment, reappointment, and any interim time when reasonable suspicion has been shown.

(d) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal, or state agency concerning participation in any health insurance program, including Medicare or Medicaid; and any civil judgments or settlements related to the delivery of health care.

(e) Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate the applicant can perform functions of Medical Staff membership and exercising the privileges requested. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board.

(f) Program Participation: Information concerning the applicant's current participation and/ or previous participation in any rehabilitation or impairment program, or termination of participation a program without successful completion.

(g) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment.

(h) Education: Detailed information concerning the applicant's education and training.

(i) Insurance: Information as to whether the applicant has current professional liability coverage meeting the requirements of the Bylaws together with a letter from the insurer stating the Hospital will be notified should the applicant's coverage change at any time.

(j) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity, and release provisions of Section 6.3(b) and (c).

(k) Professional Sanctions: Information of previous successful or currently pending challenges to, or voluntary relinquishment of:

(i) membership/ fellowship in local, state, or national professional organizations (excluding any voluntary surrender of membership/fellowship while in good standing and there are no pending investigations or disciplinary proceedings).
(ii) specialty board certifications.
(iii) license to practice any profession in any jurisdiction.
(iv) Drug Enforcement Agency (DEA) number/ controlled substance license (except pathologists and any other Practitioner whose scope of practice does not require DEA number/ controlled substance license as determined by the MEC and Board) including any sanction or notice of intent to sanction or to revoke, suspend or modify the DEA number/ controlled substance license.
(v) medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation, and receipt of sanction/notice of intent to sanction from any peer review or professional review body).
(vi) applicant's management of patients which may have given rise to investigation by the state board; or
(vii) participation in any private, federal, or state health care or procurement program (including Medicare or Medicaid) including conviction of a crime that meets the criteria for mandatory exclusion from the program, regardless of whether such exclusion has yet become effective.

If any such actions were taken, particulars shall be obtained before the application is considered complete.

(l) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested Medical Staff category, including information of basic qualifications specified in Section 3.2(a) and applicant's current professional license and federal drug registration numbers.
(m) References: The names of at least two (2) practitioners (excluding, when determined by the MEC and Board to be feasible, partners, associates in practice, employers, employees or relatives) who have worked with the applicant within the past three (3) years and personally observed professional performance and are able to provide knowledgeable peer recommendations to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise privileges requested and work with others.
(n) Request: Specific requests stating Medical Staff category and specific clinical privileges for which the applicant wishes to be considered.
(o) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is/has been affiliated.
(p) Photograph: A recent, wallet sized photograph of the applicant.
(q) Citizenship Status: Proof of United States citizenship or legal residency including but not limited to copies of a U.S. passport, U.S. civil issued birth certificate, or naturalization/ citizenship certificate.
(r) Professional Practice Review Data: For all new applicants, AHPs and Practitioners requesting new or additional privileges, evidence of applicant's, AHP's or Practitioner's professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant unless such organization(s) refuse to provide information to the Hospital and/ or

the applicant after sufficient efforts to obtain requested information. If the organization(s) refuse to provide requested information after sufficient efforts, the Hospital must at least obtain case logs specific to the requested privileges for the most recent appointment period from organization(s) that currently privilege the applicant; and

(s) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC directed education or safety training as required by this Hospital, which should relate to the physician's specialty and provision of quality patient care in the Hospital.

The applicant has a continuing duty to keep the above information updated and current. Failure to update anything on the list within seven (7) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

An applicant wishing to be considered for appointment/reappointment and clinical privileges may obtain an application form by submitting request to the CEO/ CAO or designee.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies willingness to appear for interviews and acknowledges he/ she shall have the burden of producing adequate information for a proper evaluation of qualifications for Medical Staff membership and clinical privileges.

(2) Authorizes Hospital representatives to consult with others who have been associated with him/ her and/ or who may have information bearing on current competence and qualifications and agrees to execute a formal agreement regarding such authorization and release of information upon the Hospital's request.

(3) Consents to inspection by Hospital representatives of all records and documents that may be material to an evaluation of licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/ she requests and professional ethical qualifications for Medical Staff membership.

(4) Represents and warrants all information provided true, correct, and complete in all material respects and agrees to notify the Hospital of any change in any of the information furnished in the application.

(5) Acknowledges provision of false or misleading information, or omission of information whether intentional or not shall be grounds for immediate rejection of application without fair hearing rights.

(6) Acknowledges if determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/ or the granting of clinical privileges, he/she shall have Medical Staff membership and clinical privileges automatically removed, without fair hearing rights.

(7) Pledges to provide continuous care for patients treated in the Hospital; and

(8) Agrees to be bound by the statements described in Section 6.3(c).

6.3(c) Statement of Release & Immunity from Liability

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice in

the Hospital during his/ her term of appointment or reappointment. In addition, statements shall be included on the application form, and by applying for appointment, reappointment, or clinical privileges the applicant expressly accepts the conditions during processing and consideration of application and thereafter regardless of whether granted appointment or clinical privileges.

I hereby apply for Medical Staff appointment as requested in this application and whether my application is accepted, I acknowledge, consent, and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for interview, if requested.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree as a condition to making application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges without fair hearing rights. I further acknowledge if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/ or the granting of clinical privileges, I shall be deemed to have immediately and automatically lost my appointment and clinical privileges without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by the Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating to:
    (i) applications for appointment or clinical privileges, including temporary privileges.
    (ii) periodic reappraisals.
    (iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action.
    (iv) summary suspension.
    (v) hearings and appellate reviews.
    (vi) medical care evaluations.
    (vii) utilization reviews.
    (viii) any other hospital, medical staff, service, or committee activities.

(ix) inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on competence, patient care or orderly operation of this Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to Medical Staff, and to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of third parties. I authorize the third parties to release information to the Hospital and authorized representatives upon request.

(3) "Hospital" and "its authorized representatives" means Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating credentials, or acting upon application or conduct in the Hospital: members of the Board and appointed representatives, the CEO/ CAO or designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and partners, associates or designees, and all appointees to the Medical Staff. "Third parties" means all individuals, including appointees to Medical Staff and appointees to medical staff of other hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or authorized representatives or who have requested information from the Hospital and authorized representatives.

I acknowledge: (1) Medical Staff appointments at this Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in the Bylaws and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Hospital through the CEO/ CAO of any change in the areas of inquiry; and (5) appointment and continued clinical privileges remain contingent upon continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities and factors relevant to effective and efficient operation of the Hospital. Appointment and continued clinical privileges shall be granted only on formal application according to the Hospital and the Bylaws and Rules & Regulations and upon final approval of the Board.

I understand before this application will be processed: (1) I will be provided a copy of Medical Staff Bylaws and Hospital policies and directives applicable to appointees to Medical Staff including the Bylaws and Rules & Regulations of Medical Staff; and (2) I must sign a statement acknowledging receipt and opportunity to read the copies and agreement to abide by all Bylaws, policies, directives and Rules & Regulations as are in force and as they may thereafter be amended during the time I am appointed to Medical Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other Practitioner or AHP who is not qualified to undertake responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any Practitioner or AHP providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) accept committee assignment and duties and responsibilities as assigned to me by the Board and Medical Staff.

6.3(d) Submission of Application &Verification of Information

Upon completion of the application form and attachment of all required information, the applicant shall submit the form to the CEO/ CAO or designee. The application shall be returned to the applicant and shall not be processed further if:

(1) Not Licensed. The applicant is not licensed in this state to practice in a field of health care eligible for appointment to Medical Staff or a state licensing entity has revoked the applicant's license to practice in any state; or

(2) Privileges Denied or Terminated. The applicant (i) has had application for medical staff appointment denied, (ii) has resigned medical staff appointment or any clinical privileges during the pendency of an active investigation which could have led to revocation of appointment or privileges, (iii) has had appointment or any clinical privileges revoked or terminated, or (iv) had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty, at this Hospital within one (1) year immediately preceding application or at another hospital at any time preceding the application; or

(3) Exclusive Contract or Moratorium. The applicant practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicants' specialty; or

(4) Inadequate Insurance. The applicant does not meet the liability insurance coverage requirements of these Bylaws; or

(5) Ineligible for Medicare Provider Status. The applicant has been excluded, suspended, or debarred, or otherwise declared ineligible from any state or federal health care program or procurement program, or is currently the subject of a pending investigation by any such program or has been convicted of a crime that meets the criteria for mandatory exclusion regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible; or

(6) No DEA Number. The applicant's DEA number/ controlled substance license has been revoked or voluntarily relinquished (shall not apply to pathologists and any other Practitioner whose scope of practice does not require DEA number/ controlled substance license as determined by the MEC and Board); or

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain a practice or residence within 50 miles of the Hospital; or

(8) Application Incomplete. The applicant has failed to provide any information required by the Bylaws or requested on the application, has provided false or misleading

information on the application, or has failed to execute an acknowledgment, agreement or release required by the Bylaws or included in the application; or

(9) Electronic Health Record Education/ Training. The applicant has failed to complete education in accordance with a facility approved curriculum related to electronic clinical information systems, or fails to appropriately utilize the Electronic Health Record as outlined in more detail in the Electronic Health Record Policy of this Hospital; or

(10) Felony. The applicant has plead guilty/ no contest to a felony charge or has been convicted of a felony.

The refusal to further process an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under these Bylaws.

In the event none of the above apply to the application, the CEO/ CAO, designee, or CVO pursuant to agreement with the Hospital, shall promptly seek to collect or verify the references, licensure and other evidence submitted. The CEO/ CAO or designee shall be deemed an authorized agent of the MEC in the performance of all credentialing functions, including but not limited to the gathering, verification, communication and reporting of information and any decisions on the completeness of an application. The CEO/ CAO or designee shall promptly notify the applicant in writing of any problems in obtaining the information required and it shall be the applicant's obligation to ensure the required information is provided within a timely manner of receipt of notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall action on the application be taken until verification of all information including query of the Data Bank is complete.

An applicant who withdraws application after it has been deemed complete may not resubmit application for membership or clinical privileges for one (1) year after the date of withdrawal unless good cause is shown. The determination of good cause shall be made by the MEC and Board in their sole discretion.

6.3(e) Description of Initial Clinical Privileges

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Hospital. Each Practitioner who is appointed to Medical Staff of the Hospital shall be entitled to exercise only clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing qualifications for and competence to exercise clinical privileges he/she requests.

6.3(f) Credentials Committee Action

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, supporting documentation and other information available relevant to consideration of the applicant's qualifications for Medical Staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to Medical Staff appointment and if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee may recommend the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents and transmitted with the majority report.

6.3(g) Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee recommendation but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request additional evaluation. The MEC shall make specific findings to the applicant's satisfaction of the requirements of experience, ability, and current competence in Section 6.3(n). The MEC shall forward to the Board a written report on the prescribed form concerning Medical Staff recommendations and if appointment is recommended, Medical Staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references, and documents, and transmitted with the majority report.

6.3(h) Effect of Medical Executive Committee Action

(1) Deferral: Action by the MEC to defer a complete application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons and describe additional information needed. If additional information is required, applicant shall be notified and bear the burden of providing.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO/ CAO or designee shall promptly forward it together with supporting documentation to the Board. "All supporting documentation" generally shall include the application form, accompanying information and the report/ recommendation of the Credentials Committee.

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO/ CAO or designee shall immediately inform the applicant by special notice specifying the reason or reasons for denial. Applicant shall be entitled to the procedural rights as provided in the Fair Hearing Plan or for AHPs as outlined in 5.4(b). The applicant shall have an opportunity to exercise procedural rights prior to

submission of the adverse recommendation to the Board. “Adverse recommendation" by the MEC is defined as denial of appointment or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan or for AHPs as outlined in 5.4(b).

6.3(i) Board Action

(1) Decision; Deadline. The Board shall act upon the recommendation at its next scheduled meeting or may defer action if additional information is needed, or if verification is not yet complete. The Board of Trustees may accept, reject, or modify the MEC recommendation.

(2) Favorable Action. If the Board of Trustees’ decision is favorable to the applicant such decision shall constitute final action on the application. The CEO/ CAO or designee shall promptly inform the applicant the application has been granted. The decision to grant Medical Staff appointment or reappointment together with all requested clinical privileges shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant’s ability to exercise the requested clinical privileges.

(3) Adverse Action. If the MEC’s recommendation was favorable to the applicant but the Board of Trustees’ action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan or for AHPs as outlined in 5.4(b). The CEO/ CAO or designee shall immediately deliver to the applicant by special notice a letter enclosing the Board of Trustees’ written decision and containing a summary of the applicant’s rights as specified in the Fair Hearing Plan or for AHPs the procedure outlined in 5.4(b).

If the Board’s action is more restrictive than the MEC’s recommendation after the evidentiary hearing, the affected Practitioner may request for a reconsideration of the Board’s decision pursuant to the appellate procedure outlined in these Bylaws and the Fair Hearing Plan. Reconsideration shall be based on the record of the preceding evidentiary hearing.

6.3(j) Interview

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(k) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision because of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent.

Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require. “Final adverse decision” shall include denial after exercise or waiver of fair hearing rights and/ or rejection or refusal to further process an application due to the applicant’s provision of false or misleading information on, the omission of information from, or failure to timely update, the application materials.

6.3(l) Time Periods for Processing

Complete applications for Medical Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO/ CAO or designee shall transmit a completed application to the Credentials Committee upon completing verification tasks, but in any event within ninety (90) days after receiving the completed application unless the applicant has failed to provide requested information needed to complete the verification process. An application will not be processed until the applicant submits a complete application.

6.3(m) Denial for Hospital's Inability to Accommodate Applicant

A decision by the Board to deny Medical Staff membership, Medical Staff category assignment or clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan, or for AHPs the procedure outlined in Sections 5.4(b) and 5.4(c):

(1) On the basis of the Hospital's present inability to provide adequate facilities or supportive services for the applicant and patients as supported by documented evidence; or
(2) On the basis of inconsistency with the Hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or
(3) On the basis of professional contracts, the Hospital has entered for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the Hospital finds it possible to accept applications for Medical Staff positions for which the applicant is eligible and the Hospital has no obligation to applicants with prior pending status, the CEO/ CAO or designee shall promptly inform the applicant by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide in writing on the prescribed form supplemental information as required to update all elements of the original application. The procedure in Section 6.2 for initial appointment shall apply.

6.3(n) Appointment Considerations

Each recommendation concerning the appointment of a Medical Staff member and/ or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant’s experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant’s proficiency in areas such as the following:

(1) Patient Care with the expectation applicants provide patient care that is compassionate, appropriate and effective.
(2) Medical/ Clinical Knowledge of established and evolving biomedical clinical and social sciences, and the application of patient care and educating others.
(3) Practice-Based Learning and Improvement through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices.
(4) Interpersonal and Communication Skills that enable establishment and maintenance of professional working relationships with patients, patients' families, members of the Medical Staff, Hospital Administration and employees, and others.
(5) Professional behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and
(6) Systems-Based Practice reflecting an understanding of the context and systems in which health care is provided.

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of an applicant's present Medical Staff appointment and/or clinical privileges, the CEO/ CAO or designee shall provide the applicant a reapplication form for use in considering reappointment. The Medical Staff member or AHP who desires reappointment or renewal of clinical privileges shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information regarding practice during the previous appointment period and shall forward reapplication form to the CEO/ CAO or designee. Failure to return a completed application form shall result in automatic termination of membership and clinical privileges at the expiration of the member's or AHP's current term.

6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) Education: Continuing training, education, and experience during the preceding appointment period that qualifies the applicant for the privileges sought on reappointment.
(2) License: Current licensure.
(3) Health Status: Current physical and mental health status only to the extent necessary to determine ability to perform the functions of Medical Staff membership or to exercise the privileges requested.
(4) Program Participation: Information concerning the applicant's current/ previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion.
(5) Previous Affiliations: The name and address of any other health care organization or practice setting where the applicant provided clinical services during the preceding appointment period.
(6) Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions, or organizations during the preceding appointment period.

(7) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/ fellowship in local, state, or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/ controlled substance license (except pathologists and other Practitioner whose scope of practice does not require DEA registration/ controlled substance certificate as determined by the MEC and Board), including any sanction or notice of intent to sanction or to revoke, suspend or modify DEA number/controlled substance license; or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges (including relinquishment of Medical Staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation or receipt of a sanction/ notice of intent to sanction from any peer review or professional review body); or

(vi) the applicant's management of patients which may have been given rise to investigation by the state board; or

(vii) participation in any private, federal, or state health care or procurement program (including Medicare or Medicaid), including conviction of a crime that meets the criteria for mandatory exclusion from such program, regardless of whether such exclusion has yet become effective.

If any such actions were taken, particulars shall be obtained before the application is complete.

(8) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, or pursued to final judgment.

(9) Criminal Charges: Any current criminal charges pending against the applicant including any federal and/ or state criminal convictions related to the delivery of health care and any convictions or pleas during the preceding appointment period. This includes any arrests related to the use, misuse or abuse of drugs or alcohol including DUIs and DWIs.

(10) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, and any investigations during the preceding appointment period by any private, federal, or state agency concerning participation in health insurance programs including Medicare or Medicaid during the preceding appointment period and any civil judgments or settlements related to delivery of health care.

(11) Managed Care Affiliations: The names of all HMO's, PPOs, and other managed care organizations the applicant has participated in the past three (3) years during the preceding appointment period.

(12) Insurance: Information applicant has current professional liability coverage meeting the requirements of the bylaws together with a letter from the insurer stating the Hospital will be notified if coverage changes at any time.

(13) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of evaluations of care and peer evaluations. Evidence shall include results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Applicants who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the applicant's professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.

Applicants who refer patients to a Hospitalist for inpatient treatment may satisfy this requirement by producing information in the form of quality profiles from other facilities where the applicant has actively practiced during the prior appointment period, quality profiles from managed care organizations with whom the applicant has been associated, or submitting medical record documentation from his/her office or other practice locations that demonstrates current competency for the privileges sought. Applicants who refer patients to a Hospitalist for inpatient treatment shall have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist shall provide evaluation of the applicant's care based upon consultation and interaction with the applicant about the applicant's hospitalized patients. The Hospitalist shall provide his/ her opinion as to the applicant's current competency based upon the condition of the applicant's patients upon admission/ readmission to the Hospital, with particular emphasis on any readmission related to complications of a previous admission.

(14) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Sections 6.3(b) and (c).

(15) Information on Ethics/ Qualifications: Other information about the applicant's professional ethics and qualifications that may bear on ability to provide patient care in the Hospital.

(16) References: At the request of the Credentials Committee, the MEC, or the Board, when there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least two (2) practitioners (excluding, when determined by the MEC and Board to be feasible, partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed professional performance and are able to provide knowledgeable peer recommendations to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others; and

(17) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC directed education or safety training as required by this Hospital which should be related to the physician's specialty and the provision of quality patient care in the Hospital.

The applicant has a continuing duty to keep information updated and current. Failure to update within seven (7) days of any change or action while the application is pending shall result in a refusal to process the application without Fair Hearing Rights.

Failure to update within seven (7) days during any period of appointment or reappointment shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

6.4(c) Verification of Information

The CEO/ CAO, designee, or CVO shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other information deemed pertinent including information regarding the applicant's professional activities, performance and conduct in the Hospital and query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the CEO/ CAO or designee shall transmit the Reapplication Form and supporting materials to the Chairman of the Credentials Committee. An application shall not be deemed complete nor action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(d) - 6.3(n) for initial appointment except an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in this Article VI as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, discharge of Medical Staff obligations, including participation in continuing medical education, compliance with the Medical Staff Bylaws, Rules & Regulations, cooperation with other Practitioners and AHPs and with patients, results of the Hospital monitoring and evaluation process including Practitioner and AHP-specific information compared to aggregate information from performance improvement activities which consider criteria directly related to quality of care, and other matters bearing on ability and willingness to contribute to quality patient care.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Medical Staff member or AHP may, either in connection with reappointment or at any other time, request modification of Medical Staff category or clinical privileges by submitting the request in writing to the CEO/ CAO. Requests shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No Medical Staff member or AHP may seek modification of privileges or Medical Staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

A Practitioner or AHP who is providing contract services to the Hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/ her membership category as any other applicant or Medical Staff member.

