Community Rehabilitation Hospital North
Medical Staff Bylaws
and
Rules and Regulations

Medical Staff Approval: 5.15.2018
Board of Managers Approval: 5.31.18

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PREAMBLE

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WHEREAS, Community Health Network Rehabilitation Hospital North, LLC ("Hospital") is operated and organized as a Delaware limited Liability Company;

WHEREAS, its purpose is to serve as an acute rehabilitation hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Managers, and that the cooperative efforts of the Medical Staff, the CEO and the Board of Managers are necessary to fulfill the Hospital's obligation to its patients;

THEREFORE, the practitioners practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and adopt these Bylaws, subject to approval by the Board of Managers.

DEFINITIONS

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1. The term "Medical Staff" means all medical or osteopathic physicians, and duly licensed dentists and podiatrists who are privileged through the Medical Staff process and who are subject to the Medical Staff Bylaws to attend patients in the Hospital.

2. The term "physician" shall mean any person holding a license to practice medicine and/or surgery under Indiana state statutes, as amended from time to time, and/or any person holding a license to practice osteopathic medicine and/or surgery under Indiana state statutes as amended from time to time. The term "dentist" shall mean any person holding a license to practice dentistry under Indiana state statutes as amended from time to time. The term "podiatrist" shall mean any person holding a license to practice podiatric medicine under Indiana state statues as amended from time to time.

3. The term "Board" and/or "Board of Managers" means the Board of Managers of the Hospital.

4. The terms Quality Council Committee" and "Quality Council" mean the Medical Staff membership participating with Hospital leaders and staff in overseeing functions of the Hospital.

5. The terms "Medical Executive Committee" and "MEC" means the officers of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws.

6. The term "CEO" means the individual appointed by the Board of Managers to act in its behalf in the overall management of the Hospital.

7. The term "practitioner" means appropriately medical physician, an osteopathic physician with unlimited license, appropriately licensed dentist, podiatrist, and licensed or certified/registered practitioners of Allied Services including psychologists and optometrists.

8. The term "Medical Director" means the Medical Director of the Hospital, as appointed by the Board of Managers.

9. The term "Allied Health Professional" (AHP) means an individual with license or certificate appropriate to his/her specialty, other than licensed physicians, dentists, or podiatrists who are not credentialed as members of the Medical Staff of the Hospital, who exercises independent judgment in areas of his/her professional competence, and who is qualified to render medical or surgical care. Allied Health Professionals assigned to the AHP category shall have a member in good standing of the Medical Staff in the same medical discipline and act as his/her collaborating physician, accepting responsibility for the patient care rendered by the Allied Health Professional. The following may be deemed AHPs for the purposes of this section: psychologists, audiologists, nurse anesthetists, nurse clinicians/practitioners, physician assistants, psychologists, optometrists, and other AHPs as shall be deemed appropriate by the Board of Managers.

ARTICLE I:
NAME

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of Community Rehabilitation Hospital North.

ARTICLE II:
PURPOSES

ARTICLE II: PURPOSES

The purposes of this organization are:

1. To promote high-quality acute rehabilitative care for all patients admitted to or treated in any of the facilities or services of the Hospital.

2. To promote a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through an ongoing review and evaluation of each practitioner's performance in the Hospital.

3. To develop, adopt and maintain the Medical Staff Bylaws, rules, regulations and policies for self-government of the Medical Staff in accordance with the policies of the Board of Managers, subject to the ultimate authority of the Board of Managers to approve the adoption of such Bylaws and policies, and to propose such Bylaws and policies (and amendments thereto) directly to the Board of Managers.

4. To provide an appropriate education setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

5. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board of Managers and the CEO.

6. To provide information to any Hospital committee for the purpose of reducing morbidity and mortality in a manner considered privileged and inaccessible in legal proceedings by taking measures of confidentiality.

7. To provide that all patients admitted to or treated in the Hospital shall receive quality medical care regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.

8. To ensure compliance with these Bylaws and policies adopted hereunder and to enforce such Bylaws, subject to any required approval by the Board of Managers.