6.6(b) Requirements for Service

In approving any such Practitioners or AHP for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall Hospital quality assessment and improvement program.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6, shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. The Fair Hearing does not apply in this case.

If the Hospital enters into an exclusive contract and that contract results in the total or partial termination, or reduction of Medical Staff membership or clinical privileges of a current Medical Staff member, the Hospital shall provide the affected Medical Staff member sixty (60) days prior notice of the effect on his/ her Medical Staff membership or privileges. A Medical Staff member who is so affected is entitled to a hearing under the Fair Hearing Plan but must request this hearing within fourteen (14) days after the date he/ she is notified of the effect on his/ her Medical Staff membership or clinical privileges. The requested hearing shall be commenced and completed in accordance with the Fair Hearing Plan. After exhaustion of all remedies under the Fair Hearing Plan, if the adverse staff decision is based substantially on economic factors, the Hospital will give the Practitioner fifteen (15) days written notice in advance of the implementation.

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Practitioner or AHP providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/ her by the Board. Said privileges must be within the scope of the license authorizing the Practitioner or AHP to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of Practitioner and AHP, and each Practitioner or AHP shall bear the burden of establishing his/ her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the Practitioner or AHP's

qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for Medical Staff membership, each Practitioner and AHP must provide documentation establishing that he/ she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a Medical Staff member for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and Hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the Practitioner's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For Practitioners or AHPs who have not actively practiced in the Hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(13) herein. In addition, those Practitioners or AHPs seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a Medical Staff member or AHP.

7.2(c) Procedure

All requests for clinical privileges shall be evaluated and granted, modified, or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new privileges are requested.

7.2(d) Limitations on Privileges

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.2(e) Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation. The evaluation period may be renewed and extended for additional periods. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the Practitioner or AHP’s evaluation for reappointment. The period of focused professional practice evaluation and any renewal or extension must be approved by the MEC and Board.

7.3 SPECIAL CONDITIONS FOR PODIATRIC AND DENTAL PRIVILEGES

Requests for clinical privileges from podiatrists, dentists and oral surgeons shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by podiatrists, dentists and oral surgeons shall be under the overall supervision of the Chief of Surgery, however, other podiatrists, dentists and/or oral surgeons shall participate in the review of the Practitioner through the performance improvement process. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.3(a) SPECIALCONDITIONS FOR DIRECT ACCESS TO PHYSICAL THERAPY: In accordance with state rules and regulations, a patient may be evaluated and treated by a licensed physical therapist without a provider order in the following circumstances: Licensed to provide physical therapy within the state, and Granted membership and privileges as an allied health member of the medical staff. A physical therapist providing services without a referral from a health care professional must notify the patient's treating health care professional within 5 business days after the patient's first visit that the patient is receiving physical therapy. This does not apply to physical therapy services related to fitness or wellness, unless the patient presents with an ailment or injury. A physical therapist shall refer a patient to the patient's treating health care professional of record or, in the case where there is no health care professional of record, to a health care professional of the patient's choice, if: The patient does not demonstrate measurable or functional improvement after 10 visits or 15 business days, whichever occurs first, and continued improvement thereafter; The patient returns for services for the same or similar condition after 30 calendar days of being discharged by the physical therapist; or The patient's condition, at the time of evaluation or services, is determined to be beyond the scope of practice of the physical therapist. Wound debridement services may only be provided by a physical therapist with written authorization from a health care provider. A physical therapist shall promptly consult and collaborate with the appropriate health care professional anytime a patient's condition indicates that it may be related to temporomandibular disorder so that a diagnosis can be made by that health care professional for an appropriate treatment plan.

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: TEMPORARY PRIVILEGES

7.4(a) Temporary Privileges – Important Patient Care Need – Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Chief of Staff and pending MEC review and Board approval. “New applicant” includes an individual applying for clinical privileges at the Hospital for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

In these cases only, the CEO/ CAO or his/ her designee, upon recommendation of the Chief of Staff may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and

completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the Practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days of service.

The letter approving temporary privileges shall identify the specific privileges granted. Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

7.4(b) Temporary Privileges – Important Patient Care Need – No Pending Application

Temporary privileges may be granted by the CEO/ CAO upon recommendation of the Chief of Staff when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period, when no application for medical staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a Practitioner is needed to cover his/ her practice immediately Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a Practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the Practitioner establishing his/ her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service within a calendar year. All Practitioners providing coverage for other Practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, evidence of the Practitioner's license to practice medicine and DEA certificate and telephone confirmation of privileges at the Practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute Practitioner shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the Practitioner and the dates during which the services will be utilized to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(c) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff may, without applying for membership on the

Medical Staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the Practitioner establishing his/ her qualifications to the satisfaction of the MEC and the Board and in no event to exceed the period of proctorship, or a maximum of one hundred and twenty (120) days. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, evidence of the Practitioner's license to practice medicine and DEA certificate and confirmation of privileges at the Practitioner's primary hospital. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases, the CEO/ CAO or designee, upon recommendation of the President of the Medical Staff, Chairperson of the Credentials Committee and Chairperson of the applicable department, may grant such privileges upon receipt of the required information.

7.4(d) Conditions

Temporary and proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant's qualifications, ability, and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such applicant be admitted upon dual admission with a member of the Active Staff. Before temporary privileges are granted, the applicant must acknowledge in writing that he/ she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/ she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

Temporary privileges may not be granted to extend a Medical Staff appointment period absent a documented important/ immediate patient care need and compliance with all other requirements of these Medical Staff Bylaws.

7.4(e) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a Practitioner's qualifications or ability to exercise any or all privileges granted, the CEO/ CAO may, after consultation with the Chief of Staff terminate Practitioner's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment by the Practitioner, the termination may be affected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute Practitioner.

7.4(f) Rights of the Practitioner

A Practitioner shall not be entitled to procedural rights afforded by the Bylaws because of inability to obtain temporary or proctoring privileges or because of any termination or suspension of such privileges.

7.4(g) Term

No term of temporary or proctoring privileges shall exceed a total of one hundred twenty (120) days.

7.5 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: EMERGENCY & DISASTER PRIVILEGES

For this section, an "emergency" is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger, delay in administering treatment immediately would add to that danger and no appropriately credentialed individual can be available in the time required to respond. A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available Medical Staff members or AHPs is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, or disaster as defined herein, any Practitioner, or AHP, to the degree permitted by his/ her license and regardless of staff status or clinical privileges, shall, as approved by the CEO/ CAO or his/ her designee or the Chief of Staff, be permitted to do, and be assisted by Hospital personnel in doing everything reasonable and necessary to save the life of a patient or to prevent imminent harm to the patient.

Disaster privileges may be granted by the CEO/ CAO or Chief of Staff when and so long as the Hospital's emergency management plan has been activated and the Hospital is unable to handle immediate patient needs. Prior to granting disaster privileges the volunteer Practitioner or AHP shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current Hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current Medical Staff member who possesses personal knowledge regarding the volunteer Practitioner's qualifications. The CEO/ CAO and/ or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours the Practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address emergency patient care needs. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the Practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Chief of Staff or designee shall review the decision to grant disaster privileges and shall, based on information obtained regarding the professional practice of the Practitioner, decide concerning continuation of disaster privileges.

In addition, each Practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that

clearly indicates the identity of the Practitioner and the scope of the Practitioner's disaster responsibilities and/or privileges. A member of the Medical Staff shall be assigned to each disaster volunteer Practitioner for purposes of overseeing the professional performance of the volunteer Practitioner through mechanisms such as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

7.6 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: TELEMEDICINE

7.6(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board of Trustees regarding clinical services appropriately delivered through the medium of telemedicine and the scope of services. Clinical services shall be provided consistent with commonly accepted quality standards. Physicians applying for clinical privileges to provide treatment to Hospital patients through telemedicine shall not be permitted to serve as the attending physician.

7.6(b) Telemedicine Physicians

Any physician who prescribes, renders diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the "telemedicine physician") must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in the Medical Staff Bylaws. An exception is outlined below for those circumstances in which the Practitioner's distant-site entity or distant-site hospital is Joint Commission accredited.

In circumstances in which the distant-site entity or distant-site hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telemedicine physician's credentialing information from the distant-site entity or distant-site hospital to credential and privilege the telemedicine physician ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

(1) The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), regarding to the distant-site entity's or distant-site hospital's physicians and practitioners providing telemedicine services.

(2) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and in accordance with 42 CFR § 482.12(e) furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services.

(3) The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet standards set forth in CMS Hospital Conditions of Participation.

(4) The telemedicine physician is privileged at the distant-site entity or distant-site hospital providing the telemedicine services and the distant-site entity or distant-site hospital provides the Hospital with a current list of the telemedicine physician's privileges at the distant-site entity or distant-site hospital.

(5) The telemedicine physician holds a license issued or recognized by the state in which the Hospital is located; and

(6) The Hospital has evidence or will collect evidence of an internal review of the physician's performance of telemedicine privileges at the Hospital and shall send the distant-site entity or distant-site hospital performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the physician and all complaints the Hospital has received about the physician) for use in periodic appraisal of the physician by the distant-site entity or distant-site hospital.

The Hospital will remain responsible for primary source verification of licensure, Medicare/ Medicaid eligibility and for query of the Data Bank. The Hospital shall also remain responsible for primary source verification of professional liability insurance unless the distant-site entity has provided the Hospital with a current certificate of insurance meeting the requirements set forth in these Bylaws and a malpractice claims history consistent with the standard claim history required for members of Medical Staff. Medical Staff shall comply with the Hospital telemedicine credentialing procedures manual when credentialing telemedicine physicians.

For the purposes of this Section, "distant-site entity" shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital using its services to meet applicable CMS Hospital Conditions of Participation particularly those related to the credentialing and privileging of physicians providing telemedicine services. For the purposes of this Section, "distant-site hospital" shall mean a Medicare-participating hospital that provides telemedicine services.

ARTICLE VIII - CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

When activities, omissions, or any professional conduct of a Practitioner with clinical privileges are detrimental to patient safety, delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Hospital operations, or violate provisions of the Bylaws, Medical Staff Rules and Regulations, or duly adopted policies and procedures, corrective action against the Practitioner may be initiated by any officer of Medical Staff, the CEO/ CAO, or Board. Procedural guidelines from the Health Care Quality Improvement Act shall be, and corrective action shall be taken in good faith in the interest of quality patient care.

Every adverse Medical Staff membership and clinical privileges decision based substantially on economic factors shall be reported pursuant to the Illinois Hospital Licensing Act before the decision takes effect.

8.1(b) Request & Notices

All requests for corrective action under this Section shall be submitted in writing to the MEC and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff shall promptly notify the CEO/ CAO or designee

in writing of requests for corrective action received by the MEC and continue to keep the CEO/ CAO or designee informed of all action taken.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting, whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the Hospital's Practitioner Wellness Policy. When the MEC is considering initiating an adverse action, it may interview the Practitioner. The Practitioner shall be informed of the general nature of the concerns and may present relevant information in response. Within sixty (60) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall act upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action.
(2) Recusing itself from the matter and referring to the Board without recommendation together with a statement of its reasons for recusing itself, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the physician.
(3) Issuing a warning or a reprimand to which the Practitioner may write a rebuttal if desired.
(4) Recommending a period of focused professional practice evaluation (FPPE).
(5) Recommending terms of probation or required consultation.
(6) Recommending reduction, suspension, or revocation of clinical privileges.
(7) Recommending reduction of Medical Staff category/ limitation of any Medical Staff prerogatives; or
(8) Recommending suspension or revocation of Medical Staff membership.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)(4), (5), (6), (7), or (8) where such action materially restricts a Practitioner's exercise of privileges, or any combination of such actions shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation but shall take no action until the member has either waived the right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3), (4), or (5) where such action does not materially restrict a Practitioner's exercise of privileges, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) Board Action

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board and shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan.

If the MEC fails to investigate or to adequately investigate, or to take appropriate disciplinary action, contrary to the weight of the evidence, the Board may direct the MEC to initiate or perform additional investigation or take disciplinary action or additional disciplinary action. If the MEC fails to take appropriate action in response to the Board's direction, the Board may initiate corrective action pursuant to the terms described in this Section.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1, whenever a Practitioner's conduct may require immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, the Chief of Staff, the CEO/ CAO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. The CEO/ CAO or designee shall, on behalf of the imposer, promptly give special notice of the suspension to the Practitioner.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended Practitioner's patients still in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the Chief of Staff and CEO/ CAO in enforcing all suspensions and in caring for the suspended Practitioner's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. If the MEC met as a full body to impose the summary suspension for investigational purposes (not to exceed fourteen (14) days), the MEC is not required to meet again within seventy-two (72) hours. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified within fourteen (14) days of the original imposition, such that the Practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify, or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the Practitioner's clinical privileges, the Practitioner shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 AUTOMATIC SUSPENSION

8.3(a) License

A Medical Staff member or AHP whose license, certificate, or other legal credential authorizing practice in any state is revoked relinquished, suspended, or restricted shall immediately and automatically be suspended from Medical Staff and practicing in the Hospital. Allowing license or certificate in another state to expire shall not result in automatic suspension, so long as no investigation, sanction or other action is active or pending.

8.3(b) Drug Enforcement Administration (DEA) Registration Number

Any Practitioner or AHP (except a pathologist and any other Practitioner or AHP whose scope of practice does not require DEA number/ controlled substance license or state equivalent as determined by the MEC and Board) whose DEA registration number/ controlled substance certificate or equivalent state credential is revoked, suspended or relinquished shall immediately and automatically be suspended from Medical Staff and practicing in the Hospital until such time as the registration is reinstated.

8.3(c) Medical Records

(1) Automatic suspension of a Practitioner's or AHP's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the Practitioner satisfies the Chief of Staff of a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Any Medical Staff member or AHP who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under subsection 8.3(c)(1) shall automatically be expelled from Medical Staff. Expulsion shall be effective the first day after the forty-fifth (45th) consecutive day of such automatic suspension. Any Medical Staff member or AHP who is automatically suspended five (5) times pursuant to Section 8.3(c)(1) in a rolling twelve-month period shall be automatically expelled from Medical Staff.

8.3(d) Malpractice Insurance Coverage

Any Practitioner or AHP unable to provide proof of current medical malpractice coverage in amounts prescribed in the Bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO/ CAO.

8.3(e) Failure to Appear/Cooperate

Failure of a Practitioner or AHP to appear at any meeting with respect to which given special notice and/ or failure to comply with reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of the Practitioner's or AHP's clinical privileges as the MEC may direct. Failure to complete required initial training/ updates regarding electronic health information systems as directed by the MEC and described in the Electronic Health Record Policy shall result in automatic suspension until such training is completed.

8.3(f) Exclusions/Suspension from Medicare

Any Practitioner or AHP who is excluded, debarred, suspended, or otherwise declared ineligible from any state or federal government health care program or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible) will be automatically suspended.

8.3(g) Contractual Prohibitions

Any Practitioner or AHP who is subject to any valid agreement (e.g., a non-compete agreement) that prevents practicing at the Hospital shall be immediately and automatically suspended from Medical Staff and practicing at the Hospital. The affected Practitioner or AHP shall not be reinstated unless or until the agreement is terminated or expires.

8.3(h) Felony

Any Practitioner or AHP who pleads guilty or no contest to or who has been convicted of a felony shall be immediately and automatically suspended from the Medical Staff and practicing at the Hospital.

8.3(i) Effect of Automatic Suspension

Notwithstanding the provisions of Section 8.3(c), any Practitioner or AHP who has been automatically suspended pursuant to this Section 8.3 for at least ninety (90) consecutive days shall have Medical Staff membership and/ or clinical privileges automatically terminated without any hearing rights. Any attempt to reapply for membership or privileges at the Hospital shall be processed in accordance with the Bylaws as an initial applicant.

8.3(j) Automatic Suspension/ Termination - Fair Hearing Plan Not Applicable

No Medical Staff member whose privileges are automatically suspended or terminated under Section 8.3, shall have the right of hearing or appeal as provided under Article IX of these Bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended/ terminated Practitioner's patients.

8.3(k) Chief of Staff

It shall be the duty of the Chief of Staff to cooperate with the CEO/ CAO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO/ CAO or designee shall periodically keep the Chief of Staff informed of the names of Medical Staff members who have been suspended or expelled under Section 8.3.

8.4 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws for peer review and corrective action.

8.5 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action, the Practitioner or AHP may be summarily placed under supervision concurrently with the initiation of professional review activities until final determination is made regarding privileges. Chief of Staff, the CEO/ CAO, or the Board shall have the right to impose supervision.

8.6 PROTECTION FROM LIABILITY

All members of the Board, Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 6.3(c) of the Bylaws.

8.7 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1 or 8.2 shall not be considered for appointment to Medical Staff for a period of five (5) years after notice is sent or until the defect constituting grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as Medical Staff or the Board may require.

8.8 FALSE INFORMATION ON APPLICATION

Any Practitioner or AHP who, after being granted appointment and/ or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately and automatically terminated appointment and clinical privileges. No Practitioner or AHP who is deemed to have lost appointment and clinical privileges pursuant to this Section shall be entitled to procedural rights under the Bylaws and Fair Hearing Plan except the MEC may upon written request from the Practitioner or AHP permit the Practitioner or the AHP to appear before it and present information. If permitted by the MEC, the MEC shall review the material presented and render a decision as to whether the finding was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX - INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a Practitioner, it may in its discretion give the Practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a Practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in

accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, initiating FPPE, nor any other actions which do not materially restrict the Practitioner's exercise of clinical privileges, shall give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING AHPS

Any adverse actions affecting AHPs shall be accomplished in accordance with Section 5.4 of these Bylaws.

ARTICLE X - OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the Medical Staff shall be:

(1) Chief of Staff.
(2) Vice-Chief of Staff.
(3) Secretary.
(4) Treasurer.

10.1(b) Qualifications

Officers must be members of Active Staff at time of nomination and election and must remain in good standing during the term of office. Failure to maintain such status shall create a vacancy in the office.

10.1(c) Nominations

(1) The Nominating Committee shall consist of the Chief of Staff, Vice-Chief of Staff and CEO/ CAO. This committee shall offer one (1) or more nominees for each office to the Medical Staff thirty (30) days before the annual meeting.
(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff with a signed statement of willingness to serve by the nominee filed with the Chief of Staff at least thirty (30) days before the annual meeting.

10.1(d) Election

Officers shall be elected at the annual meeting of the Medical Staff and when otherwise necessary to fill vacancies. Only members of Active Staff present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot as determined by members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all valid ballots cast, subject to approval by the Board of Trustees which approval may be withheld only for good cause.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below standards established by Medical Staff, undermining a culture of safety, or to be disruptive to or interfering with operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Staff or Board. Reasons for removal may include, but shall not be limited to, violation of these Bylaws, breaches of confidentiality or unethical behavior. Removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

10.1(f) Term of Elected Officers

Each officer shall serve a two (2) year term commencing on the first day of Medical Staff year following election. Each officer shall serve until the end of the term and until a successor is elected, unless resignation or removal from office. Officers may continue to serve the MEC if elected per approval of the majority of those present at the annual staff meeting.

10.1(g) Vacancies in Elected Office

Vacancies in office other than Chief of Staff shall be filled by the MEC until an election can be held. If there is a vacancy in the office of Chief of Staff the Vice-Chief of Staff shall serve the remaining term.

10.1(h) Duties of Elected Officers

(1) Chief of Staff: The Chief of Staff shall serve as principal official of the Medical Staff. He/she will:

(i) appoint multi-disciplinary Medical Staff committees.

(ii) aid in coordinating activities of the Hospital administration and of nursing and other non-physician patient care services with those of Medical Staff.

(iii) be responsible to the Board in conjunction with the MEC for quality and efficiency of clinical services and professional performance within the Hospital and for effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff, work with the Board in implementation of the Board's quality, performance, efficiency, and other standards.

(iv) in concert with the MEC and Credentials Committee, develop and implement methods for credentials review and for delineation of privileges, along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies.

(v) participate in the selection or appointment of Medical Staff representatives to Medical Staff and Hospital management committees.

(vi) report to the Board and CEO/ CAO concerning the opinions, policies, needs and grievances of the Medical Staff.

(vii) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for implementation of sanctions when indicated compliance with procedural safeguards where corrective action has been requested against a Practitioner.

(viii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff.

(ix) serve as a voting member of the MEC and an ex-officio member of all other Medical Staff committees or functions.
(x) assist in coordinating the educational activities of the Medical Staff.
(xi) serve as liaison for the Medical Staff in its external professional and public relations.
(xii) confer with the CEO/ CAO, CFO, CNO and Service Chiefs as necessary to determine whether sufficient space, equipment, staffing, and financial resources are available or will be available within a reasonable time to support privileges requested by applicants to Medical Staff and report findings to the MEC and Board; and
(xiii) assist the Service Chiefs obtain the types and amounts of data used in determining/ informing the Medical Staff of the professional practice of its members.

(2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC. In absence of the Chief of Staff, he/ she shall assume the duties and have authority of the Chief of Staff. He/ She shall perform duties as may be assigned by the Chief of Staff, the MEC or the Board.

(3) Secretary: The duties of the Secretary shall be to:
(i) give proper notice of all Medical Staff meetings.
(ii) prepare accurate and complete minutes for MEC and Medical Staff meetings.
(iii) assure an answer is rendered to all official Medical Staff correspondence.
(iv) be responsible for preparation of financial statements and report status of Medical Staff funds, if any; and
(v) perform such other duties as ordinarily pertain to the office.

(3) Treasurer: The duties of the Treasurer shall be to:
(i) be responsible for preparation of financial statements and report status of Medical Staff funds, if any; and
(ii) perform such other duties as ordinarily pertain to the office.

10.1(i) Conflict of Interest

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members and AHPs who are objective in the pursuit of their duties, and exhibit objectivity. The decision-making process of the Medical Staff may be altered by interests or relationships which might, either intentionally or coincidentally, bear on opinions or decision. It is considered in the best interest of the Hospital and Medical Staff for relationships of any Medical Staff member or AHP which may influence decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member or AHP shall use the position to obtain or accrue any improper benefit. All Medical Staff members and AHPs shall avoid even the appearance of influencing the actions of any other Medical Staff member, AHP or employee of the Hospital or Corporation except through vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/ or clinical privileges, or appointed as an AHP and granted privileges and upon any grant of reappointment and/ or renewal of clinical privileges, each Medical Staff member and AHP shall file with the MEC a written statement describing each actual or proposed relationship of that member or AHP, whether economic or otherwise, other than the member's status as a Medical Staff member, AHP's status and grant of privileges at the Hospital, and/ or a member of the community which in any way and to any degree may impact on the finances or operations of the Hospital or its Medical Staff, or the Hospital's relationship to the community, including but not limited to:

(1) Any leadership position on another medical staff or educational institution that creates a fiduciary obligation on behalf of the Practitioner or AHP, including, but not limited to membership on the governing body, executive committee, or service chairmanship with an entity or facility that competes directly or indirectly with the Hospital.
(2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital.
(3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or
(4) Business practices that may adversely affect the Hospital or community.

A new Medical Staff leader (defined as any member of the Medical Executive Committee, officer of the Medical Staff, and/ or members of Medical Staff who are members of the Hospital's Board of Trustees) shall file the written statement immediately upon being elected or appointed to leadership positions. This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures if uncertain on the side of disclosure including ownership and control of any health care delivery organization related to or competes with the Hospital. This disclosure requirement will not require any action which would be a breach of any state or federal confidentiality law but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict as required by this Section or failure to abstain from voting on an issue in which Medical Staff member has an interest other than as fiduciary of Medical Staff may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal from leadership position by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI - COMMITTEES & FUNCTIONS

11.1 GENERAL PROVISIONS

11.1(a) The standing committees and functions of Medical Staff are set forth. The MEC shall appoint special or ad hoc committees to perform functions not within the stated functions of the standing committees.

11.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

11.1(c) All information pertaining to activities performed by Medical Staff and committees shall be privileged and confidential to the full extent provided by law.

11.1(d) The CEO/ CAO or designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

11.2 MEDICAL EXECUTIVE COMMITTEE

11.2(a) Composition

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson.
(2) One (1) Physician Members at large to be appointed by the Board.
(3) Secretary to the Medical Staff.
(4) Treasurer to the Medical Staff.
(5) The CEO/ CAO, ex-officio, or designee.

11.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between Medical Staff, Hospital administration and the Board and shall be empowered to act for Medical Staff in intervals between Medical Staff meetings. All Active Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section and additional functions may be delegated or removed through amendment of this Section. The functions/ responsibilities of the MEC shall include:

(1) Receiving and acting upon committee reports.
(2) Implementing approved policies of the Medical Staff.
(3) Recommending to the Board matters relating to appointments and reappointments, delineation of clinical privileges, Medical Staff category and corrective action.
(4) Fulfilling Medical Staff's accountability to the Board for quality of medical care rendered to the patients in the Hospital.
(5) Initiating and pursuing corrective action when warranted in accordance with Medical Staff Bylaws.
(6) Recommending action to the CEO/ CAO on matters of a medico-administrative nature.
(7) Developing and implementing programs for continuing medical education for Medical Staff.
(8) Developing and implementing programs to inform Medical Staff about physician health and recognition of illness and impairment in physicians and addressing prevention of physical, emotional, and psychological illness.
(9) Assuring regular reporting of performance improvement and other Medical Staff issues to the MEC and to the Board of Trustees and communicating findings,

conclusions, recommendations, and actions to improve performance to the Board and appropriate Medical Staff members.

(10) Evaluating areas of risk in clinical aspects of patient care and safety and proposing plans and recommendations for reducing risks.

(11) Assuring an annual evaluation of effectiveness of the Hospital's performance improvement program is conducted.

(12) Informing Medical Staff of regulatory/ accreditation programs/ status of the Hospital.

(13) Requesting evaluation of Practitioners when there is doubt about an applicant's ability to perform privileges requested. Initiating an investigation of any incident, conduct, or allegation indicating an applicant or Practitioner on Medical Staff may not be complying with the Bylaws, may be rendering care below standards established for Practitioners or not be qualified for continued Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards.

(14) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

(15) Developing and monitoring compliance with the Bylaws, Rules & Regulations, policies, and other Hospital standards; and

(16) Making recommendations to the Board regarding Medical Staff structure and mechanisms for review of credentials and delineation of privileges, fair hearing procedures and mechanism by which Medical Staff membership may be terminated.

11.2(c) Meetings

The MEC shall meet as needed but at least monthly and maintain a permanent record of its proceedings and actions.

11.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the Chief of the Medical Staff when a quorum of the MEC can be convened.

11.2(e) Removal of MEC Members

The removal process including the reasons for removal for those members at large of the MEC who are elected by Medical Staff shall be the same as described in Section 10.1(e) with respect to Medical Staff officers. Those members at large of the MEC who are appointed by the Board may be removed by a two-thirds (2/3) majority of the Board for those reasons described in Section 10.1(e) with respect to Medical Staff officers.

All other members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions. Officers of the Medical Staff who are ex officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e).

11.3 MEDICAL STAFF FUNCTIONS

11.3(a) Composition of Committees

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

11.3(b) Functions

The functions of Medical Staff are to:

(1) Monitor, evaluate, and improve care provided in and develop clinical policy for all areas including special care areas, support services, physical medicine, anesthesia, emergency, surgical, and outpatient care.

(2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood/ blood component usage, drug usage, medical record, and other appropriate reviews.

(3) Conduct or coordinate utilization review activities.

(4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new developments, services provided within the Hospital and perceived needs and supervise Hospital's professional library services.

(5) Develop and maintain surveillance over drug utilization policies and practices.

(6) Investigate and control nosocomial infections and monitor the Hospital's infection control program.

(7) Plan for response to fire and other disasters, Hospital growth and development, and provision of services required to meet the needs of the community.

(8) Direct Medical Staff organizational activities, including Medical Staff Bylaws, review and revision, Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation.

(9) Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care and provide a mechanism to coordinate care provided by members of Medical Staff with care provided by nursing and with the activities of other services.

(10) Medical Staff has adopted a Practitioner Wellness Policy (Appendix B). to provide education about Practitioner health, prevent physical, psychiatric, or emotional illness and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from potentially impairing conditions. The Practitioner Wellness Policy affords resources separate from the corrective action process to address physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling, or referrals.

(11) Provide leadership in activities related to patient safety.

(12) Ensure Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on activities of individuals with clinical privileges:

- (i) medical assessment and treatment of patients.
- (ii) use of medications, use of blood/ blood components.
- (iii) use of operative and other procedure(s).
- (iv) efficiency of clinical practice patterns; and
- (v) significant departure from established patterns of clinical practice.

(13) Ensure Medical Staff participates in the measurement, assessment, and improvement of other patient care processes, including, but not limited to:

- (i) education of patients and families.
- (ii) coordination of care, treatment and services with Practitioners and Hospital personnel.

(iii) accurate, timely and legible completion of medical records including history and physicals.
(iv) patient satisfaction.
(v) sentinel events; and
(vi) patient safety.

(14) Ensure when findings of assessment processes are relevant to an individual's performance, the Medical Staff determines use in peer review or the ongoing evaluation of a Practitioner's competence.

(15) Recommend to the Board policies and procedures that define trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a Practitioner's performance and evaluation of a Practitioner's performance by peers. The process and procedure for focused professional review shall be substantially in accord with the Hospital's Peer Review Policy, Appendix "D" to these Bylaws. The information relied upon to investigate a Practitioner's professional conduct and practice may include internal or external chart reviews, prospective, concurrent and/ or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, assistants, nursing, or administrative personnel involved in the care of patients.

(16) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis.

(17) Engage in functions reasonably requested by the MEC and Board or those outlined in the Medical Staff Rules & Regulations, or other policies of Medical Staff.

(18) Review and evaluate qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges.

(19) Periodically review applications for reappointment including information regarding competence of Medical Staff members and make recommendations for the granting of privileges and reappointments.

(20) Investigate any breach of ethics reported.

(21) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and

(22) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

11.3(c) Meetings

The functions shall be performed as required by state and federal regulatory requirements, accrediting agencies, and as deemed appropriate by the MEC and the Board.

11.4 CONFLICT RESOLUTION COMMITTEE

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Committee shall consist of two (2) members of Medical Staff selected by the Medical Executive Committee (and may or may not be members of the Board), two (2) non-physician Board members who are selected by the Board Chair and the CEO/ CAO. The Committee shall meet as needed when a conflict arises that if not managed could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, resolve the conflict and protect safety and quality of care.

ARTICLE XII - MEETINGS

12.1 ANNUAL MEDICAL STAFF MEETING

12.1(a) Meeting Time

The annual Medical Staff meeting shall be held at a date, time and place as determined by MEC.

12.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff, including:

(1) Reading and accepting minutes of the last regular and all special meetings held since the last regular meeting.
(2) Administrative reports from the CEO/ CAO or designee, Chief of Staff, and appropriate Service Chiefs.
(3) The election of officers and other officials of the Medical Staff when required by the Bylaws.
(4) Recommendations for maintenance and improvement of patient care; and
(5) Other old or new business.

12.2 REGULAR MEDICAL STAFF MEETINGS

12.2(a) Meeting Frequency & Time

The Medical Staff shall meet quarterly. The Medical Staff may by resolution designate the time for holding regular meetings and no notice other shall be required. If the date, hour, or place of a regular Medical Staff meeting must be changed for any reason, the notice procedure in Section 12.3 shall be followed.

12.2(b) Order of Business & Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff.

12.2(c) Special Meetings

Special meetings of the Medical Staff or committee may be called at any time by the Chief of Staff or, for Committees, the Chief of Staff or Committee Chair and held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

12.3 NOTICE OF MEETINGS

The MEC may by resolution provide the time for holding regular meetings and no other notice shall be required. If a special meeting is called or if the date, hour, and place of a regular Medical Staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

13.4(a) General Medical Staff Meeting

The voting members of the Active Staff present at a Medical Staff meeting shall constitute a quorum for the transaction of all business at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

13.4(b) Committee Meetings

The active medical staff members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee; except the MEC shall require fifty (50%) percent of members to constitute a quorum.

12.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

12.6 MINUTES

Minutes of all meetings shall be prepared by the Secretary of the meeting or designee and shall include a record of attendance and the votes taken. Copies of minutes shall be signed by the presiding officer and approved by the attendees. A permanent file of the minutes of each meeting shall be maintained. Complete minutes must be recorded and maintained.

12.7 ATTENDANCE

12.7(a) Regular Attendance

Members of the Medical Staff are encouraged and expected to attend 50% of the regular and special meetings of Medical Staff and committees of which they are members. Any member who is compelled to be absent from Medical Staff or committee meeting shall promptly provide, in writing to the regular presiding officer the reason for absence.

12.7(b) Special Appearance: Cooperation with the MEC

Any committee of Medical Staff may request appearance of a Medical Staff member at a committee meeting when the committee is questioning the Practitioner's clinical course of treatment. Special appearance requirements shall not be considered adverse action and shall not constitute a hearing under the Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved advance notice of the time and place of the meeting shall be given to the Practitioner. When special notice is given, it shall include a statement of the issue involved and the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at a meeting with respect to which given special notice and/or failure to comply with any reasonable directive of the MEC shall unless excused by the MEC upon a showing of good cause result in automatic suspension of all or portion of the Practitioner's clinical privileges as the MEC may direct. Suspensions shall remain in effect until the matter is resolved by the MEC or the Boar, or through corrective action if necessary.

ARTICLE XIII - GENERAL PROVISIONS

13.1 STAFF RULES & REGULATIONS AND POLICIES

Subject to approval by the Board, Medical Staff shall adopt Rules & Regulations and policies necessary to implement general principles found within the Bylaws. These shall relate to proper conduct of Medical Staff organizational activities and embody the level of practice required of each staff member or affiliate in the Hospital. The Rules & Regulations shall be considered a part of the Bylaws except they may be amended or repealed at any regular Medical Staff meeting at which a quorum is present and without previous notice or at any special meeting on notice by a majority vote of those present and eligible to vote. Changes shall become effective when approved by the Board. The Rules & Regulations shall be reviewed periodically and revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices.

13.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of Medical Staff propose to adopt a rule, regulation or policy, or an amendment, they must first communicate the proposal to the MEC. Where the MEC proposes to adopt a rule or regulation or amendment it must first communicate the proposal to the Medical Staff. The MEC is not required to communicate adoption of a policy or an amendment prior to adoption. The MEC must promptly communicate action to Medical Staff.

13.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to Rules & Regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. The Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 13.1(c) of this Article shall be implemented.

13.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between Medical Staff and MEC on issues including proposals to adopt a rule, regulation, or policy or an amendment this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing is intended to prevent Medical Staff from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board's final authority as to such issues.

13.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment and except in the case of a provisional adoption provided for in Section 13.1(b) no such rule, regulation or policy or amendment shall be effective until approved by the Board.

13.2 PROFESSIONAL LIABILITY INSURANCE

Each Practitioner or AHP granted clinical privileges and/or Medical Staff membership in the Hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions or should the state have no minimum statutory requirement in an amount not less than $1,000,000.00 in indemnity limits per occurrence and $3,000,000.00 in indemnity in aggregate. Policies in which defense costs reduce available indemnity limits ("wasting policies") do not meet the requirements.

The insurance coverage shall be with a carrier reasonably acceptable to the Hospital and shall be on an occurrence basis or if on a claims made basis the Practitioner shall agree to obtain tail coverage covering practice at the Hospital. Each Practitioner shall also provide annually to the MEC and CEO/ CAO the details of such coverage including evidence of compliance with all provisions of this paragraph. He/ She shall be responsible for advising the MEC and CEO/ CAO of any change in coverage.

13.3 FORMS

Application forms and any other prescribed forms required by the Bylaws for use with appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO/ CAO or designee subject to adoption by the Board after considering the advice of the MEC. Forms shall meet applicable legal requirements including non-discrimination requirements.

13.4 CONSTRUCTION OF TERMS & HEADINGS

Words used in the Bylaws shall be read as masculine or feminine gender and as singular and plural as the context requires. The captions or headings in the Bylaws are for convenience and not intended to limit or define scope or effect.

13.5 TRANSMITTAL OF REPORTS

Reports and other information which the Bylaws require Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO/ CAO or designee.

13.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

13.6(a) Reports to be Confidential.

Information with respect to any Practitioner, including applicants, Medical Staff members or AHPs, submitted, collected, or prepared by any representative of the Hospital including its Board or Medical Staff, related to achievement of quality care or contribution to clinical research shall to the extent permitted by the law be confidential and not be disseminated beyond those who need to know. Confidentiality shall apply to information provided by third parties.

13.6(b) Release from Liability

No representative of the Hospital, including Board, CEO/ CAO, administrative employees, Medical Staff or third party shall be liable to a Practitioner or AHP for damages or other

relief by reason of providing information including privileged and confidential information to a representative of the Hospital including Board, CEO/ CAO or designee, or Medical Staff or to any other organization concerning a Practitioner or AHP who is/ has been an applicant to or member of the staff or who has exercised clinical privileges or provided specific services for the Hospital provided disclosure is in good faith and without malice.

13.6(c) Action in Good Faith

The representatives of the Hospital, including Board, CEO/ CAO, administrative employees and Medical Staff shall not be liable to a Practitioner or AHP for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties if such representative acts in good faith and without malice after a reasonable effort to ascertain facts in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XIV - ADOPTION & AMENDMENT OF BYLAWS

14.1 DEVELOPMENT

The Medical Staff shall have initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments effective when approved by the Board. The Medical Staff shall exercise responsibility in a reasonable, timely and responsible manner reflecting the interest of providing patient care of recognized quality and efficiency and maintaining a harmony of purpose and effort with the Hospital, the Board, and community.

Medical Staff has been advised of their right to opt out of a unified and integrated medical staff structure by majority vote to maintain a separate medical staff for the hospital.

14.2 ADOPTION, AMENDMENT & REVIEWS

The Bylaws shall be reviewed and revised periodically as needed. When necessary, the Bylaws will be revised to reflect changes in regulatory requirements, corporate and Hospital policies, and current.

14.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended, or repealed by the affirmative vote of a two-thirds of the Medical Staff members eligible to vote who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written or electronic notice, accompanied by proposed bylaws and/or alternatives has been given. This action requires the approval of the Board.

14.2(b) Board

The Medical Staff Bylaws may be adopted, amended, or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of Medical Staff. If Medical Staff fails to act within a reasonable time after notice from the Board, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or comply with accreditation standards or applicable law. Should the Board act upon its own initiative it shall consult with Medical Staff at the next regular staff meeting or at a special called meeting as provided and shall advise the staff of the basis for its action.

14.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to the Bylaws shall be documented by:

14.3(a) Appending the approved amendment which shall be dated and signed by the Chief of Staff, CEO/ CAO, and Chairperson of the Board of Trustees; or

14.3(b) Restating the Bylaws incorporating the approved amendments and prior approved amendments appended to the Bylaws since last restatement, 7dated and signed by the Chief of Staff, CEO/ CAO and Chairperson of the Board of Trustees.