ARTICLE III:
MEDICAL STAFF MEMBERSHIP

ARTICLE III: MEDICAL STAFF MEMBERSHIP

NATURE OF MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT

1. Appointment and reappointment to the Medical Staff is a privilege which may be extended only to professional competent doctors of medicine, doctors of osteopathic medicine, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted by the Board of Managers from time to time. Privileges shall not be restricted on grounds of age, race ethnicity, religion, culture, language, physical ability, sex, and sexual orientation.

2. Only physicians, dentists and podiatrists who can document their background, experience, training and demonstrated current competence, their adherence to the ethics of their profession, their good reputation and character, and their ability to work harmoniously with others sufficiently to assure the Medical Staff and the Board of Managers that all patient(s) treated by them in the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner, may be qualified for appointment and reappointment to the medical staff. No individual shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual is duly licensed to practice a profession in this or in any other state, or that such individual is a member of any professional organization, or that such individual had in the past, or presently has, such privileges at another hospital.

3. Without limiting the generality of the foregoing, each Member of the Medical Staff shall meet, at the time of initial appointment and continuously throughout his or her membership, at least the following minimum criteria:

    a. Current licensure to practice in the state of Indiana
    b. Current DEA registration and Indiana CSR to prescribe controlled substances, unless prescribing is not part of such member's practice
    c. A degree from a school of medicine, osteopathic medicine, dentistry or podiatric medicine and successful completion of an appropriate residency program accredited by the American Board of Medical Specialties, the Commission on Dental Accreditation of the American Dental Association, or another nationally recognized accrediting body.
    d. An appropriate level of clinical experience measured by national care criteria.
    e. Under no current exclusion from participation in federal healthcare programs.

4. Additional minimum criteria may be imposed with respect to clinical privileges in particular specialties or subspecialties. The Board may make exceptions or additions to any of the above qualifications and requirements after consulting with and obtaining a recommendation from the MEC.

5. On an annual basis, each Member of the Medical Staff shall provide to the Hospital a certificate of insurance evidencing current professional liability coverage and qualification under the Indiana Medical Malpractice Act (IC 34-18 et seq.). The minimum amount of liability insurance shall be the

limit provided for by the state, or such greater amount as may be established by the Board from time to time.

6. A physician, dentist or podiatrist who does not meet the basic qualifications is ineligible to apply for Medical Staff membership, and any application from such a physician, dentist or podiatrist shall not be processed. The qualifications for membership must be documented with sufficient adequacy to satisfy the Medical Staff and Board that each has enough information to make a fully informed decision regarding appointment and assignment of privileges. No person shall be appointed to the Medical Staff if the Board, in its sole discretion, is unable to provide adequate facilities and support services for the applicant or his/her patients.

CONDITIONS AND DURATION OF APPOINTMENT

1. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Managers in accordance with the processes specified in these Bylaws. The Board of Managers shall act on appointments, reappointments, or revocation of appointments after there has been a recommendation from the Medical Staff as provided in these Bylaws; however, subject to the exhaustion of application processing time frames as noted in Article V, the Board of Managers may act without such medical Staff recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

2. Initial appointments shall be for a period of not less than one year nor more than two years. Reappointments shall be for a period of not more than two years. If during initial appointment or reappointment, the practitioner moves out of the service area (defined as within 20 miles of the hospital), does not continue malpractice insurance as required by the Bylaws, or fails to apply for reappointment after notification, such practitioner's staff membership will be administratively discontinued. This will be considered a voluntary relinquishment and a non-reportable event in relation to the National Practitioner Data Bank.

3. Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Managers, in accordance with these Bylaws.

4. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by the Medical Staff Bylaws, rules and regulations, to accept physician liaison and performance improvement assignments and to accept consultation assignments.

ARTICLE IV:
CATEGORIES OF THE MEDICAL STAFF

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into "Active" and "Courtesy". A one-year provisional period is required in the Active and Courtesy categories prior to being eligible for full staff membership. The provisional status will be waived during the first 12 months of Hospital operation, and practitioners appointed to the Medical Staff during that period will automatically be placed in Active or Courtesy categories. The provisional status is for a minimum of one year and may be extended for one additional year by action of the Board of Managers.

Failure of the applicant to fulfill all of the requirements of appointment relating to meeting attendance, completion of medical records or participation in quality improvement activities may result in the extension of the initial provisional period or relinquishment of staff membership and clinical privileges. By applying for staff membership, the applicant expressly agrees to be bound by these terms, and that any extension of the initial provisional period or relinquishment by reasons such failure does not afford the applicant any rights under the hearing and appellate review procedures outlined in these Bylaws.

A. THE ACTIVE MEDICAL STAFF

The Active Medical Staff shall consist of physicians, dentists and podiatrists who regularly admit or attend, or are regularly involved in the treatment of patients in the Hospital or are regularly involved in the Medical Staff functions (as determined by the Medial Staff) and who are located close enough (as may be determined by the Medical Executive Committee) to the Hospital to provide continuous care to their patients, and who fulfill all the functions and responsibilities of membership on the Active Medical Staff, including participating in the call schedule and other assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office and to serve as functional liaisons, and shall be encouraged to attend Quality Council Committee meetings. Any reference in these Bylaws to votes or elections by the Medical Staff shall refer only to votes by the voting Medical Staff, which shall be limited to the Active Medical Staff.

B. THE COURTESY MEDICAL STAFF

The Courtesy Medical Staff shall consist of qualified physicians, dentists and who hold privileges to actively manage patient care or to refer and follow hospitalized patients but who do not regularly admit or attend, or are not regularly involved in the treatment of patients in the Hospital or are not regularly involved in the Medical Staff functions as determined by the Medical Staff. Courtesy staff members may provide coverage for members of the Active and Courtesy Medical Staff. Courtesy Medical Staff members shall not be eligible to vote or hold office in this Medical Staff organization. Any Member of the Courtesy Medical Staff who applies for appointment to the Active Medical Staff, upon approval of such application, will be placed on the provisional Active Medical Staff and be subject to all the rules and regulations thereof for a period of at least one year but not to exceed two years.
Those members of the medical staff who only have patient contact via telemedicine shall be considered members of the Courtesy Staff and will be credentialed as other Courtesy Staff.

ARTICLE V:
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

A. APPLICATION FOR APPOINTMENT

All applications for appointment and reappointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall include content approved by the Board of Managers. The application shall require detailed information concerning the applicant's professional qualifications, shall include the name of at least two peers who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character. Peer recommendations shall include the following information: (i) medical/clinical knowledge; (ii) technical and clinical skills; (iii) clinical judgment; (iv) interpersonal skills; (v) communication skills; and (vi) professionalism. The applicant shall include information as to whether the applicant's membership status and/or clinical privileges have been voluntarily surrendered or involuntarily revoked, suspended, reduced or not renewed, or if the applicant is under any current or pending challenges at any other hospital or institution, whether licensure or registration has been voluntarily surrendered or involuntarily limited or relinquished, or is under any current or pending challenges; shall include information as to whether the applicant's membership in local, state or national medical societies, or such applicant's license to practice any profession in any jurisdiction, has been voluntarily surrendered or involuntarily suspended or terminated, or is under any current or pending challenges; and shall include involvement in any current, pending or past professional liability actions with a report on all final judgments and settlements.

1. The Hospital will verify the identity of the applicant by viewing one of the following:
    a. A current picture hospital ID card
    b. A valid picture ID issued by a state or federal agency (e.g. driver's license or passport)

2. All applicants, by virtue of their application for staff membership and clinical privileges, agree to inform the Hospital during their membership on this Medical Staff of any actions that would serve to reduce or suspend their membership or clinical privileges on any other Medical Staff of which they are a member. All applicants for medical staff membership shall be required to be members in good standing of the medical staff of an acute care hospital located in the same service area as may be determined by the Board of Managers. (This is not a requirement for Allied Health Practitioners including Optometrists and Psychologists).