Each member of Medical Staff shall be given a copy of any amendments to the Bylaws in a timely manner, upon request.

HOSPITAL FAIR HEARING PLAN

This Fair Hearing Plan is adopted in connection with Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the Fair Hearing Plan and proceedings hereunder.

D E F I N I T I O N S

The following definitions in addition to those stated in Medical Staff Bylaws or herein shall apply to provisions of this Fair Hearing Plan.

1. "Appellate Review Body": The group designated to hear a request for Appellate Review properly filed and pursued by the Practitioner.
2. "Corporation": Red Bud Regional Hospital.
3. "Hearing Committee": Committee appointed to hear a request for evidentiary hearing properly filed and pursued by a Practitioner.
4. "Parties": Practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.
5. “Practitioner”: A physician, dentist, or podiatrist who has been granted clinical privileges at the Hospital.
6. "Special Notice": Written notification sent by certified or registered mail, return receipt requested, or delivered by hand with a written acknowledgment of receipt.

ARTICLE I: INITIATION OF HEARING

1.1 RECOMMENDATION OR ACTIONS

The following recommendations or actions shall if deemed adverse pursuant to Article I, Section 1.2 of this Fair Hearing Plan (hereinafter “Plan”), entitle the Practitioner affected thereby to a hearing:

(1) Denial of initial staff appointment unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment.
(2) Denial of reappointment unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment.
(3) Suspension of staff membership for a period more than thirty (30) days except automatic suspensions pursuant to the Medical Staff Bylaws.
(4) Revocation of staff membership.
(5) Denial of requested advancement of staff category if denial materially limits the exercise of privileges.
(6) Reduction of staff category due to adverse determination of a Practitioner’s competence or professional conduct.
(7) Limitation of the right to admit patients for a period more than thirty (30) days unless based upon a reduction of staff category not related to adverse determination of a Practitioner’s competence or professional conduct.
(8) Denial of an initial request for clinical privileges, unless based upon failure to meet basic objective criteria for the privileges requested.
(9) Reduction of clinical privileges for a period more than thirty (30) days.

(10) Permanent suspension of clinical privileges except automatic suspensions pursuant to Medical Staff Bylaws.
(11) Permanent revocation of clinical privileges.
(12) Terms of probation or consultation, if such terms of probation or consultation materially restrict exercise of privileges for more than thirty (30) days; and
(13) Summary suspension of privileges or staff membership for a period more than fourteen (14) days.

1.2 WHEN DEEMED ADVERSE

A recommendation or action listed in Article I, Section 1.1 of this Plan shall be deemed adverse only if based upon competence or professional conduct, is Practitioner -specific and has been:

(1) Recommended by the MEC; or
(2) Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or
(3) Taken by the Board on its own initiative without prior recommendation by the MEC.

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Article I, Section 1.1 of this Plan shall promptly be given special notice of such action:

(1) Advise the Practitioner of the basis and the right to a hearing pursuant to provisions of Medical Staff Bylaws of this Plan.
(2) Specify the Practitioner has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted except in the case of a suspension. The Practitioner shall be notified he/ she is entitled to an expedited hearing within fifteen (15) days of the action if the Practitioner meets the requirements of Section 1.4 below.
(3) State failure to request a hearing within the specified time shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter.
(4) State upon receipt of hearing request, the Practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, a list of the witnesses expected to testify and provided the right to inspect information in the Hospital's possession with respect to the decision.
(5) Provide a summary of the Practitioner's rights at the hearing; and
(6) Inform the Practitioner if the recommended action may be reportable to the National Practitioner Data Bank and appropriate licensing agencies.

1.4 REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following receipt of a notice pursuant to Article I, Section 1.3 to file a written request for a hearing except in the case of a suspension. The Practitioner must request a hearing within two (2) business days of receipt of notice should he/ she desire expedited hearing as permitted by the Medical Staff Bylaws. Failure to submit request within two (2) business days shall be deemed a request by the Practitioner to comply with the time frames established by the Health Care Quality Improvement Act. Requests shall be delivered to the CEO/ CAO either in person or by certified or registered mail.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified waives any right to hearing and to Appellate Review to he/ she might otherwise have been entitled. Such waiver in connection with:

(1) An adverse recommendation or action by the Board, CEO/ CAO or designees shall constitute acceptance of recommendation or action; and

(2) An adverse recommendation by the MEC or designee shall constitute acceptance of recommendation which shall become and remain effective pending final decision of the Board. The Board shall consider the MEC's recommendation at its next regular meeting following the waiver. In deliberations the Board shall review relevant information and material considered by the MEC and may consider other relevant information received from any source. The Board's action shall constitute a final decision of the Board. The CEO/ CAO shall promptly send the Practitioner special notice informing of action taken pursuant to Article I, Section 1.5(2) and shall notify the Chief of Staff and the MEC.

ARTICLE II: HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

Upon receipt of a timely request for hearing, the CEO/ CAO shall deliver request to the Chief of Staff or the Board depending on whose recommendation or action prompted the request for hearing. The CEO/ CAO shall send the Practitioner special notice of the time, place, and date of the hearing. The hearing will begin as soon as practicable, but no sooner than thirty (30) days from the date of the notice of time, place and date, unless an earlier hearing date has been specifically agreed to in writing by the parties. A hearing for a Practitioner under suspension then in effect shall, at the Practitioner's request, be held as soon as arrangements for it reasonably may be made but not later than fifteen (15) days from the initiation of the summary suspension.

2.2 STATEMENT OF ISSUES & EVENTS

The notice of hearing required by Article II, Section 2.1 shall contain a concise statement of the Practitioner's alleged act or omissions and a list by number of specific or representative patient records in question and/ or other reasons or subject matter forming the basis for adverse recommendation or action which is the subject of the hearing. The notice shall contain a list of witnesses expected to testify in support of the adverse recommendation or action and the names of the Hearing Committee members and Presiding Officer if known.

2.3 PRACTITIONER'S RESPONSE

Within ten (10) days of receipt of the notice of hearing under Section 2.1 the affected Practitioner shall deliver by special notice a list of witnesses expected to testify at the due process hearing.

2.4 EXAMINATION OF EVIDENCE

The Practitioner may request to be allowed to examine documents to be introduced in support of adverse recommendation. If the Practitioner requests, the body initiating the adverse action shall be entitled to examine documents expected to be produced by the Practitioner at the hearing. The parties shall exchange such documents at a mutually agreeable time at least ten (10) days prior to the pre-hearing conference. Copies of any patient charts, which form the basis for the adverse action shall be made available to the Practitioner, at his/her expense, within a reasonable time after a request is made for same.

Neither the Practitioner, nor any other person acting on behalf of the Practitioner, may contact Hospital employees or individuals whose names appear on the Medical Executive Committee's or Board's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such witnesses and confirmed their willingness to meet. Any witness may agree or decline to be interviewed by or on behalf of the Practitioner who requested a hearing.

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

A hearing occasioned by an adverse MEC recommendation pursuant to Article I, Section 1.2(1) shall be conducted by a Hearing Committee appointed by the CEO/ CAO after consultation with the Chief of Staff and composed of three (3) members of the Medical Staff. None of the Hearing Committee members shall be partners, associates, relatives or in direct economic competition with the affected individual. Should the Chief of Staff find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize practitioners outside the staff, upon approval by the CEO/ CAO, may appoint an independent panel of three (3) practitioners meeting all requirements except for Medical Staff membership.

The affected individual shall have ten (10) days after notice of appointment of the Hearing Committee members to object and identify in writing any conflict of interest with any Hearing Committee members the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the individual to object and identify conflicts of interest shall constitute a waiver. Within seven (7) days of receipt of the objections, the CEO/ CAO shall determine whether grounds asserted by the individual are sufficient for disqualification. The Chief of Staff shall be given reasonable opportunity to comment. If a determination is made a disqualification is appropriate, a replacement shall be appointed within seven (7) days of the determination. The CEO/CAO shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(b) By Board

A hearing occasioned by adverse action of the Board pursuant to Article I, Section 1.2(2) or 1.2(3) shall be conducted by a Hearing Committee appointed by the Chairperson of the Board and composed of three (3) people. At least one (1) Active Medical Staff member shall be included on this committee. Should the Board Chairperson find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize a practitioner outside the staff, upon approval by the CEO/ CAO, may appoint a practitioner meeting all requirements of this section except for Active Medical Staff membership. One (1) of the appointees to the committee shall be designated as Chairperson. If the matter concerns or arises from issues regarding a Practitioner's clinical competence or performance, the Hearing Committee must be composed of three (3) physicians who may or may not be members of the Hospital's Medical Staff.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee members which the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the Board Chairman shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made disqualification is appropriate, a replacement shall be appointed within seven (7) days of the determination. The Board Chairman shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(c) Service on Hearing Committee

A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee solely because of participation in investigating the action or matter at issue. Employment by or other contractual arrangement with the Hospital or affiliated entity will not preclude an individual from serving on the Hearing Committee.

2.6 PRE-HEARING CONFERENCE

A pre-hearing conference shall be scheduled at least fourteen (14) days prior to the hearing. The Presiding Officer will require the Practitioner who requested the hearing and the MEC or Board, as appropriate or a representative of each who may be counsel to participate in a pre-hearing conference. All objections to exhibits or witnesses will be submitted in writing five (5) days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions including any objections to exhibits or witnesses. Evidence unrelated to reasons for the recommendation or to the individual's qualifications for membership or relevant clinical privileges will be excluded. The Presiding Officer will establish the time allotted to each witness's testimony and cross-examination. The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

ARTICLE III: HEARING PROCEDURE

3.1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived rights in the same manner and with the same consequence as provided in Article I, Section 1.5.

3.2 PRESIDING OFFICER

Either the Hearing Officer if one is appointed pursuant to Article VIII, Section 8.1 or the Chairperson of the Hearing Committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure participants have a reasonable opportunity to present relevant oral and documentary evidence. He/ She shall be entitled to determine the order of

procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

3.3 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of Medical Staff in good standing, a member of local professional society, or other individual of the physician's choice. The MEC or Board depending on whose recommendation or action prompted the hearing shall appoint an individual to present facts in support of adverse recommendation or action and examine witnesses. Representation of either party by an attorney shall be governed by provisions of Article VIII, Section 8.2.

3.4 RIGHTS OF THE PARTIES

3.4(a) During a hearing each of the parties shall have the right to:

(1) Call and examine witnesses.
(2) Present evidence determined relevant by the Presiding Officer regardless of its admissibility in a court of law.
(3) Cross-examine any witness on any matter relevant to the issues.
(4) Impeach any witness.
(5) Rebut any evidence.
(6) Have a record made of the proceeding copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and
(7) Submit a written statement at the close of the hearing at a time designated by the Presiding Officer and agreed upon by the parties.

If any Practitioner who requested the hearing does not testify, he/ she may be called and examined as if under cross-examination.

3.5 PROCEDURE & EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence although these rules may be considered in determining the weight of the evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/ her and entitled to notarize documents in the state where the hearing is held. The Hearing Committee may question witnesses and the parties during the hearing.

3.6 OFFICIAL NOTICE

In reaching a decision, the Hearing Committee may take official notice either before or after submission of the matter for decision of any generally accepted technical, medical, or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and shall be noted in the hearing record. Any party shall be given opportunity on timely motion to request a matter be officially noticed and refute the

officially noticed matters by evidence or written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

3.7 BURDEN OF PROOF

(1) When a hearing relates to initial appointment, advancement of staff category, or denial of an initial request for clinical privileges, the Practitioner who requested the hearing shall have the burden of proving by clear and convincing evidence the adverse recommendation or action lacks any substantial factual basis or is arbitrary, capricious, or impermissibly discriminatory.

(2) For matters listed in Article I, Section 1.1, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof. The Practitioner shall be responsible for supporting the challenge to the adverse recommendation/ action by a preponderance of the evidence that the grounds lack any substantial factual basis, or the action is arbitrary, capricious, or impermissibly discriminatory. The standards of proof shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

3.8 RECORD OF HEARING

A record of the hearing shall be kept of sufficient accuracy to permit an informed and valid judgment to be made by any group called upon to review the record and render a recommendation in the matter. The method of recording the hearing shall be by use of a court reporter.

3.9 POSTPONEMENT

Request for postponement of a hearing shall be granted by agreement between the parties or the Hearing Committee only upon a showing of good cause and only if the request therefore is made as soon as is reasonably practical.

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from a substantial portion of the proceedings, he/ she shall not be permitted to participate in the deliberations of the decision.

3.11 RECESSES & ADJOURNMENT

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence for consultation. Upon conclusion of oral and written evidence, the hearing shall be closed. The Hearing Committee shall conduct deliberations outside the presence of the parties and without a record of the deliberation being made. Upon conclusion of deliberations the hearing shall be declared finally adjourned.

ARTICLE IV: HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

The Hearing Committee shall make a written report of findings and recommendations within thirty (30) days of receiving written closing statements from the parties, or if no closing statements will be provided thirty (30) days after the hearing ends. The Hearing Committee shall

forward, together with the hearing record and all other documentation, to the Board or MEC for action consistent with Section 4.2. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and documentation considered. Recommendations must be made by a majority vote of the members and the committee may only consider the specific recommendations of the Board or MEC. The Practitioner who requested the hearing shall be entitled to receive written recommendations of the Hearing Committee including a statement of basis for the recommendation.

4.2 ACTION ON HEARING COMMITTEE REPORT

If the MEC initiated the action and the Hearing Committee's report alters, amends or modifies the MEC's recommendation, the MEC shall take action on the Hearing Committee report no later than twenty-eight (28) days after receipt and prior to any appeal by the Practitioner. If the MEC initiated the action and the Hearing Committee has not altered, amended or modified the MEC recommendation or if the Board initiated the action and the action remains adverse to the Practitioner, the Practitioner shall be given notice of the right to appeal pursuant to Section 4.3(c) prior to final action by the Board. If the Board initiated the action and the Hearing Committee recommendation is favorable to the Practitioner, the Board shall act on the Hearing Committee's report no later than twenty-eight (28) days from receipt of same.

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

The CEO/ CAO shall promptly send a copy of the result to the Practitioner by special notice including a statement of basis for the decision.

4.3(b) Effect of Favorable Result to the Practitioner

(1) Adopted by the Board: If the Board's result is favorable to the Practitioner such result shall become the final decision of the Board and the matter shall be considered finally closed.

(2) Adopted by the Medical Executive Committee: If the MEC's result is favorable to the Practitioner, the CEO/ CAO shall promptly forward it with supporting documentation to the Board for final action. The Board shall act by adopting or rejecting the MEC's result in whole or in part or by referring the matter back to the MEC for further consideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation to the Board must be made and may include a directive that an additional hearing be conducted to clarify issues in doubt. After receipt of recommendation and any new evidence and consultation with the Corporation as necessary, the Board shall take final action. The CEO/ CAO shall promptly send the Practitioner special notice informing of action taken pursuant to Article IV, Section 4.3(b)(2). Favorable action shall become the final decision of the Board and the matter shall be considered finally closed.

(3) Appeal by the Medical Executive Committee or Board: If the Hearing Committee's report alters, amends, or modifies the MEC's or Board's recommendation, the MEC or Board may request an Appellate Review as provided in Article V.

4.3(c) Effect of Adverse Result

At the conclusion of the process in Section 4.2, if the result continues to be adverse to the Practitioner, the Practitioner shall be informed by special notice of the right to request an Appellate Review as in Article V, Section 5.1. Notice shall be delivered to the Practitioner no later than fourteen (14) days from the MEC action or Hearing Committee report as under Section 4.2.

ARTICLE V: INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

Either party shall have fourteen (14) days following receipt of a notice pursuant to Article IV to file a written request for an Appellate Review. Request shall be delivered to the CEO/ CAO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, considered in reaching the adverse result.

5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A party who fails to request an Appellate Review within the time and manner specified in Article V, Section 5.1 shall be deemed to have waived any right to such review. Waiver shall have the same force and effect provided in Article I, Section 1.5.

5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for Appellate Review, the CEO/ CAO shall deliver request to the Board. As soon as practicable, the Board shall schedule and arrange for an Appellate Review which shall be not less than twenty-one (21) days from the date of receipt of the Appellate Review request. Appellate Review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made. At least ten (10) days prior to the Appellate Review, the CEO/ CAO shall send the parties special notice of the time, place, and date of the review. The time for the Appellate Review may be extended by the Appellate Review Body for good cause and if the request is made as soon as reasonably practical.

5.4 APPELLATE REVIEW BODY

The Appellate Review Body shall be composed of the Board of Trustees or a committee of at least three (3) members of the Board of Trustees. One (1) of its members shall be designated as the Chairperson of the committee.

ARTICLE VI: APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

The proceedings of the Appellate Review Body shall be an Appellate Review based upon the record of the hearing before the Hearing Committee, the committee's report, and all subsequent results/ actions. The Appellate Review Body also shall consider written statements submitted pursuant to Article VI, Section 6.2 and other material presented and accepted under Article VI, Sections 6.4 and 6.5. The Appellate Review Body shall apply the standards of proof set forth in Article III, Section 3.7.

6.2 WRITTEN STATEMENTS

The party seeking the review shall submit a written statement detailing the findings of fact, conclusions, and procedural matters with which the party disagrees and the party's reasons for disagreement. The written statement may cover matters raised in the hearing process but may not raise new factual matters not presented at the hearing. The statement shall be submitted to the Appellate Review Body through the CEO/ CAO at least seven (7) days prior to the scheduled date of the Appellate Review except if time limit is waived by the Appellate Body. A written statement in reply may be submitted by the other party, and the CEO/ CAO shall provide a copy to the party seeking review at least three (3) days prior to the scheduled date of the Appellate Review.

6.3 PRESIDING OFFICER

The Chairperson of the Appellate Review Body shall be the Presiding Officer and determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4 ORAL STATEMENT

The Appellate Review Body may allow the parties/ representatives to personally appear and make oral statements supporting their positions. If the Appellate Review Body allows one of the parties to make an oral statement, the other party shall be allowed. Any party/ representative shall be required to answer questions offered by any member of the Appellate Review Body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall not be introduced at the Appellate Review except by leave of the Appellate Review Body. The Appellate Review Body shall determine if evidence shall be considered or accepted following establishment of good cause by the party requesting the consideration. If considered it shall be subject to cross examination and rebuttal.

6.6 PRESENCE OF MEMBERS & VOTING

A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member of the Appellate Review Body is absent from a substantial portion of the proceedings, he/ she shall not be permitted to participate in the deliberations or the decision.

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice. Upon conclusion of oral statements, the Appellate Review shall be closed. The Appellate Review Body shall conduct deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 ACTIONS TAKEN

The Appellate Review Body may affirm, modify, or reverse the adverse result or action taken by the MEC or by the Board pursuant to Article IV, Section 4.2 or Section 4.3(b)(2) or may refer the matter back to the Hearing Committee for further review and recommendation to be returned within fourteen (14) days. Within seven (7) days after referral the Appellate Review Body shall make its final determination.

6.9 CONCLUSION

The Appellate Review shall not be concluded until all procedural steps have been completed or waived.

ARTICLE VII: FINAL DECISION OF THE BOARD

7.1 No later than twenty-eight (28) days after receipt of the recommendation of the Appellate Review Body or twenty-eight (28) days after waiver of Appellate Review, the Board shall consider and affirm, modify, or reverse the recommendation. When a matter of Hospital policy or potential liability is presented the Board shall consult with Corporation prior to taking action. The decision made by the full Board after receipt of the written recommendation from the Appellate Review Body will be deemed final subject to no further appeal under the provisions of the Fair Hearing Plan. If the decision is based substantially on economic factors the final decision will not become effective until fifteen (15) days after notice to the Practitioner. The action of the Board will be promptly communicated to the Practitioner in writing by certified mail.