3. Upon appointment, renewal, and revision of privileges the following criteria shall also be evaluated:
    a. Verification of current licensures and/or certification, as appropriate, with primary source.
    b. OIG Exclusion Database is checked.
    c. The National Practitioner Data Bank (NPDB) is queried.
    d. Primary source verification of applicant's relevant training.
    e. Data from professional practice review by an organization that currently privileges the applicant (if available).
    f. Peer and/or faculty recommendations based on:
        i. Medical/clinical knowledge
        ii. Technical and clinical skills
        iii. Clinical judgment

iv. Interpersonal skills
v. Communication skills
vi. Professionalism

g. When renewing or expanding privileges, review of the practitioner's performance within the Hospital.

4. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

5. Health status documentation will include the applicant's statement that no health problems exist that could affect his/her practice.

6. The application will be submitted to the CEO for review and verification that all questions are fully answered. If additional information is required, the applicant will be informed that processing will not begin until the application is complete. When complete, the CEO shall submit the application and all supporting materials to the Medical Director for evaluation and recommendations, which will then be presented to the Medical Executive Committee.

7. By applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to the application; authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the clinical privileges he/she requests as well as his/her moral and ethical qualifications for staff membership; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and releases from any liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information. The applicant further agrees to abide by these Bylaws; to provide appropriate continuing care to all patients in the hospital for which he/she is responsible; to accept and actively participate in committee assignments to which he/she is assigned; to serve on any required on-call schedules; to abide by the ethical principles of his/her profession; to notify the CEO or his/her designee of any change in eligibility for payments from any third-party payor or his/her participation in the Medicare program and any other governmental healthcare programs; and all other conditions of appointment as noted in the application for Medical Staff membership and clinical privileges, or as required by the Board of Managers.

8. The following procedure will be utilized for initial or provisional staff appointments:

    a. A focused Professional Practice Review shall be completed on each physician no later than nine months after an initial appointment. Indicators or triggers for performance improvement shall be identified by the Medical Executive Committee for the Focused Professional Practice

Review. The indicators may include data on acute care transfers, patient safety data such as infections and falls; complaints, admissions, etc. as specified by the Medical Executive Committee. The review shall be presented to the Medical Executive Committee.

b. The Medical Executive Committee will review all available information, interview the applicant, and will recommend to the Board of Managers:
   - Active or Courtesy staff membership with defined privileges.
   - Continuance on the provisional Medical Staff with defined privileges for an additional year, in accordance with Article IV, Courtesy Medical Staff.
   - Denial or limitation in staff membership and/or privileges.

9. The application for privileges shall include a statement that the applicant has received the Bylaws, including the section on rules and regulations of the Medical Staff and that they agree to be bound by the terms thereof if they are granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not they are granted membership and/or clinical privileges in all matters relating to consideration of their application.

Each application for staff appointment and clinical privileges shall be processed as expeditiously as possible. After the CEO and Medical Director have determined that the application is complete, the Medical Executive Committee shall make a report and recommendation to the Board of Managers within 120 days, except where continued ongoing investigation of the applicant is required or if a hearing has been requested by the applicant in response to an adverse recommendation.

B. APPOINTMENT PROCESS

1. The Medical Director or designee shall make a report of his/her investigation to the Medical Executive Committee. Prior to making the report, the Medical Director shall examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner. Additionally, it shall be determined through information obtained in references given by the practitioner and from other sources available to the Medical Director (including an appraisal from the clinical specialty in which privileges are sought), whether the practitioner has established and meets all the necessary qualifications for the category of staff membership and requested clinical privileges. The Medical Director may require a meeting with the applicant to discuss the application, the applicant's qualifications, and the clinical privileges being requested. The Medical Director shall transmit to the Medical Executive Committee the completed application and a recommendation that the practitioner be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration. The Medical Executive Committee shall determine whether to recommend to the Board of Managers that the practitioner be provisionally appointed to the Medical Staff, that he/she be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

2. When the recommendation of the Medical Executive Committee (MEC) is to defer the application for further consideration, it must be followed up within thirty (30) days, with a subsequent

recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

3. When the recommendation of the MEC is favorable to the practitioner, the CEO shall promptly forward it, together with all supporting documentation to the Board of Managers.

4. When the recommendation of the MEC is adverse to the practitioner either in respect to appointment or clinical privileges, the CEO shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board of Managers until after the practitioner has exercised or has been deemed to have waived their right to a hearing as provided in Article VIII of these Bylaws.

5. When a hearing is requested, the record of the hearing and the recommendation of the hearing committee will be reported to the MEC. When the Medical Executive Committee's reconsideration is favorable to the practitioner, it shall be processed. If such recommendation continues to be adverse, the CEO shall promptly so notify the practitioner, by certified mail, return receipt requested. The CEO shall also forward such recommendation and documentation to the Board of Managers, but the Board of Managers shall not take any action thereon until after the practitioner has exercised or has deemed to have waived their right to an appellate review as provided in Article VIII of these Bylaws.

6. At its next regular meeting after receipt of a favorable recommendation, the Board of Managers shall act on the matter. If the Board of Managers' decision is adverse to the practitioner in respect to either appointment or clinical privileges, the CEO shall promptly notify the practitioner of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under Article VIII of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

7. At its next regular meeting after all the practitioner's rights under Article VIII have been exhausted or waived, the Board of Managers shall act on the matter. The Board of Managers' decision shall be conclusive, except that the Board of Managers may defer final determination by referring the matter back to the MEC for further consideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board of Managers shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Board of Managers shall make a decision either to provisionally appoint the practitioner to the staff or to reject them for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

8. When the Board of Managers' decision is final, it shall send notice of such decision through the CEO to the Chairman of the MEC and by certified mail, return receipt requested, to the practitioner. If the decision is adverse to the applicant, the applicant cannot reapply for membership on the Medical Staff for a period of two years, unless there is substantial evidence of additional training and/or there is substantial evidence of improvement in the identified problems.

C. REAPPOINTMENT PROCESS

1. Reapplication, reappointment, and granting of privileges shall be for a period of no more than two years, in a manner established by the Medical Staff Bylaws. If a practitioner has been sent two reappointment forms (one by certified mail) and no response is received, he/she will be considered to have voluntarily relinquished his/her privileges. The Medical Director or his/her designee shall evaluate the practitioner's professional performance by reviewing reports including quality and performance improvement data as defined by the Medical Staff and information which addresses general competencies of (1) patient care, (2) medical/clinical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism and (6) systems based practice. Recommendations for reappointment shall be presented to the MEC.

2. Where non-reappointment or a change in clinical privileges is recommended by the MEC, the reason for such recommendation shall be stated and documented. Where sufficient information regarding current competencies, patient activity or performance improvement cannot be determined based on the practitioners in-house activity, the practitioner may be asked to provide information from other facilities where the practitioner has privileges.

3. Each recommendation concerning the reappointment of a Medical Staff Member and the clinical privileges to be granted upon reappointment shall be based upon such Member's professional competence and clinical judgment in the treatment of patients, ethics and conduct, health status, involvement in performance improvement activities, and participation in staff affairs, participation in continuing medical education related to relevant clinical privileges, and compliance with the Hospital policies and the Medical Staff Bylaws, Rules and Regulations.

4. Each reapplication requires primary source verification of licensure, as well as verification of any education or training completed as evidence of qualification for clinical privileges. The applicant shall provide a current professional liability insurance certificate with a carrier licensed or approved by the State Insurance Department. The minimum amount of liability insurance shall be the amount required by the state or such higher amount as may be established by the Board of Managers. Reapplication should include any current or pending challenges to board certification, any licenses or DEA or state permits or registrations. The reapplication should include a description of any active professional liability claims including any that have arisen since the prior application and the status of each such claim.

5. The MEC shall make written recommendations to the Board of Managers, through the CEO and Medical Director, concerning the reappointment, non-reappointment and/or clinical privileges of each practitioner then scheduled for periodic appraisal. When non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

   Thereafter, the procedure provided relating to recommendations on applications for initial appointment shall be followed.