ARTICLE VIII: GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

The use of a Hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of an officer shall be determined by the Board. A Hearing Officer may or may not be an attorney at law but must be experienced in conducting hearings. He/ She shall act as the Presiding Officer of the hearing and participate in deliberations.

8.2 ATTORNEYS

If the affected Practitioner desires to be represented by an attorney at any hearing or any Appellate Review appearance pursuant to Article VI, Section 6.4, the initial request for the hearing should state the wish at either or both proceedings in the event they are held. The MEC or the Board may be represented by an attorney regardless of whether the affected Practitioner is represented.

8.3 NUMBER OF HEARINGS & REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws or this Plan no Practitioner shall be entitled the right to more than one (1) evidentiary hearing and Appellate Review to an adverse recommendation or action.

8.4 RELEASE

By requesting a hearing or Appellate Review under the Fair Hearing Plan a Practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability in all matters.

8.5 WAIVER

If any time after receipt of special notice of an adverse recommendation, action, or result, a Practitioner fails to make a required request of appearance or otherwise fails to comply with this Fair Hearing Plan or to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action, or result and have voluntarily waived all rights to which he/she might otherwise have been entitled.

MEDICAL STAFF BYLAWS APPENDIX "B"

HOSPITAL POLICY REGARDING PRACTITIONER WELLNESS

It is the policy of this Hospital to properly review and act upon concerns that a Practitioner or AHP as defined in the Medical Staff Bylaws is suffering from an illness or impairment. The Hospital will review and act in accordance with pertinent state and federal law including but not limited to the Americans with Disabilities Act. The purpose of this policy is to provide education about Practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition. The Practitioner Wellness Policy affords resources separate from the corrective action process to address physician health. This policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling, or referrals.

Impairment as used in this policy includes acute and ongoing physical, psychiatric, and emotional illness or injury, and health issues due to drugs or alcohol.

As part of the Hospital's commitment to the safe and effective delivery of care to patients the Hospital and Medical Staff shall conduct education sessions concerning Practitioner health and impairment issues including illness and impairment recognition issues specific to Practitioners ("at-risk" criteria). These sessions shall address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners or AHPs who suffer from an illness or potentially impairing condition.

Report & Review

If any individual in the Hospital has a reasonable suspicion that a Practitioner or AHP appointed to the Medical Staff is impaired the following steps shall be taken:

1. An oral or, preferably, a written report shall be given to the CEO/ CAO or the Chief of Staff. The reporting individual shall otherwise keep the report and facts confidential. The report shall include a description of the incident(s) that led to the belief the Practitioner/ AHP may be impaired. The report must be factual. The individual making the report need not have proof of the impairment but must state the facts leading to the suspicions. A Practitioner/AHP who feels he/she may be suffering from impairment may also make a confidential self-report.

2. In the event any person observes a Practitioner/ AHP who appears to be currently impaired by drugs or alcohol, that person shall report the events to the Chief of Staff and/ or CEO/ CAO immediately. The Chief of Staff and/ or CEO/ CAO may order an immediate drug or alcohol screen if in their opinion circumstances warrant.

3. If after discussing the incidents with the individual who filed the report, the CEO/ CAO and Chief of Staff believe there is sufficient information to warrant further inquiry, the CEO/CAO and/ or Chief of Staff shall meet personally with the Practitioner/ AHP or designate another appropriate person to do so to discuss the alleged incident(s). If the CEO/ CAO and/ or Chief of Staff determine further investigation and/ or action is warranted to address a potential wellness issue, either or both shall direct in writing a review be instituted and a report be rendered by an ad hoc committee to be appointed by the Chief of

Staff. The Chief of Staff shall appoint an ad hoc committee of three (3) physicians to convene within five (5) days of receipt of the request. In the alternative, if the Medical Staff Bylaws provide for a standing physician health or wellness committee, that committee will be convened within five (5) days. The ad hoc committee or standing physician wellness committee shall be referred to as "the committee" hereafter.

4. In performing these functions, the CEO/ CAO and Chief of Staff shall be deemed authorized agents of the MEC and the committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

5. Following a written request to review, the committee shall review the concerns raised and incidents that led to the belief the Practitioner/ AHP may be impaired. The committee's review may include any of the following:

(a) a review of any documents or other relevant materials.

(b) interviews with individuals involved in the incidents or who may have information relevant to the review, provided specific inquiries made regarding the Practitioner/AHP's health status are related to the performance of the Practitioner/AHP's clinical privileges and Medical Staff duties and are consistent with proper patient care or effective operation of the Hospital.

(c) a requirement the Practitioner/ AHP undergo a complete medical examination as directed by the committee, so long as the exam is related to the performance of the Practitioner/AHP's clinical privileges and Medical Staff duties and is consistent with proper patient care or the effective operation of the Hospital; and/ or

(d) a requirement the Practitioner/AHP take a drug test to determine if the Practitioner/AHP is currently using drugs illegally or abusing legal drugs.

6. The committee shall meet informally with the Practitioner/AHP as part of its review. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent credentialing policy and is not part of a disciplinary action. At this meeting the committee may ask the Practitioner/AHP health-related questions so long as they are related to the performance of the Practitioner/AHP's clinical privileges and Medical Staff duties and are consistent with proper patient care and the effective operation of the Hospital. The Committee may discuss with the Practitioner/AHP whether a reasonable accommodation is needed or could be made so the Practitioner/AHP could competently and safely exercise clinical privileges and the duties and responsibilities of Medical Staff appointment.

7. Based on the information reviewed the committee shall determine:

(a) whether the Practitioner or AHP is impaired or what other problem, if any, is affecting the Practitioner/ AHP.

(b) whether the Practitioner/AHP would benefit from professional resources such as counseling, medical treatment, or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and what services would be appropriate.

(c) if the Practitioner/ AHP is impaired, the nature of the impairment and whether it is classified as a disability under the ADA.

(d) if the Practitioner/AHP's impairment is a disability, whether a reasonable accommodation can be made for the Practitioner/AHP's impairment with reasonable accommodation, the Practitioner/AHP would be able to perform clinical privileges, duties, and responsibilities of Medical Staff appointment competently and safely.

(e) whether a reasonable accommodation would create an undue hardship upon the Hospital such that reasonable accommodation would be excessively costly, extensive, substantial, or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and/ or

(f) whether the impairment constitutes a "direct threat" to the health or safety of the Practitioner/AHP, patients, Hospital employees, physicians, or others within the Hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the Practitioner/AHP appears to pose a direct threat because of a disability, the Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

8. If the review produces sufficient evidence the Practitioner/AHP is impaired, the CEO/ CAO shall meet personally with the Practitioner/AHP or designate another appropriate individual. The Practitioner/AHP shall be told the results of a review the Practitioner/AHP suffers from an impairment that affects his/ her practice. The Practitioner/AHP should not be told who filed the report and does not need to be told the specific incidents contained in the report.

9. If the committee determines there is a reasonable accommodation that can be made, the Committee shall attempt to work out a voluntary agreement with the Practitioner/AHP so long as that arrangement would neither constitute an undue hardship upon the Hospital nor create a direct threat. The CEO/ CAO and Chief of Staff shall be kept informed of attempts to work out a voluntary agreement between the Committee and the Practitioner/AHP and shall approve any agreement before it becomes final and effective.

10. If the committee determines there is no reasonable accommodation that can be made or if the committee cannot reach a voluntary agreement with the Practitioner/AHP, the committee shall make a recommendation and report to the MEC through the Chief of Staff for appropriate corrective action pursuant to the Bylaws. If the MEC’s action would provide the Practitioner/AHP with a right to a hearing as described in the Hospital's Medical Staff Bylaws or credentialing policy, all action shall be taken in accordance with the Fair Hearing Plan, and strict adherence to all state and federal reporting requirements will be required. The CEO/ CAO shall promptly notify the Practitioner/AHP of the recommendation in writing by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the Hospital's Medical Staff Bylaws or credentialing policy.

11. The original report and a description of actions taken by the committee shall be included in the Practitioner/ AHP's confidential file. If the initial or follow-up review reveals no merit to the report, the report shall be maintained in the Practitioner/AHP’s confidential file but shall be accompanied by a notation, signed by the reviewing person or body, that indicates the report is wholly without merit. If the initial or follow-up review reveals there may be some merit to the report but not enough to warrant immediate action, the report shall be included in a separate portion of the Practitioner/AHP's file and the Practitioner/AHP's activities and practice shall be monitored until it can be established if there is or is not an impairment problem.

12. The CEO/ CAO shall inform the individual who filed the report that follow-up action was taken but shall not disclose confidential peer review information or specific actions implemented.

13. All parties shall maintain confidentiality of the Practitioner/AHP referred for assistance except as limited by law, ethical obligation, or when safety of a patient is threatened. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

14. In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the Hospital or its Medical Staff including the due process sections of those bylaws and policies, the provisions of this policy shall control.

15. Nothing shall preclude commencement of corrective action including summary suspension under the Medical Staff Bylaws or termination of any contractual agreements between the Hospital and the Practitioner/AHP, including any employment agreement in the event the Practitioner/AHP's continued practice constitutes a threat to the health or safety of patients or any person.

Rehabilitation & Reinstatement Guidelines

A. *Substance Abuse*

If it is determined the Practitioner/AHP suffers from a drug or alcohol related impairment that could be reasonably accommodated through rehabilitation the following are guidelines for rehabilitation and reinstatement:

1. Hospital and Medical Staff leadership shall assist the Practitioner/AHP in locating a suitable rehabilitation program. A Practitioner/AHP who may benefit from counseling or rehabilitative services but is not believed to be impaired in his ability to competently and safely perform clinical privileges or the duties of Medical Staff membership may be referred for assistance while still actively practicing at the Hospital. In cases where the Practitioner/AHP's ability is believed to be impaired the Practitioner/AHP shall be allowed a leave of absence if necessary. A Practitioner/AHP determined to have an impairment which requires a leave of absence for rehabilitation shall not be reinstated until it is established to the satisfaction of the committee the MEC and the Board the Practitioner/AHP has successfully completed a program in which the Hospital has confidence.

2. Upon sufficient proof a Practitioner/AHP who has been found to be suffering from an impairment has successfully completed a rehabilitation program that Practitioner/AHP may be considered for reinstatement to the Medical Staff.

3. In considering an impaired Practitioner/AHP for reinstatement the Hospital and Medical Staff leadership must consider patient care interests paramount.

4. The committee must first obtain a letter from the physician director of the rehabilitation program where the Practitioner/AHP was treated. The Practitioner/AHP must authorize the release of information. That letter shall state:

(a) whether the Practitioner/AHP is participating in the program.
(b) whether the Practitioner/ AHP follows all of the terms of the program.
(c) whether the Practitioner/AHP attends AA meetings or other appropriate meetings regularly (if appropriate).
(d) to what extent the Practitioner/AHP's behavior and conduct are monitored.
(e) whether in the opinion of the director the Practitioner/AHP is rehabilitated.

(f) whether an after-care program has been recommended to the Practitioner/AHP and if so a description of the after-care program; and

(g) whether in the director's opinion the Practitioner/AHP is capable of resuming medical practice and providing continuous, competent care to patients.

5. The Practitioner/AHP must inform the committee of the name and address of the primary care physician and must authorize that physician to provide the Hospital with information regarding condition/treatment. The committee has the right to require an opinion from other physician consultants of its choice.

6. From the primary care physician, the committee needs to know the precise nature of the Practitioner/AHP's condition, course of treatment, and answers to the questions posed above in (4)(e) and (g).

7. Assuming the information received indicates the Practitioner/AHP is rehabilitated and capable of resuming care of patients the committee, MEC and Board shall take the following additional precautions when restoring clinical privileges:

(a) the Practitioner/AHP must identify another Practitioner/AHP who is willing to assume responsibility for the care of patients in the event of inability or unavailability; and

(b) the Practitioner/AHP shall be required to obtain periodic reports for the committee from the primary physician for a period specified by the CEO/ CAO stating the Practitioner/AHP is continuing treatment or therapy as appropriate and ability to treat and care for patients in the Hospital is not impaired.

8. The Practitioner's or AHP's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of monitoring shall be determined by the committee after its review of the circumstances.

9. The Practitioner or AHP must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the CEO/ CAO or designee, the Chairperson of the committee or the pertinent department chair.

10. All requests for information concerning the impaired Practitioner or AHP shall be forwarded to the CEO/ CAO for response.

11. Should a Practitioner fail to complete any required rehabilitation program or directive made pursuant to this Policy, he/ she shall not be considered for reinstatement, and the matter shall be referred to the MEC for action in accordance with the Medical Staff Bylaws.

B. *Physical, Psychiatric or Emotional Illness*

If it is determined the Practitioner/AHP suffers from an acute or ongoing physical, psychiatric, or emotional illness or injury that is not drug or alcohol related and could be reasonably accommodated through rehabilitation or treatment the following are guidelines for rehabilitation or treatment and reinstatement:

1. If applicable, Hospital and Medical Staff leadership shall assist the Practitioner/AHP in locating a suitable rehabilitation program or treatment plan. A Practitioner/AHP who may benefit from counseling or rehabilitative services but whose illness or injury is not believed to interfere with ability to perform clinical privileges or the duties of Medical Staff membership may be referred for assistance while still actively practicing competently and safely at the Hospital. In cases where the Practitioner/AHP's ability is believed to be undermined the Practitioner/AHP shall be allowed a leave of absence if necessary. A Practitioner/AHP who is determined to have an illness or injury which requires a leave of absence for rehabilitation or treatment shall not be reinstated until it is established to the satisfaction of the committee the MEC and the Board that the Practitioner/AHP has successfully completed any necessary rehabilitation or treatment in which the Hospital has confidence.

2. Upon sufficient proof a Practitioner/AHP who has been found to be suffering from an illness has successfully completed treatment or has been cleared for return to practice by the treating physician (as applicable) that Practitioner/AHP may be considered for reinstatement to the Medical Staff.

3. In considering a Practitioner/AHP for reinstatement the Hospital and Medical Staff leadership must consider patient care interests paramount.

4. If requested by the committee the Practitioner/AHP must provide the name and address of the primary care physician and must authorize that physician to provide the Hospital with information regarding condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.

5. Assuming the information received indicates the Practitioner/AHP is rehabilitated or recovered and capable of resuming care of patients, the committee, MEC and Board may take the following additional precautions when restoring clinical privileges:

(a) the Practitioner/AHP must identify another Practitioner/AHP who is willing to assume responsibility for the care of patients in the event of inability or unavailability; and

(b) the Practitioner/AHP may be required to obtain periodic reports for the committee from the primary physician for a period specified by the Committee stating the Practitioner/AHP is continuing treatment or therapy as appropriate and ability to treat and care for patients in the Hospital is not impaired.

6. The Practitioner/AHP's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of monitoring shall be determined by the committee after its review of all the circumstances.

7. All requests for information concerning the impaired Practitioner or AHP shall be forwarded to the CEO/ CAO for response.

8. Should a Practitioner fail to complete any required rehabilitation program or directive he/ she shall not be considered for reinstatement, and the matter shall be referred to the MEC for action in accordance with the Medical Staff Bylaws.

RED BUD REGIONAL HOSPITAL POLICY REGARDING BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

For purposes of this policy "behavior that undermines a culture of safety" is any conduct that intimidates others, affects morale or staff turnover, disrupts smooth operation of the Hospital, poses a threat to patient care, or exposes the Hospital and/ or Medical Staff to liability. Such conduct may include:

1. Attack verbal or physical leveled at other appointees to the Medical Staff, Hospital personnel, patients, or visitors that are personal, irrelevant, or beyond the bounds of fair professional conduct.
2. Impertinent and inappropriate comments or illustrations made in patient medical records or other official documents or inappropriate written or verbal statements to patients and/ or members of the community impugning the quality of care in the Hospital or attacking physicians, nurses, other employees, or Hospital policies.
3. Nonconstructive criticism addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.
4. Refusal to accept or causing a disturbance of Medical Staff assignments or participation in committee or departmental affairs in a disruptive or non-constructive manner.
5. Discrimination, harassment and/ or retaliation.
6. Passive activities such as quietly exhibiting uncooperative attitudes during routine activities, reluctance, or refusal to answer questions, return phone calls, condescending language, or voice intonation and impatience with questions.

Objective

The objective of this policy is to provide a mechanism for timely reporting and addressing of behavior that undermines a culture of safety and ensure quality patient care by promoting a safe, cooperative, and professional health care environment and to prevent or eliminate to the extent possible conduct that:

1. Disrupts the operation of the Hospital.
2. Affects the ability of others to do their jobs.
3. Creates a "hostile work environment" for Hospital employees or other Medical Staff members.
4. Interferes with an individual's ability to practice competently; or
5. Adversely affects or impacts the community's confidence in the Hospital's ability to provide quality patient care.

Documentation of Behavior That Undermines a Culture of Safety

1. Documentation of behavior that undermines a culture of safety is critical. Physicians, nurses, and other Hospital employees who observe or are otherwise made aware of[1] undermining behavior by a Practitioner must document the behavior. Whenever possible the behavior shall be documented on the attached Practitioner Behavior that Undermines a Culture of Safety Report Form (the "Report", "Exhibit A"). Such documentation shall be provided to the CEO/ CAO as soon as practicably

[1] Physicians, nurses or other staff who receive a complaint from a patient, family member or community member shall encourage those individuals to document their complaint. Should the individual refuse to do so the physician, nurse or staff member receiving the complaint shall document the information.

possible.[2] The documentation shall include:

(a) the name of the Practitioner(s) involved in the questionable behavior.

(b) the date and time of questionable behavior.

(c) a statement of whether the behavior affected or involved a patient in any way and if so the chart number of the patient.

(d) the circumstances that precipitated the situation, if known.

(e) a description of the questionable behavior limited to factual objective language.

(f) the consequences if any of the behavior as it relates to patient care or Hospital operations.

(g) a record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

2. Once the Report is received by the CEO/ CAO, the CEO/ CAO shall provide a copy of the Report to the Chief of Staff. The CEO/ CAO and Chief of Staff shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

Investigation

1. Once received a report will be investigated by the CEO/ CAO and the Chief of Staff. As part of the investigation, the CEO/ CAO will interview the employee or other person completing the report to gather additional, more complete information. The CEO/ CAO will document the time, date, and substance of this meeting. Documentation will be made part of the investigative file.

2. If the report is determined to be credible the Practitioner who is the subject of the report shall be interviewed prior to conclusion of the investigation. Once an investigation is completed the CEO/ CAO will follow-up with the reporting employee or other individual to inform them of the conclusions of the investigation and appropriate actions will be taken. The employee or person reporting should be encouraged to report any further behavior that undermines a culture of safety. The employee or other reporting individual shall be advised retaliatory action will not be tolerated and will be encouraged to report any action which appears to have been taken in retaliation for making report.

3. Reports determined to be credible based on the facts and information gathered during the investigation will be addressed through the procedure set out below and will become a part of the physician's quality file.

4. If at any time it appears to the Chief of Staff, CEO/ CAO or any committee charged with implementation of this policy that a Practitioner's behavior may result from an impairment, the procedure set forth in the Practitioner Wellness Policy shall be followed.

Progressive Corrective Action

1. A single confirmed incident warrants a formal discussion with the offending Practitioner. This meeting will be held in conjunction with the interview described 2 above. The Chief of Staff and CEO/ CAO shall initiate a meeting with the Practitioner. The CEO/ CAO shall create a record of the meeting and document the Practitioner was informed the conduct was inappropriate. The CEO/ CAO will review the substance of this policy with the Practitioner and explain to the Practitioner the possible results of continued behavior that undermines a culture of safety. A follow-up letter to the Practitioner

[2] The CEO/CAO will strongly encourage any employee or physician reporting conduct to document the conduct as outlined above. Should the individual refuse to do so the CEO/CAO shall document the conduct as described and shall note on the form the conduct was not personally observed and the reporting individual refused to document the conduct. The CEO/CAO shall have a duty to investigate any credible verbal complaint that describes conduct that may create a risk to the well-being of any person, a hostile working environment, or expose the Hospital to liability.

shall state that the Practitioner is required to behave professionally and cooperatively.