C. EVALUATION OF PRACTITIONER PROFESSIONAL PERFORMANCE

Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation are credible processes to determine competency through data collection and evaluation. These activities serve to enable objective, evidence based decisions regarding appointment to membership on the Medical Staff and for recommendations to grant or deny initial and renewed privileges.

ARTICLE VI:
CLINICAL PRIVILEGES

ARTICLE VI: CLINICAL PRIVILEGES

A. CLINICAL PRIVILEGES

1. Every practitioner at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to such practitioner by the Board of Managers, as provided in this Article VI.

2. Every initial application for staff appointment and every application for reappointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information may include an appraisal by physicians of the clinical specialty in which such privileges are sought. The applicant shall have the burden of establishing their qualifications and competence in the clinical privileges requested.

3. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the observation of care provided, review of the records of patients treated in this Hospital or other hospitals and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.

4. The Medical Staff Bylaws establish criteria for the granting of clinical privileges. Such criteria shall be consistent with both community standards and applicable professional standards. Further, the MEC shall be authorized and entrusted with the responsibility of seeking all resources of information available and necessary to ensure the completion of a full credentials evaluation recommendation. This may include a variety of external resources.

B. CLINICAL PRIVILEGES - RESTRICTED

1. **Allied Health Professionals (AHPs)**
   a. Qualified members of the Allied Health Professions, whose patient care activities require that their appointment and authority for specified services shall be processed through the usual Medical Staff channels.

      <u>Eligibility for privileges shall be determined on the basis of the following criteria:</u>

- Only an AHP holding a license, certificate or other credentials as may be required by applicable state law, and who has had the required training and education appropriate for their special services is eligible to provide specified services in the Hospital within the scope of their recognized professional qualifications and skills. The Medical Executive Committee may establish additional qualifications required of members of any particular category of AHPs.
- AHPs exercise judgment within their areas of competence, provided that a physician member of the Medical Staff shall have the ultimate responsibility for patient care;
- As licensure and scope of practice requirements dictate, AHPs participate directly in the management of patients under the supervision or direction of a member of the Medical Staff;

- AHPs record reports and progress notes on the patient's records and write orders or recommendations to the extent established for them by the Medical Staff; and
- AHPs perform services in conformity with the applicable provisions of the Medical Staff Bylaws, including the section on rules and regulations.
- AHPs shall be licensed to practice in the state.
- Members of Allied Health Professions shall carry out their activities subject to policies and procedures that foster optimal achievable patient care.
- A copy of the Medical Staff Bylaws, including the section on rules and regulations will be provided to each Allied Health Professional. Each member of the Allied Health Professional staff shall sign, on notification of appointment to the Allied Health Professional Staff, an agreement to abide by the current Medical Staff Bylaws, including the section on rules and regulations.
- In those cases involving use by physicians of allied health professionals, the organized Medical Staff shall work closely with members of the appropriate discipline in delineating such functions, e.g., Medical Executive Committee, the Medical Director, the administration, patient care services, etc.
- The Allied Health Professional staff shall be reappointed on a biennial basis. Members of the Allied Health Professional staff shall not vote or hold office, but may attend Medical Staff meetings and shall be responsible for all other functions and responsibilities of the Medical Staff as outlined in the Bylaws, including the section on rules and regulations.

- Procedure for Specification of Service:
  Position Evaluations and Descriptions: Written guidelines for the performance of specified services by AHPs will be developed by the appropriate disciplines to which they are assigned, or by the assigned physician who has the final responsibility for the welfare of the patient. For each category of AHPs such guidelines must include, without limitation:
  - Specification of the classes of patients that may be seen (e.g., only those of the employer-physician, only those referred by or from a particular clinical service, or any referred by a physician or other authorized practitioner); and,
  - A description of the services to be provided and procedures to be performed, including the equipment or special procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient's medical record; and,
  - Definition of the degree of assistance that may be provided to an AHP in the treating of patients on Hospital premises and any limitations thereon, including the degree of physician supervision required for each service.