2. If there is a second incident of behavior that undermines a culture of safety the CEO/ CAO and Chief of Staff shall follow the same process. This meeting with the Practitioner shall constitute the Practitioner's final warning. A letter shall be sent to the Practitioner following the meeting informing the Practitioner if a third incident of behavior the matter will be referred to the Medical Executive Committee for appropriate corrective action which may include a referral to the Board of Trustees for suspension from the Medical Staff or termination of Medical Staff privileges.

3. If there is a pattern of behavior that undermines a culture of safety defined as three or more incidents of behavior, the CEO/ CAO and/ or Chief of Staff shall refer the matter to the Medical Executive Committee for recommendation and to the Board of Trustees for final action and resolution. Any action, recommendation, or communication by the MEC becomes a part of the Practitioner's permanent file. More formal corrective action may be pursued if deemed warranted by the Chief of Staff and/ or CEO/ CAO.

4. Nothing shall prohibit more formal corrective action as result of a single incident or during the investigative or corrective action process should the Chief of Staff and/ or CEO/ CAO determine the seriousness of the incident justifies such action.

5. If at any time during the process any participant has reason to believe the Practitioner's behavior may result from an impairment the procedures set forth in the Practitioner Wellness Policy should be followed.

6. Summary suspension may be appropriate pending the completion of this process depending on the substance and seriousness of the reported offense. Any summary suspension pursuant to this policy must meet the requirements for summary suspension as outlined in the Medical Staff Bylaws.

Disciplinary Action Pursuant to Medical Staff Bylaws

1. The CEO/ CAO and Chief of Staff shall be responsible for presenting the history of conduct to the Medical Executive Committee.

2. The Medical Executive Committee shall be fully apprised of any reports of behavior that undermines a culture of safety, and any meetings and warnings so it may pursue whatever action is necessary to terminate the unacceptable conduct.

3. The Medical Executive Committee may refer the matter to the Board of Trustees with or without recommendation. If the Medical Executive Committee makes a recommendation, it shall be processed as provided in the corrective action section of the Medical Staff Bylaws.

4. Should the Medical Executive Committee forward the matter without a recommendation any further action including hearing and appeal shall be initiated by the Board of Trustees and processed as provided in the corrective action section of the Medical Staff Bylaws.

Although this policy is intended to outline a suggested method of progressive counseling and discipline nothing shall be deemed to require such progressive discipline in the event the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, or damaging Hospital property may result in immediate corrective action.

Documentation and Document Retention

1. All meetings with the Practitioner and/ or relating to the reported behavior that undermines a culture of safety shall be documented and maintained in the Practitioner's quality file.

2. After each meeting with the Practitioner a letter summarizing the substance of the

meeting shall be sent to the Practitioner.

3. A copy of all original Reports shall be maintained in the Practitioner's quality file with the documents and notes. The Practitioner may submit a written response to be placed in the file if desired.

Date Form Completed: _____ Completed by:_____

Section 1: General Information

Practitioner Involved: _____
Date of undermining behavior: _____
Time of undermining behavior: _____am / pm
Location of incident: _____
Were any patients involved in the incident? If yes, please provide patient chart number:

Section 2: Description of Behavior that Undermines a Culture of Safety

Describe the circumstances which precipitated the situation, if known: _____
_____

Describe the questionable behavior in objective, fact-based terms: _____
_____

Describe the results, if any, of the undermining behavior as it relates to patient care or Hospital operations: _____
_____

What actions, if any, were taken to remedy the situation? Include the names of other individuals that may have intervened: _____
_____
_____

Section 3: Confidentiality and Non-retaliation

Your report of behavior that undermines a culture of safety will be treated as confidentially as possible consistent with Hospital and Medical Staff policy and applicable law. We cannot assure you the Practitioner will never become aware of your identity. We can assure you retaliation against any person for making a complaint of undermining conduct will not be tolerated. Retaliation is taken very seriously and will be a basis for corrective action. We encourage you to report any behavior which you believe to be retaliatory in nature.

Section 4: Verification of Report

Please sign below verifying the contents of this report are true and accurate to the best of your knowledge, and based on personal knowledge of the reported behavior that undermines a culture of safety. Once completed, this report should be delivered to the CEO/ CAO.

Name of Person Reporting: _____ Signature: _____

PRACTITIONER BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY REPORT Privileged & Confidential for use by Legal Counsel-Not Part of the Medical Record/ DO NOT PHOTOCOPY

MEDICAL STAFF POLICY REGARDING PEER REVIEW, ONGOING PROFESSIONAL PRACTICE EVALUATION & FOCUSED PROFESSIONAL PRACTICE EVALUATION

This Policy is adopted in connection with the Medical Staff Bylaws. The definitions and terminologies of the Bylaws also apply to the policy and procedures described herein.

SCOPE

Applies to all members of Medical Staff and Allied Health Practitioners granted clinical privileges to provide patient care services in the Hospital.

EXCEPTION: No volume providers with Medical Staff membership and without clinical privileges per TJC clarification are exempt from Ongoing Professional Performance Evaluation and Focused Professional Practice Evaluation requirements.

I. PURPOSE:

To assure the Hospital through the activities of its Medical Staff assesses ongoing professional practice and competence of Medical Staff conducts professional practice evaluations and uses results of assessments and evaluations to improve professional competence, practice, quality and safety of patient care. To define those circumstances in which an external review or focused review may be necessary. To address identified issues in an effective and consistent manner.

"Professional Practice Evaluation" is considered an element of the peer review process and the records and proceedings relating to this policy are confidential and privileged to the fullest extent permitted by applicable law.

II. DEFINITIONS

Peer: Any Practitioner who possesses the same or similar knowledge and training in a medical specialty as the Practitioner whose care is the subject of review.

Individual Case Review: The process outlined for peer review of a particular case identified with a potential quality of care issue.

Ongoing Professional Practice Evaluation: The ongoing process of data collection for the purpose of assessing a Practitioner's clinical competence and professional behavior. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the three-year membership and privilege renewal cycle.

Focused Professional Practice Evaluation: The time-limited evaluation of Practitioner competence in performing a specific privilege or privileges. The process is consistently implemented to evaluate the privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged Practitioner's ability to provide safe, high-quality care.

FPPE affects only the privileges for which a relevant concern has been raised and related privileges for which the same concern would apply. Existing privileges in good standing should not be affected by the decision to initiate FPPE.

Peer Review: The process by which a Practitioner or committee of Practitioners examines the work of a peer and determines whether the Practitioner under review has met accepted standards of care in rendering medical services. The professional or personal conduct of a physician or other health care professional may be investigated. Individual Case Review, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation are components of peer review.

Practitioner Proctoring: The personal presence of an assigned Practitioner who does not have a treatment relationship with the patient who is designated to provide clinical teaching or to monitor the clinical performance of another Practitioner to facilitate quality of care to patients as required for purposes of credentialing, reappointment, quality improvement, FPPE, or corrective action.

Focused Professional Practice Evaluation (FPPE)

A. Initiation of FPPE

FPPE will be initiated in the following instances:

- Upon initial appointment.
- When a new privilege is requested by an existing Practitioner.
- When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged Practitioner's ability to provide safe, high-quality patient care.

A recommendation of FPPE may be made by:

- The Credentials Committee.
- A Department of the Medical Staff.
- The Chief of the Department.
- The Chief of Staff.
- A special committee of the Medical Staff.
- The MEC

The appropriate department or committee must authorize the initiation of the FPPE, record the date and reason for initiation of FPPE, and designate the Quality Department designee responsible for coordinating the FPPE process and reporting back to the department/ committee.

The FPPE monitoring plan for a new Practitioner or newly requested privilege(s) will be specific to the requested privileges or group of privileges. FPPE is not considered corrective action as defined in the Medical Staff Bylaws and is not subject to the Bylaws provisions related to the corrective action process. If the outcome of FPPE results in an action plan to perform an investigation the process identified in the Medical Staff Bylaws would be followed.

A. Timeframe for Collection and Reporting

The period of FPPE must be time limited. Time-limited may be defined by:

- A specific period; or
- A specific volume (number of procedures/ admissions/ encounters)

The duration of FPPE may be tiered for different levels of documented training and experience:

- Practitioners coming directly from an outside residency program (unknown data)
- Practitioners coming directly from the organization's residency program (have data)
- Practitioners coming with a documented record of performance of the privilege and associated outcomes versus those with no record.

FPPE shall begin with the applicant's first admission(s), encounter(s), or performance of the newly requested privilege and continue for a period of six months The period of FPPE may be extended as necessary at the discretion of the Medical Staff.

C. Methods for Conducting FPPE/Communication to the Practitioner

FPPE may be accomplished by:

- Chart reviews, both concurrent and/ or retrospective
- Simulation
- Discussion with the involved Practitioner and/ or other individuals involved in the care of the Practitioner's patients.
- Direct observation/ proctoring
- For dependent AHPs may include review or proctoring by the sponsoring physician
- Internal or external peer review

FPPE completed via medical record review may have a screening portion delegated to quality staff in accordance with their scope of practice. A peer (as defined in Section 11) is responsible for judgments regarding the appropriateness of clinical care and determinations of current competence. The terms of all FPPE shall be communicated in writing to the affected Practitioner or AHP, including:

- The cause for the focused monitoring
- The anticipated duration
- The specific mechanism by which monitoring will occur.

D. Conclusion of FPPE

At the conclusion of the initial FPPE findings will be reviewed by the Medical Executive Committee or responsible Department for decision and recommendation. Decisions may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending limiting or suspending the privilege. Recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges the processes pursuant to Medical Staff Bylaws Appendix A will apply.

Each Practitioner/AHP will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member or AHP including but not limited to:

- An overall summary of the findings and outcome of FPPE.

- Specific actions if any that need to be taken by the Practitioner/AHP to address quality concerns and method for follow-up to ensure concerns have been addressed.
- If the focused review is complete or will continue (duration will be specific if the focused review will continue).
- The period of initial FPPE is completed and the Practitioner/AHP will move into OPPE.
- The period of FPPE for a specific privilege is completed and Practitioner/AHP will continue with OPPE.

At the end of the period of focused evaluation, if the Practitioner/AHP's activity/ volume has not been sufficient to meet the requirements of FPPE:

- The Practitioner/AHP may voluntarily resign the relevant privilege(s), or
- The Practitioner/AHP may submit a written request for an extension of the period of focused evaluation, or
- If the Practitioner/AHP has sufficient volume of the privileges at another facility, external peer references specific to the privilege/ procedure may be obtained.
- FPPE may be extended at the discretion of the responsible Medical Staff department or committee and approved by the MEC and Board.

The Practitioner/AHP is not entitled to a hearing or other procedural rights for any privilege voluntarily relinquished. Even in the absence of entitlement to hearing rights a report to the National Practitioner Data Bank may still be triggered.

FPPE Practitioner-specific data reports are maintained in the Practitioner/AHP's Confidential Quality File. A summary document/ report shall be maintained in the Credentials File. The summary document/ report shall mean the general communication letter sent to the Practitioner following the review informing him/her whether he/ she successfully met the established expectation for FPPE during the review period. The summary document/ report shall not include quality screens, reviews, data reports, etc., which shall all be maintained in the confidential quality file.

E. Performance Improvement Plan

If FPPE outcomes identify the need for an improvement plan the plan will be drafted by the responsible Medical Staff department, committee, or chair. The written improvement plan and supporting FPPE outcomes are presented to the Medical Executive Committee for approval. The involved Practitioner/AHP should be offered the opportunity to address the MEC and respond to the findings before the improvement plan is finalized and implemented. Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

- Necessary education
- Proctoring and/or mentoring
- Counseling
- Practitioner Assistance Program
- Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or Chief of Staff will meet with the Practitioner/AHP to communicate the improvement plan. If the Practitioner/AHP agrees with the plan the written document should be signed by the Practitioner/AHP

and forwarded to the Quality Department. If the Practitioner/AHP does not agree with the plan and/ or refuses to implement the improvement plan the outcome will be reported to the responsible department chief and/ or Medical Executive Committee for resolution.

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

A. Timeframe for Collection and Reporting

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/ or action.

B. Indicators for Review

1. The type of data to be collected and thresholds/triggers is determined by individual Medical Staff committees/ departments and approved by the MEC. Indicators may change as appropriate by the department and/or Medical Staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/ outlier trending data. Good performance data should also be considered. The indicators for each specialty/ Practitioner must be inclusive of the scope of practice / privileges granted for that specialty/ Practitioner and include the items in Section A below if appropriate to their practice.

   The organized Medical Staff measures and assesses processes that primarily depend on the activities of one or more credentialed Practitioners and AHPs:

   i. Use of medications
   ii. Use of blood and blood components
   iii. Operative and other procedure(s)
   iv. Use of anesthesia / sedation
   v. Performance of histories and physicals

   b. The Medical Staff may consider the six areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME). These include:

   i. Patient care
   ii. Medical/clinical knowledge
   iii. Practice-based learning and improvement
   iv. Interpersonal and communication skills
   v. Professionalism
   vi. Systems-based practice

   c. Information used in the ongoing professional practice evaluation may be acquired through:

   - Periodic chart review
   - Direct observation
   - Monitoring of diagnostic and treatment techniques
   - Discussion with other individuals involved in the care of each patient.

2. Thresholds/ triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable within the established defined criteria and are used to identify performance outcomes that could trigger FPPE. Triggers to consider include:

   - Defined number of events occurring

- Defined number of individual peer reviews with adverse determinations
- Elevated infection, mortality, and/or complication rates
- Sentinel events
- Increasing lengths of stay in comparison to peers.
- Increasing number of returns to surgery
- Frequent unanticipated readmission for the same issue
- Patterns of unnecessary diagnostic testing/treatments
- Failure to follow approved clinical practice guidelines.

C. Oversight and Reporting

The organized Medical Staff delegates the collection of performance indicators to the appropriate department. The overall process data compilation and reporting is coordinated by the Quality Department. The review of performance data and any recommendation(s) for action if necessary is performed through the Medical Staff committee process:

- The Medical Executive Committee.
- The specific Medical Staff Department.
- The Chief of the Department; or
- A standing or special committee of the medical staff.

D. Results and Reporting of Data Analysis

Data are analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized Practitioner or AHP report are referenced in the MEC meeting minutes, maintained in the quality file, and incorporated into the two-year reappointment process.

During the course of OPPE, FPPE may be triggered by the following special circumstances:

- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE.
- Patient/ staff complaints
- Non-compliance with Medical Staff Bylaws, Rules, and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines.
- Behavior that undermines a culture of safety

Practitioners will be notified in writing when triggers results in resumption of FPPE. The appropriate department or committee must authorize the initiation of the FPPE, record the date and reason for initiation of FPPE, and designate the Quality Department or designee shall be responsible for coordinating the FPPE process and reporting back to the department/ committee. If unprofessional behavior or disruptive conduct is identified, the Behavior that Undermines a Culture of Safety Policy (Appendix C) will be initiated as a component of the OPPE.

<u>RESPONSIBILITIES OF THE QUALITY MANAGEMENT DEPARTMENT</u>

1. The Quality Department will be responsible for compiling and reporting results of FPPE and OPPE to the Medical Staff Committee(s).

2. OPPE Practitioner or AHP-specific profile illustrates performance over the three-year reappointment cycle will be utilized at the time of reappointment.
3. The Quality Department will be responsible for collaborating with each Medical Staff Committee/ Department on an annual basis to review the continued relevance of the selected indicators and triggers.
4. The Quality Department must obtain authorization from the appropriate department or committee prior to initiating a specific FPPE or individual case review process.

Individual Case Review Process

Cases identified with potential quality of care issues are referred to appropriate Medical Staff Department or Committee for review. The appropriate Department or Committee authorize the initiation of the review, record the date and reason for initiation of the review, and designate the Quality Department or appropriate designee responsible for coordinating the review process and reporting back to the Department/ Committee.

Cases may be identified through OPPE, FPPE, case management, risk management, audits, sentinel events/ serious safety events, clinician referrals, and other sources. All cases are initially screened by the Quality department utilizing Medical Staff approved screening criteria, prior to forwarding for Medical Staff review. If the Medical Staff reviewer determines no potential quality of care issues identified the case is closed, the findings are documented, and trending is performed in the Quality Department.

If potential quality of care issues are identified by the Medical Staff reviewer the following process for peer review shall be implemented:

1. Reviewer Selection & Duties

Reviews are completed by the designated Medical Staff Practitioner, Department or Committee. A designated reviewer may not review a case where he/ she participated in the care or there is a conflict with the Medical Staff member involved as determined by the MEC and/ or Board in their sole discretion.

2. Reviewer Disqualification & Replacement

If a reviewer does not feel he/ she can adequately review a medical record due to a conflict of interest or believes he/ she is not qualified to address a certain issue the reviewer may discuss the issue with the Chairperson of the Committee, Department Chief or Chief of Staff. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer.

3. Communication to Involved Practitioner

Any Practitioner/AHP who is the subject of a review receiving an assigned peer review score of 3 or greater shall be notified in writing at least two weeks prior to the Medical Staff meeting where the outcome of review is reported. Communication shall include the case medical record number, admission/ discharge date, reasons, and outcome of the review. Comments and/ or opinions made by the reviewer may be included. The identity of the reviewer should be redacted.

The involved Practitioner/AHP is provided the opportunity to respond to the results of the review in writing in advance of the meeting where the outcome is reported. At the request of the Department

Chief, or Chief of Staff, the Practitioner /AHP may be invited to attend the meeting and discuss the case.

4. Circumstances Requiring External Peer Review

The MEC, Chief of Staff, Department/ Chair, Peer Review Committee/ Chair, or the Board of Trustees may request external peer review by a practitioner who is Board certified within the same specialty in circumstances including:

- The pool of eligible reviewers is unable to serve.
- There is no qualified Practitioner on staff to conduct the review.
- Litigation risk
- The facility has only a single Practitioner in a particular specialty and no other Practitioner has similar background, training or experience.
- The procedure is new to the organization.
- Other reasons as deemed by the MEC and Board.

No Practitioner/AHP may require the Hospital to obtain external peer review if it is not deemed necessary by the Chief of Staff, MEC, Department Chair, Peer Review Committee, or the Board of Trustees.

5. Review Form Summary

Reviewing Practitioners must complete the Peer Review Form Attachment One, clearly and concisely. The reviewing Practitioner must sign his/ her name on the review form and shall grade the care and outcome based on:

- Level 1 = Most experienced, competent practitioners would have handled the case in a similar manner.
- Level 2 = Most experienced, competent practitioners might have managed the case differently.
- Level 3= Most experienced, competent practitioners would have managed the case differently.

DOCUMENTATION OF PEER REVIEW ACTIVITIES:

Reports of OPPE, FPPE, and individual case review findings and recommendations shall be presented to the MEC. The MEC may adopt the recommendations of the Medical Staff Department/ Committee and/ or make further recommendations including recommendation for further investigation and/ or Corrective Action in accord with the Medical Staff Bylaws. All recommendations of the MEC other than further investigation shall be delivered to the Board. The Board shall make a final determination concerning any actions warranted based on the findings and recommendations of the MEC. Results of OPPE, FPPE and Peer Review outcomes shall be documented and maintained in the Practitioner's quality file and referenced at reappointment. A summary of OPPE shall be provided to the MEC and Board annually. FPPE reports will be provided to the MEC and Board at every meeting. A summary of Peer Review outcomes shall be reported to the Board on at least a quarterly basis.

Practitioner Review of Confidential Quality File

A Practitioner/AHP may review the quality file by making an appointment with the Director of Quality. The Chief of Staff will be notified. No copies of the quality file may be made nor may the Practitioner/AHP remove any portion of the quality file. In the discretion of the CEO/ CAO in

consultation with the Chief of Staff, personal information or the identity of patients or employees reporting quality issues may be redacted before the Practitioner/AHP may review the file.