  Evaluation of Individual AHP Applications: An application for specified services for an AHP is submitted and processed in the same manner as provided for initial Medical Staff appointments. An AHP is subject to a provisional period and formal periodic reviews as determined for his/her category.

b. Psychologists
   - Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license

to practice. They will not prescribe drugs or in any other way practice outside the area of their approved clinical privileges or expertise.

- Psychologists may not admit patients. They may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care. All patients who receive psychological care shall receive the same medical appraisal as all other patients of the Hospital. A Member of the Medical Staff who is a physician shall admit the patient and be responsible for the history and physical and any medical care that may be required during hospitalization, and shall determine the appropriateness of any psychological therapy in the context of the total health status of the patient. Psychologists may provide consultation within their area of expertise.

c. Optometrists

- Optometrists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. They will not prescribe drugs, or in any way practice outside the area of their approved clinical privileges or expertise.
- Optometrists may not admit patients. They may determine and address the visual abilities, changes in vision and corrective lens needs as part of a patient's comprehensive care. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and be responsible for the history and physical and any medical care that may be required during hospitalization, and shall determine the appropriateness of any visual assessment or corrective lenses on the total health status of the patient. Optometrists may provide consultation within their area of expertise and develop individualized treatment plans by adapting and fitting corrective lenses to promote rehabilitative recovery and aid in return to previous functional levels.

C. TEMPORARY PRIVILEGES

1. Circumstances - Temporary privileges/specified services may be granted in the following circumstances:
   - To fulfill a patient care need or
   - When an applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Board of Managers.

   Temporary Privileges are only granted by the Medical Director and CEO , or his designee, following the individual providing, and the Medical Staff office verifying current licensure and/or certifications, relevant training or experience, current competence, professional liability insurance coverage, as well as an inquiry made to the National Practitioner Data Bank, and after there has been a favorable recommendation made by the Medical Director regarding the applicant's application for appointment to the Medical Staff. The applicant shall act under the supervision of the Medical Director. Such temporary privileges may be granted for up to one hundred twenty (120) days.

2. The practitioner shall agree to abide by the Bylaws and the rules and regulations of the Hospital and Medical Staff. The number of patients treated by the practitioner may be limited at the discretion of

the Medical Director. The practitioner is encouraged to apply for membership on the Medical Staff. Special requirements of supervision and reporting may be imposed by the Medical Director on any practitioner granted temporary privileges. Where such imposed requirements are not followed, temporary privileges shall be immediately terminated by the CEO upon notice of any failure by the practitioner to comply with such special conditions. There will be no procedural rights in this situation.

3. The CEO may at any time, based upon the recommendation of the Medical Director terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) then under their care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any persons entitled to impose a summary suspension pursuant to item B1 of Article VII of these bylaws, and the same shall be immediately effective. The Medical Director or designee shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

D. EMERGENCY PRIVILEGES

In the case of emergency, any physician or dentist Member of the Medical Staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, the patient shall be assigned to a Member of the Medical Staff who holds privileges appropriate to address the patient's medical conditions. For the purpose of this section, an "emergency" is defined as a condition or set of circumstances in which any delay in administering treatment would increase the danger to the patient's life or the danger of serious harm.

E. CREDENTIALS IN THE EVENT OF A DISASTER

In the event of a declared disaster at the Hospital, practitioners who are not Members of the Medical Staff may be granted temporary privileges by the Medical Director. To be granted such privileges for the duration of such disaster, the practitioner must provide a valid government-issued photo identification issued by a State or federal agency and at least one of the following:

- a current professional license to practice in Indiana;
- a current hospital picture identification card that clearly identifies professional designation;
- primary source identification licensure;
- identification by current organizational member(s) who possess personal knowledge regarding the volunteer practitioner's qualifications; or,
- proof that the physician participates in armed forces or federal disaster relief programs

Primary source verification shall be completed within 72 hours from the time the volunteer practitioner presents to the Hospital. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or lack of resources), it is expected to be

performed as soon as possible. In this circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure is not required if the practitioner has not provided care, treatment and services under the disaster privileges. The Medical Director or other Member of active Medical Staff in charge of the disaster shall determine (based on information obtained regarding the practice of the volunteer) within 72 hours whether to continue the disaster privileges initially granted, if the volunteer practitioner shall continue to assist during the disaster. Emergency temporary privileges of the volunteer practitioner shall be terminated if any adverse information is obtained during the verification process. Emergency temporary privileges shall be terminated at the end of the disaster or as directed by the Member of the Active Medical Staff in charge of the disaster.