Medical Staff Bylaws Appendix "E"

Swing Bed Program

The common goal of the Swing Bed Program is to maintain and improve the patient's functional status to the highest mental and physical level, which is practical.

Article I: Admission, Transfer and Discharge of Swing Bed Patients

Admitting

A. Red Bud Regional Swing Bed Program shall accept patients for skilled care and treatment as defined by the swing bed admission policy.
B. Individuals with a communicable, contagious, or infectious disease or a person who is destructive of property, self or others shall be evaluated on an individual basis and will only be admitted if the well-being of the individual, other patients, and staff can be protected.
C. A patient may be admitted to the Swing Bed Program only by order of a Red Bud Regional Medical Staff credentialed physician.
D. The admitting physician shall have primary responsibility for the care of the patient and shall be responsible for the prompt and accurate completion of the medical records and for any necessary special instructions (including the Medical Care Plan).
    1. These responsibilities may be transferred to another Staff member with admitting privileges. A note covering the transfer of medical responsibility shall be entered on the Physician Order sheet of the medical record.
    2. It shall be the responsibility of the attending physician to transmit reports of the condition of the patient to the referring physician.
E. Each member of the Medical Staff shall name a qualified alternate member of the Medical Staff with admitting privileges to attend his/her patients when the attending physician is not available.
    1. The alternate physician is responsible for responding to patient needs while he/she is covering for a physician.
    2. When the alternate cannot administer such care, he/she is responsible for obtaining coverage.

Patient Transfers

A. No patient will be transferred without the order of the attending physician.
B. In the event of a significant change in the health status of a patient, the attending physician will be notified for orders to transfer the patient to acute care if appropriate.
C. If the attending physician can not be reached in an emergent situation or patient's condition requires immediate attention, the Rapid Intervention Team or Code Blue Team may be activated. If the patient's condition warrants a level of care higher than Swing Bed, the

patient may be transferred to inpatient status or the Emergency Room pending transfer to an outside facility.

D. When a patient is transferred from one physician to another within the institution, the acceptance of said patient shall be documented in the Progress Note by the accepting physician.

Discharge

A. The patient and/or family or guardian may initiate the request for discharge of a patient at which time the attending physician will be notified and a discharge order requested from the attending physician.
    1. Should the patient leave the Swing Bed unit division against the advice of the attending physician, or without the proper discharge, a notation of the incident shall be made on the patient's medical record and, if possible, the applicable release from responsibility form signed and placed in the patient's medical record.
B. At the time of discharge, the attending physician shall see that the record is complete including principal diagnosis and secondary diagnosis. The physician shall be responsible for execution of the medical record discharge sheet in the EMR.

Patient Expiration

A. In the event of a patient death in the Swing Bed program, the attending physician or his/her designee physician will be notified by the nurse of the patient's absence of vital signs.
    1. An entry shall be made and signed as to cause of death by the attending physician in the medical record of the deceased.
    2. Policies with respect to release of a body shall conform to applicable local and State law.
B. Staff members will seek to obtain autopsies per policy and in accordance with State law.

Article II: Medical Records

A. The attending physician shall be responsible for the complete and legible medical record for each patient.
    1. The record shall include the patient's name, address, date of birth and name of legally authorized representatives.
    2. The attending physician performs a medical assessment.
        a. The time frame must not exceed 24 hours before admission or within 72 hours after admission.
        b. Any previous medical history does not have to be completely redone. It can be updated with information about the most recent illness and hospitalization since the date the last history was taken within a time frame appropriate to the patient's condition.
        c. Durable, legible originals or reproductions of a medical history and physical examination, obtained from the attending physician or other licensed independent practitioner, completed within 30 days before admission, are acceptable, provided that there is a summary of the patient's condition and course of care during the interim period, and the summary also includes the

patient's current physical/ psychosocial status. The attending physician must sign and date the additional information to attest to its currency.

3. Medical information required at the time of admission includes (IL 77 Code Chapter I §300.1010):
    a. Admitting diagnosis
    b. Current medical findings (including patient's height & weight)
    c. Physician's orders for immediate care (including frequency of weighing patient)
    d. Code Status
    e. Rehabilitation potential both short-term and long-term
    f. Pertinent diagnostic test results
    g. Freedom from communicable disease
4. An initial plan of treatment shall be documented as part of each record which shall be periodically reviewed as appropriate.
5. Diagnostic and Therapeutic Orders: these orders shall be written legibly and signed by those physicians of the Medical Staff who have been assigned practice privileges.
6. In the event the attending physician utilizes telephone orders to direct care of the patient, the order will be sent to the physician for signature or signed at the next patient visit but shall be signed within 10 days.
7. Evidence of informed consent for treatments and procedures shall be documented by the attending physician.
8. Pertinent progress notes shall be recorded legibly at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.
9. There shall be evidence in the patient medical record of current Advance Directives.
10. Discharge Summary (§483.20): The discharge summary shall be completed by members of the health care team after discharge and should include the following:
    a. Physicians must document the principal diagnosis and secondary diagnoses.
    b. The condition of the patient on discharge should be stated in terms that permit a specific, measurable comparison with the condition on admission.
    c. A brief recapitulation of the patient's stay with the reason for the long term care stay, significant findings and events of the stay, the patient's condition on discharge and recommendations and any specific instructions given, arrangements for future care (i.e. diet, medication, physical activity, and follow-up care).
    d. A post-discharge plan of care that is developed with the participation of the patient and his or her family, which will assist the patient to adjust to his or her new living environment.

B. Medical Record Completion Policy
    1. Following the discharge of the patient, the medical record shall be completed and the face sheet dated and signed within thirty (30) days of the discharge.
    2. Should the record be incomplete at the end of the thirty (30) day period, the incomplete record will be deemed delinquent.

3. Diagnoses shall be recorded in full, without the use of symbols or abbreviations, and dated and signed on the physician's discharge order sheet by the responsible physician at the discharge of all patients.
4. Reports of diagnostic procedures are to be recorded in the patient's record promptly. Only reports from licensed clinical labs shall be used in the patient's permanent medical record.
5. A medical record shall not be permanently filed until it is completed by the responsible physician or as ordered filed by the QI committee.

C. Release of Records
1. Medical records are the property of Red Bud Regional Hospital and are not to be released without the written consent of the patient, his/her legal representative, court order, subpoena, or statue.

Article III: Swing Bed Medical Director

A. The organization has a licensed physician who serves as the medical director to coordinate medical care provided to the patients and provide clinical guidance and oversight regarding the implementation of patient care policies. The medical director is appointed by the CEO.
B. The medical director's responsibilities are defined in a written agreement between the governing body and the medical director and include:
1. Directing and coordinating medical care in the organization.
2. Helping to arrange for continuous physician coverage to handle medical emergencies.
3. Helping to develop emergency-treatment procedures for patients.
4. Helping to develop patient transfer procedures. Resolve issues related to continuity of care and transfer of medical information between the facility and other care settings.
5. Guide, approve and help oversee the implementation of the policies, procedures, and guidelines.
6. Participating in the patient care management system of the organization that obtains and maintains timely and appropriate medical care that supports the health care needs of the patient is consistent with current standards of practice, and helps the facility meet its regulatory requirements.
7. Serving as a member of the organized medical staff, attending its meetings, and helping to encourage adherence to its bylaws and rules and regulations.
8. Working with other health care professionals to establish policies and practices to encourage all health care professionals practice within the scope of their licenses.
9. Consulting in developing and maintaining an adequate medical record system.
10. Participating in in-service training programs for staff, practitioners and education for patients, families and others.
11. Consulting with the organization's administrator and service directors about the organization's ability to meet the patient's needs.
12. Advising the administrator about the adequacy and appropriateness of the organization's scope of services, medical equipment, and its professional and support staff.
13. Exploring the opportunities for and advising the administrator about future patient care programs.

14. Participating in managing the environment by reviewing and evaluating event reports or summaries of incident reports, identifying hazards to health and safety, making recommendations to the administrator.
15. Being familiar with policies and programs of public health agencies that may affect patient care programs. Participate in the survey by helping clarify issues, questions or information and attend the exit conference if requested.
16. Acting as the organization's medical representative in the community.
17. Improving performance of medical services as an integral part of improving organization performance by reviewing and evaluating aspects of physician care and practitioner services and helping to identify, evaluate and address health care issues. Assuring a system exists to monitor the performance of health care practitioners.
18. Monitoring employee's health status and advising the administrator on employee-health policies.
19. Establish a framework for physician participation and physicians should believe that they are accountable for their actions and their care.
20. Actively participates in the organization's quality improvement program by:
    i. Addressing and resolving concerns and issues between physicians, health care practitioners and facility staff.
    ii. Facilitating feedback to physicians about their performance and practices.
    iii. Review individual patient care as requested or indicated.
21. Participate and provide necessary oversight for the Swing Bed Committee.

Article IV: General Conduct of Care

A. Patient care will be provided in accordance with the Illinois Nursing Home Care Act, State regulations under Illinois Department of Public Health Long Term Care, and the Omnibus Budget Reconciliation Act (OBRA) 1987 and The Joint Commission standards and according to Swing Bed policies and procedures.
B. Patient Rights as established by Federal and State regulations shall be adhered to by all physicians.
C. Visits:
    1. Skilled care patients will be visited at least once every thirty (30) days for the first ninety (90) days after admission.
    2. Patients at all levels of care will be visited at least once every sixty (60) days thereafter.
    3. Patients with unstable conditions or those receiving rehabilitation services will be seen as often as is consistent with good medical practice.
D. The patient and/or family will be apprised of the patient's medical condition.

Red Bud Regional Hospital

Medical Staff Rules and Regulations

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings.

ARTICLE I: ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS The admission policy is as follows:

1.1(a) Excluding emergencies, all patients admitted to the hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

1.1(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated and is not automatic with Medical Staff membership. All practitioners shall be governed by the admitting policy of the hospital. Physician assignment of patients within services shall be on a rotational basis.

1.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self-harm.

1.1(d) Emergency Department physicians must be board certified (or have equivalent education and training) in family practice, emergency medicine, internal medicine or have recent Emergency Department experience consisting of at least 2,500 hours in the previous five (5) year period. Emergency Department Physicians shall be required to maintain documentation regarding current ACLS, and PALS certification. All other physicians admitting to Red Bud Regional must either maintain documentation regarding current ACLS certification or must co-manage the case with an ACLS certified physician.

1.1(e) The management and coordination of each patient's care, treatment and services shall be the responsibility of a provider with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of the hospitalized patients, prompt completeness and accuracy of the medical record, necessary special instructions, transmitting reports of the condition of the patient to any referring practitioner and relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment, and surgical intervention. Whenever a provider's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered in the medical records.

1.1(f) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician, the following should be contacted, in order of priority listed below:

(1) An alternate provider (preferably a partner, associate or designee of the Attending Physician);

(2) The Chief of Staff, who may assume care for the patient or designate an appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO/ CAO to provide care for the patient.

1.2. ADMITTING POLICY Priorities for admission are as follows:
1.2(a) Emergency Admissions Within twenty-four (24) hours following all admissions, the Attending Physician shall have a history and physical dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.
1.2(b) Pre-operative Admissions This includes all patients scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgery may decide the urgency of any specific admission.
1.2(c) Routine Admissions This will include elective admissions involving all services.
1.2(d) Question of Validity If any questions as to the validity of admission to the facility should arise, the subject shall be referred to the provider for assistance.

1.3 PATIENT TRANSFERS
1.3(a) Transfer priorities shall be as follows:
(1) Emergency Department to appropriate patient bed.
(2) From any department in an emergency.
(3) From any department to Skilled Nursing Facility.
(4) From temporary placement in an inappropriate area to the appropriate area for that patient.
1.3(b) No patients will be transferred between departments without notification to the Attending Physician.
1.3(c) If there is no agreement to transfer, the Chief of Staff may consult any appropriate specialist in making this determination and shall make the decision.

1.4 SUICIDAL PATIENTS
For the protection of patients, the medical and nursing staff, and the hospital, the care of the potentially suicidal patient shall be as follows:
1.4(a) A patient suspected to be suicidal in intent shall be admitted to a security room consistent with the patient's medical needs. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or hospital policy. The patient will be afforded psychiatric consultation.
1.4(b) The hospital Case Manager should be consulted for assistance; and
1.4(c) If the patient presents to the emergency room, the steps set forth in Section 1.4(a) shall be followed, except the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the hospital's EMTALA policy, that benefits of transfer outweigh the risks.

1.5 DISCHARGE OF PATIENTS
The discharge policy is as follows:
1.5(a) Patients shall be discharged only on order of the Attending Physician. Should a patient leave the hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. The discharge

process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.
1.5(b) If any questions as to the validity of discharge should arise, the subject shall be referred to the provider for assistance.
1.5(c) The Attending Physician is required to document the need for continued hospitalization. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate.

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason. This report must be submitted within a reasonable period. Failure to comply with this policy will be brought to the attention of the MEC for action.
1.5(d) The Attending Physician shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and hospital staff shall ensure the patient or appropriate family member/ legally designated representative is provided with information that includes:
(1) Conditions that may result in the patient's transfer to another facility or level of care.
(2) Alternatives to transfer, if any.
(3) The clinical basis for the discharge.
(4) The anticipated need for continued care following discharge.
(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and
(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.6 DECEASED PATIENT

In the event of a patient death the deceased shall be pronounced dead by the Attending Physician, another member of the Medical Staff, the Emergency Department Physician, or the medical examiner, as appropriate. Such pronouncement shall be documented in the patient's medical record.

1.7 AUTOPSIES

Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law.

1.8 UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patient's treating and/or consulting provider shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital's Policy on Disclosure of Treatment Outcomes.

ARTICLE II: MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, clinical résumé and autopsy report. The record shall also contain a report of any emergency care, evidence of known advance directives, documentation of consent, and a record of any donation of organs or tissue or receipt of transplant or implants. The record shall contain a written plan of care, treatment and services appropriate to the patient's needs, identifying the patient's needs, goals, timeframes, settings, and services required to meet patient's needs. Such plan of care shall be discussed with the patient and shall be revised as necessary and where appropriate, consider strategies to limit the use of restraints and/or seclusion of the patient.

2.2 ADMISSION HISTORY

The requirements for admission, history and physical examinations are as outlined in the Medical Staff Bylaws, Article III, Medical staff Membership, Section 3.3(n).

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam containing the information outlined in Section 3.3(n) of the Medical Staff Bylaws must be recorded before all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents delay would be a threat to the patient's health. A history and physical performed within thirty (30) days prior to the procedure may be used if the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition not consistent with or noted in the history and physical, those must be documented prior to the procedure.

2.4 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written or dictated at least daily on all patients except on the day of admission. The written admission note shall serve as the progress note for the day of admission unless the patient's condition warrants further progress notes on that date.

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/ procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/ procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient's current medical record within twelve (12) hours after completion of surgery. An operative progress note must be entered immediately, before the patient is transferred to the next level of care, if the operative report is not placed in the record immediately after surgery. Any practitioner failing to dictate operative/ procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in circumstances outlined in the mandatory consultation policy. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall be recorded prior to the operation except in emergency situations verified on the record.

2.7 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record including written and verbal orders, shall be accurately dated, timed, and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials, or computer key. The use of rubber stamp signature is not acceptable under any conditions. All orders for medications and other services shall be documented using an electronic system that supports clinical decision-making when that electronic system is available for use at the Hospital. The electronic system will be accessible at the point of care and remotely, through a secure process. Electronic system orders shall be authenticated by an electronic-signature process with applicable legal and accreditation requirements as in these Rules & Regulations and hospital policy.

2.8 ABBREVIATIONS/SYMBOLS Abbreviations and symbols utilized in medical records are approved by the MEC and filed with Health Information Management. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.9 FINAL DIAGNOSIS The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. It shall also be dated and signed by the responsible practitioner at the time of discharge of all patients.

2.10 REMOVAL OF MEDICAL RECORDS Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records including imaging films are the property of the hospital and shall not be removed. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician whether the patient is

attended by the same practitioner or by another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

2.11 ACCESS TO MEDICAL RECORDS Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

Any provider on the Medical Staff may request a release of patient information providing the patient is under his/her care and treatment. Releases will not require a Release of Information form to be signed by the patient. The intent is to address a provider's need to have information available in the office to treat patients who may come to the office after having been seen, treated, or tested at the hospital. Persons not authorized to receive medical information shall require written consent of the patient, guardian, agent, or heirs. Certain information, including psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute and require a signed release from the patient or a court order before being released. Information should not be released to a patient's family member unless signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.12 PERMANENTLY FILED MEDICAL RECORDS A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or AHP(s) or is ordered filed by the MEC, the Chief of Staff or CEO with an explanation of why it was not completed by the responsible practitioner(s) or AHP(s).

2.13 ORDERS

2.13(a) Written/ Verbal/ Telephone Treatment Orders: Orders for treatment shall be in writing, dated, timed, and authenticated. Except for CRNAs in states that have opted out of the CMS supervision requirement, orders for treatment and care of patients may not be written by Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician.

Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the provider giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and CRNAs may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate he/she has written or otherwise recorded the order and shall read the verbal order back to the provider and indicate confirmation. The provider who gave the verbal order or another practitioner who is credentialed and granted privileges to write orders responsible for the care of the patient shall authenticate and date any order including medication orders as soon as possible, in no case longer than seventy-two (72) hours from dictating the verbal order.

Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

Verbal orders will not be accepted for chemotherapy drug orders, investigational drug, device or procedure protocols, orders to withhold (including Do Not Resuscitate orders) or withdraw life support. Withdrawing of life support will only be implemented with an order written and authenticated by the prescribing practitioner AND in accordance with applicable hospital policies regarding advanced directives.

Preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by the provider as prescribed in Article III, Section 3.2 of these Rules & Regulations.

2.13(b) Standing and Preprinted Orders and Order Sets:

(i) Standing Orders: To ensure continued appropriateness, practitioner-specific standing orders shall be reviewed annually by the physician and Utilization Management Committee. Standing orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

(ii) Evidence Based Order Sets: Use of preprinted and electronic order sets that are consistent with nationally recognized and evidence-based guidelines will be permitted subject to approval by the Medical Staff. The Medical Staff delegates to the Medical Executive Committee the responsibility for approval of Evidence Based Order Set templates in consultation with nursing and pharmacy leadership. Evidence based order set templates shall be periodically reviewed to determine continuing usefulness and safety of the orders and updated to track regulatory agency requirements, patient safety requirements, and other appropriate changes. The Medical Staff delegates to the Medical Executive Committee in consultation with nursing and pharmacy leadership the responsibility for approving all updates. All orders shall be dated, timed, and authenticated in the patient's medical record pursuant to the requirements by the ordering practitioner or another practitioner responsible for the care of the patient and authorized to write orders.

2.13(c) Previous Orders: All previous orders are cancelled when patients go to surgery.

2.13(d) Illegible Treatment Orders: The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

2.14 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.15 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. Health Information Management will provide each provider with a list of incomplete medical records every seven (7) days. At the twenty-first (21) day for any incomplete medical records, the letter will include a warning the record(s) will be delinquent at thirty (30) days and the provider's privileges will be suspended if any records become delinquent.

2.16(a) Suspension. A chart not completed within thirty (30) days of discharge will trigger suspension of the responsible provider's privileges. When staff is notified of suspension, the staff may not provide any hands-on patient care whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended provider may not cover Emergency Room call, may not provide coverage for partners or other providers, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the Chief of Staff and the CEO/ CAO.
2.16(b) The suspended staff member is obligated to provide the hospital CEO/ CAO and Chief of Staff the name of another provider who will take over the care of hospitalized patients, take call, emergency room coverage, consultations and any other services that provider provides.
2.16(c) All hospital departments shall be notified of a suspension to enable the enforcement of the suspension.
2.16(d) Any provider who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the appropriate department chair, the CEO/ CAO, chairperson of the Quality Management Committee or equivalent Medical Staff committee.

2.16 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Only the original author of an entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated including use of "white-out". To correct or amend an entry, the author should cross out the original entry with a single line, ensuring it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made. Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified.

ARTICLE III: GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission. The business office should notify the Attending Physician whenever consent has not been obtained. When notified it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

3.2 ADMINISTRATION OF DRUGS/MEDICATION

All drugs and medications administered to patients shall be listed on the hospital formulary. Drugs and medications not on the formulary may be approved for dispensing as outlined in hospital policy. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC. The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

3.3 ORDERING/DISPENSING OF DRUGS

The provider must order drugs by name, dose, route, and frequency of administration. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand another qualified professional subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. When the patient brings medication to the hospital, medications clearly identified may be administered by the nursing staff only if ordered by the provider and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and the decision shall be binding. Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of a "resume" order. The provider must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

3.4 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient or believes consultation is needed and has not been obtained, he/she shall call this to the attention of the supervisor who in turn may refer the matter to the Chief Nursing Officer (CNO) or designee. The CNO/designee shall contact the Attending Physician to attempt to alleviate this question. The CNO/ designee may then bring this matter to the attention of the Chief of Staff. If the circumstances are such as to justify such action, the Chief of Staff may request a consultation.

3.5 PATIENT CARE ROUNDS Hospitalized patients shall be seen by the attending physician or designated alternate at least daily and more frequently if status warrants. Patients in Swing Beds shall be seen every thirty (30) days and more frequently if status warrants by the Attending Physician or designated alternate. Patients admitted to the Progressive Care Unit (PCU) should be seen by the Attending Physician or designated alternate as soon as possible after admission to the unit, but in any event no later than six (6) hours after admission or sooner if warranted by the patient's condition. The attending physician or another provider member of the Medical Staff with appropriate clinical privileges designated by the attending physician shall see each non-Swing Bed patient at least once every three (3) calendar days and more frequently if warranted by the patient's condition or as otherwise specified in this Section 3.5. All daily rounding by the attending physician, provider alternative and/or appropriately credentialed AHP shall be documented in the patient's medical record with appropriate progress notes.
Requirements shall apply if the attending physician or another provider member of the Medical Staff with appropriate clinical privileges designated by the attending physician does not round on a non-Swing Bed patient in any given twenty-four (24) hour period and the daily rounding is provided by an appropriately credentialed AHP as set forth herein:

The attending physician shall remain responsible for the establishment and implementation of the patient's plan of care. The direction and supervision of the AHP services shall be the responsibility of the attending physician and AHP. Failure to appropriately supervise an AHP shall be grounds for corrective action against both the attending physician and the AHP pursuant to the Medical Staff Bylaws.

2. The attending physician or another provider member of the Medical Staff with appropriate clinical privileges designated by the attending physician must either

(i) certify in the medical record he/she has reviewed and evaluated the AHP's progress notes and other medical record documentation within that twenty-four (24) hour AHP rounding period; or

(ii) verbally communicate with the AHP regarding the patient within that twenty-four (24) hour rounding period such verbal communication to be documented by the AHP and co-signed by the provider by the end of the next calendar day.

The attending physician or another provider member of the Medical Staff with appropriate clinical privileges designated by the attending physician must be available to come to the facility if needed at all times. It is not permissible for a provider to "sign out" to the rounding AHP.

3. The attending physician or another provider member of the Medical Staff with appropriate clinical privileges designated by the attending physician must come to the facility and assess the patient in person within twenty-four (24) hours or sooner as warranted by the patient's condition if requested by the patient, family, rounding AHP, or any consulting physician or other member of the treatment team. The attending physician or another member of the Medical Staff with appropriate clinical privileges designated by the attending physician must:

1. Personally evaluate each non-PCU patient and formulate/ratify the plan of care within twenty-four (24) hours of an admission or sooner if warranted by the patient's condition.

2. Personally evaluate each patient in the PCU within six (6) hours after admission or sooner if warranted by the patient's condition. Thereafter, the attending physician or provider member of the Medical Staff with appropriate clinical privileges designated by the attending physician shall personally see patients in the PCU at least once every twenty-four (24) hours.

3. Generally evaluate each patient who has undergone inpatient surgery on postoperative day one. Healthy patients who are hospitalized for a period of less than forty-eight (48) hours for a routine surgery in which defined clinical pathways are established may be see on postoperative day one by an appropriately credentialed AHP as set forth in Section 3.5 if surgeon is available to personally assess the patient if needed.

4. Personally evaluate each patient on the calendar day prior to discharge (or the day of discharge) except as specifically noted above short stay surgical patients.

5. Personally evaluate each patient within twenty-four (24) hours prior to any transfer of a patient to a different level of care (whether higher or lower) or transfer to another facility.

3.6 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable the designee will assume responsibility for patient care.

3.7 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by law, TJC standards, and hospital policies pertaining to restraints and seclusion.

3.8 PRACTITIONERS ORDERING TREATMENT

When a practitioner who is not a member of Medical Staff orders treatment, licensure and Medicare/Medicaid eligibility will be verified. It will be confirmed the practitioner is ordering within the scope of practice.

3.9 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

Treatment by practitioners of immediate family members or self-treatment shall be reserved only for minor illnesses or emergency situations. Practitioners may not self-prescribe or prescribe to immediate family members any controlled substances. Written records must be maintained of any written prescriptions or administration of any drugs. A practitioner may not perform surgery on an immediate family member except in emergency where no viable alternative is available.

ARTICLE IV: GENERAL RULES REGARDING SURGICAL **CARE**

4.1 RECORDING OF DIAGNOSIS/TESTS

Excluding emergencies, prior to any surgical procedure a history, physical and other appropriate information including the preoperative diagnosis and appropriate laboratory tests must be recorded on the patient's medical record. If not recorded, the operation shall be canceled. In all emergencies, the practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

4.2 ADMISSION OF DENTAL CARE PATIENT

A patient admitted for dental care is a dual responsibility involving the dentist and a provider member of the Medical Staff.

4.2(a) Dentist's Responsibilities--The responsibilities of the dentist are:

(1) To provide a detailed dental history justifying hospital admission.

(2) To provide a detailed description of the examination of the oral cavity and preoperative diagnosis.

(3) To complete an operative report describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the hospital pathologist for examination.

(4) To provide progress notes as are pertinent to the oral condition; and

(5) To provide a clinical summary.

4.2(b) Provider 's Responsibilities--The responsibilities of the provider are:

(1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery.

(2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and

(3) To supervise the patient's general health status while hospitalized.

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist and provider member of the Medical Staff.

4.3 ADMISSION OF PODIATRIC PATIENTS

A patient admitted for podiatric care is dual responsibility of the podiatrist who is a staff member and the provider member of the Medical Staff designated by the podiatrist.

4.3(a) Podiatrist's Responsibilities--The responsibilities of the podiatrist are:

(1) To provide a detailed podiatric history justifying hospital admission.

(2) To provide a detailed description of the podiatric findings and a preoperative diagnosis.

(3) To complete an operative report describing the findings and technique. A tissue shall be sent to the hospital pathologist for examination.

(4) To provide progress notes as are pertinent to the podiatric condition; and

(5) To provide a clinical summary.

4.3(b) Provider's Responsibilities--The responsibilities of the provider are:

(1) To provide medical history pertinent to the patient's general health on the patient's chart prior to induction of anesthesia and start of surgery.

(2) To perform a physical examination to determine the patient's condition on the patient's chart prior to anesthesia and surgery; and

(3) To supervise the patient's general health status while hospitalized.

4.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and provider.

4.4 INFORMED CONSENT

A written, informed, and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high-risk treatments as provided by hospital policy and/or state law except in situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient or properly delegated representative after risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of care, and other information necessary to make a fully informed consent has been explained to the patient by the responsible provider. After informed consent has been obtained by the surgeon, the nurse shall obtain the patient's signature on the consent form and shall witness the signature. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation is desirable before the emergency operative procedure is undertaken if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, procedures may be described and consented to on the same form.

Each consent form shall include the name of the hospital where the procedure is to take place, specific procedure for which consent is being given, name of the responsible practitioner who is performing the procedure, a statement that the procedure including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or legal representative, and the signature of the patient or legal representative. The form must also comply with the requirements of applicable state law.

4.5 PATIENT REQUESTS AND REFUSAL OF TREATMENT

All refusals of consent to treatment by the patient or legally authorized to consent to treatment on the patient's behalf must be documented in the patient's permanent hospital record. Patients have the right to request any treatment at any time requests documented in the patient's permanent chart. Requests may be declined if determined to be medically unnecessary by the treating provider or designee.

4.6 EXAMINATION OF SPECIMENS

Specimens excluding teeth and foreign objects removed during a surgical procedure shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information.

Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff and documented in writing.

4.7 ELECTIVE SURGERY SCHEDULING

To reduce patient anxiety resulting from a long wait, reduce staff overtime for elective work and allow time for possible emergencies guidelines will be used for scheduling elective surgeries. Emergency procedures shall take priority above all other cases.

4.7(a) Standing Time:

7:30 a.m.

4.7(b) Priority Cases shall include:

(1) Age 12 and under.

(2) Open bone work.

(3) Latex allergic patients; and

(4) Contaminated cases last, if possible.

4.7(c) Scheduling of Cases:

(1) Elective surgery should be scheduled by 3:00 p.m. the previous day.

(2) All cases must be scheduled with Central Scheduling or Shift Supervisor in an emergency.

(3) All cases must be taken in the order they are scheduled, whether general or local, inpatient or outpatient, except for pre-existing priority cases.

(4) If a scheduled case is canceled, the schedule will be moved up to fill the vacancy. New cases will not replace the canceled case. Any other case scheduled by the same surgeon will be added to the end of the schedule.

(5) If a surgeon desires to change the order of his/her scheduled cases, any other surgeon who will be affected by the change must be notified and consent to the change; and

(6) The start time for a surgery shall be deemed to be the time of incision or invasion. If a surgeon is more than thirty (30) minutes late for a scheduled procedure, the case will then follow other scheduled cases. If the surgeon is more than fifteen (15) minutes late the OR Supervisor will attempt to contact the surgeon and ascertain when he/she will be available. If the surgeon will not be available within a reasonable period, the next scheduled surgery shall commence, and the case will be moved to the end of the schedule.

4.7(d) Preoperative workup is as deemed appropriate.

4.8 POST-OPERATIVE EXAMINATION For outpatient surgery patients discharged from recovery room to home, a post operative examination will be conducted by the surgeon.

4.9 ANESTHESIA Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care including deep sedation, regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

4.9(a) Anesthesia services throughout the hospital shall be organized into one anesthesia service under the direction of a qualified provider. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a provider who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. The director of anesthesia services may be, but is not required to be, an anesthesiologist member of the Medical Staff. Responsibility for the management of anesthesia services for an

individual patient lies with the provider or Allied Health Practitioner who provided the anesthesia services.
4.9(b) The hospital shall maintain policies and procedures governing anesthesia services provided in all hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess to administer anesthesia as well as moderate sedation or other forms of analgesia. Policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance for specific clinical applications involve anesthesia as opposed to analgesia.
4.9(c) Only credentialed and qualified individuals as defined in the policies and procedures of the hospital may provide anesthesia services. The Department of Surgery shall approve credentialing guidelines consistent with federal regulations and Joint Commission standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations and the policies and procedures of the hospital. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care must be supervised either by the operating practitioner who is performing the procedure or by an anesthesiologist who is ‘immediately available.' An anesthesiologist is considered "immediately available" only if physically located within the same area as the CRNA and not otherwise occupied in a way that prevents immediately conducting hands-on intervention, if needed.

When supervision of CRNA administered anesthesia services by a practitioner other than an anesthesiologist is required, doctors of medicine or osteopathy with clinical privileges to perform invasive procedures may supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care. Dentists, oral surgeons, and podiatrists who are qualified to administer anesthesia under state law may supervise the qualified CRNA in the administration of regional anesthesia and monitored anesthesia care.

4.9(d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in policies and procedures of the hospital. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care, this shall include a pre-anesthesia evaluation, an intraoperative record, and post anesthesia evaluation. Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthetist or anesthesiologist will reevaluate and document the patient's condition immediately before administering moderate or deep sedation or anesthesia, as such terms are defined by The Joint Commission.

The individual who administered the patient's anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital, must also perform a post anesthesia evaluation of the patient, and document the results of the evaluation no later than forty-eight (48) hours after the patient's surgery or procedure requiring anesthesia

services. Individual patient risk factors may dictate the evaluation be completed and documented sooner than forty-eight (48) hours as addressed in hospital policies and procedures. For those patients who are unable to participate in the post anesthesia evaluation, a post anesthesia evaluation should be completed and documented within forty-eight (48) hours with notation the patient was unable to participate, description of reason(s), and expectations for recovery time, if applicable.
4.9(e) The anesthetist or anesthesiologist will be responsible to obtain and document informed consent for anesthesia in the medical record. To ascertain the patient's wishes to the continuance of advanced directives, advanced directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the Attending Physician prior to surgery. If the patient's wishes have changed, documentation signed by the patient and surgeon or other provider participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.
4.9(f) The hospital must be able to provide anesthesia services within forty-five (45) minutes after the determination that such services are necessary.

4.10 ORGAN & TISSUE DONATIONS The hospital shall refer all inpatient deaths, emergency room deaths, dead on arrival cases and imminent patients' deaths to the designated organ procurement agency and/or tissue and eye donor agency to determine donor suitability and shall comply with all CMS conditions of participation for organ, tissue, and eye procurement. No provider attending the patient prior to death or involved in the declaration of death shall participate in organ removal. The hospital will utilize the screening process and requestor as outlined by the Organ Procurement Organization (OPO) to notify the family of potential organ donor of the potential to donate or decline to donate, organs, tissues, or eyes. Any individual involved in the request for organ, tissue and/or eye donation must be formally trained in the donation request process. The patient's medical record shall reflect the results of this notification.

ARTICLE V: GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents to the Emergency Department, she will be assessed by the triage nurse (R.N.) to determine whether the presenting complaint is onset of labor or a general other complaint, not of onset of labor. Patients at term (defined as 37 or more weeks gestation), determined to be complaining of labor onset, and not suffering from any apparent complications, assessed to determine benefits and risks of transfer. Those stable for transport will be transferred (with qualified medical staff) to the nearest receiving facility with an obstetrical department. All other pregnant females presenting to the Emergency Department, whether complaining of preterm labor or presenting with other complications, will be medically screened and treated as provided in Article VI of these Rules and Regulations.

ARTICLE VI: EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

(1) Any individual who presents to the Emergency Department for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an "emergency medical condition" is defined as active labor or as a

condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

(2) Examination and treatment of emergency medical conditions shall not be delayed inquiring about the individual's method of payment or insurance status nor denied on account of the patient's inability to pay.

(3) All patients shall be examined by qualified medical personnel defined as a provider or, in the case of a woman in labor, a registered nurse trained in obstetric nursing were permitted under State law and Hospital policy.

(4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department even if not directly located in the department.

6.1(b) Stabilization

(1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.

(2) A patient is Stable for Discharge when within reasonable clinical confidence, it is determined the patient has reached the point where continued care including diagnostic work-up and/or treatment could reasonably be performed as an outpatient provided the patient is given a plan for appropriate follow-up care with the discharge instructions or when the patient requires no further treatment and the treating provider has provided written documentation of findings.

(3) A patient is Stable for Transfer if the treating provider has determined within reasonable clinical confidence the patient is expected to leave the Hospital and be received at a second facility with no material deterioration in medical condition and the treating provider reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is Stable for Transfer when protected and prevented from injuring self or others.

(4) A patient does not have to be stabilized when:

(i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations requests the transfer and signs a transfer request form; or

(ii) based on the information available at the time of transfer the medical benefits to be received at another facility outweigh the risks of transfer to the patient and a provider signs a certification which includes a summary of risks and benefits to this effect.

(5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment refusal shall take all reasonable steps to have the individual sign a form indicating refusal. The Emergency Department Physician shall document the refusal in the patient's chart which shall be witnessed by the Emergency Department supervisor. If the patient desires, the patient will be helped in finding a physician for outpatient follow-up care.

6.1(c) Transfer

(1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.

(2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.

(3) Upon transfer, the Emergency Department shall provide a copy of appropriate medical records regarding its treatment of the individual including observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer

certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period to provide stabilizing treatment.

(4) All reasonable steps shall be taken to secure the written consent or refusal of the patient or representative with respect to the transfer. The Emergency Department Physician must inform the patient or representative of the risks and benefits of the proposed transfer.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

6.2(a) When the Emergency Department Physician determines a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private provider. This request will be documented in the medical record.

6.2(b) The provider whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department and document the time of the contact in the medical record.

6.2(c) An appropriate attempt to contact the provider will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Attempted to reach the provider in the hospital.

(2) Called the provider at home.

(3) Called the provider at his/her office; and

(4) Called once on the provider's pager.

Thirty minutes will be considered a reasonable time to carry out this procedure.

6.2(d) The rotation call list containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. If the patient does not have a private provider, the private provider refuses the request to come to the Emergency Department, or the provider cannot be contacted within thirty (30) minutes of initial request, the rotation call list shall be used to select a private provider to provide the necessary consultation or treatment. A physician who has been called from the rotation list may not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the CEO/ CAO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

6.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the provider's office. If after examining the patient the physician who is consulted or is called from the rotation schedule feels consultation with another specialist is indicated, it will be that provider's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient. Members of the courtesy/consulting specialists shall participate in the on-call backup to the Emergency Department.

6.2(f) Physicians called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in, they are required to do so within sixty (60) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within forty-five *(45)* minutes of initial contact. In the event of a disaster, the Emergency Management phone tree will be utilized for additional Medical Staff coverage.

6.2(g) The system for providing on-call coverage, including specification of which specialties shall cover call and the minimum obligations, shall be approved by the Board of Trustees and documented

in writing. As a condition of Medical Staff appointment, all emergency department physicians and any provider who is or may be required to take unassigned call for Emergency Department patients pursuant to the provisions of the Bylaws, Rules and Regulations shall be required to receive hospital-sponsored or hospital-approved EMTALA training prior to initial appointment and prior to each subsequent reappointment to the medical staff.

ARTICLE VII: ADOPTION & AMENDMENT OF RULES & REGULATIONS

7.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to bring before the Board formulated, adopted, and recommended Medical Staff Rules & Regulations and amendments thereto effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO/ CAO, Board, and community.

7.2 ADOPTION, AMENDMENT & REVIEWS These rules and regulations shall be considered a part of the bylaws except they may be amended or replaced at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board, the Board may initiate revisions to the Medical Staff Rules & Regulations considering the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed but at least every two (2) years.

7.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

7.3(a) Appending Rules & Regulations approved amendment dated and signed by the Chief of Staff, CEO/CAO, and the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel; or

7.3(b) Restating Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to Rules & Regulations since last restatement which restated Rules & Regulations shall be dated and signed by the Chief of Staff, CEO/CAO, and Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel.

Each member of the Medical Staff shall be given a copy of any amendments to Rules & Regulations in a timely manner.

7.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. Should the Board suspend, override, supplement or replace rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting or at a special called meeting as provided in the bylaws and proceed as provided in Section 7.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached the Board shall have the ultimate authority to adopt/ amend Rules & Regulations but shall exercise authority unilaterally only when the Medical Staff has failed to fulfill its obligations, and it is necessary to

ensure compliance with applicable law or regulation or to protect the well-being of patients, employees or staff.

MEDICAL STAFF RULES & REGULATIONS APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____
Chief of Staff
Date: 5/31/2024

RED BUD REGIONAL HOSPITAL:

By: _____
Chief Administrative Officer
Date: 5/31/2024