The Medical Director or a member of the Active Medical Staff shall oversee the performance of volunteer practitioners receiving disaster privileges. Oversight will consist of direct observation, mentoring and review of clinical records.

F. HISTORY AND PHYSICAL PRIVILEGES

A medical history and physical examination is completed and documented for each patient within 24 hours after admission. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and be responsible for completing the history and physical.

ARTICLE VII:
CORRECTIVE ACTION

ARTICLE VII: CORRECTIVE ACTION

A. PROCEDURE

1. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or that undermine a culture of safety in the operations of the Hospital, corrective action against such practitioner may be requested by any officer of the Medical Staff, by chairman of any standing committee of the Medical Staff, by the CEO, or by the Board of Managers. All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

2. If corrective action could involve reduction or suspension of clinical privileges, the affected practitioner shall be permitted to make an appearance before the Medical Executive Committee. At such interview, the affected practitioner shall be informed of the charges against him/her and shall be invited to discuss, explain or refute them. The action of the Medical Executive Committee on a request for corrective action may be to reject or modify the request, issue a warning, letter of admonition or reprimand, to impose terms of probation, a requirement for consultation or to terminate, modify or sustain an already imposed temporary suspension of clinical privileges, recommend suspension or revoking of staff membership or no action. Any action by the Medical Executive Committee that, if ratified by decision of the Board of Managers, would adversely affect a practitioner's appointment to or status as a member of the Medical Staff or exercise of clinical privileges will entitle the affected practitioner to the procedural rights provided in Article VIII of these bylaws; provided, however, that no reprimand, letter of admonition or similar action not involving the suspension of a practitioner's privileges for longer than 14 days shall entitle the affected practitioner to such procedural rights. The Medical Director shall promptly notify the CEO of all requests for corrective action and keep the CEO fully informed of all action taken therewith.

B. SUMMARY SUSPENSION

1. Any one of the following – the Medical Director, the CEO, or the Board of Managers - shall have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition. Such suspensions shall be deemed an interim precautionary action and not a professional review action. The Medical Executive Committee shall review such summary suspension within 14 days after the effective date thereof and, in its discretion, may determine to lift such summary suspension during such time as a result of such review.

2. A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the MEC hold a hearing on the matter within a reasonable time period in accordance with Article VIII of these Bylaws.

3. The MEC may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the MEC does not recommend immediate termination of

the summary suspension, the affected practitioner shall, also in accordance with Article VIII, be entitled to request an appellate review by the Board of Managers, but the terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Board of Managers.

4. Immediately upon the imposition of a summary suspension, the Medical Director, or in his absence an officer of the Medical Staff, shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

C. AUTOMATIC SUSPENSION

1. An automatic suspension in the form of withdrawal of a practitioner's privileges, effective until medical records are completed, shall be imposed automatically after warning of delinquency for failure to complete medical records within the time prescribed by the Board of Managers.

2. Action by any applicable licensing body of any State Board of Medical Examiners, State Board of Dental Examiners, State Board of Podiatric Medicine or an appropriate licensing body for Allied Health Professionals revoking or suspending a practitioner's license, or placing such practitioner upon probation, shall automatically suspend all of such practitioner's Hospital privileges.

3. Whenever a practitioner's license authorizing him to practice in the state is revoked or has expired, his Medical Staff membership and clinical privileges shall immediately and automatically be terminated. Such practitioners shall not be entitled to the procedural rights afforded in Articles VII and VIII.

4. Whenever a practitioner's license authorizing him to practice in the state is limited or restricted by any applicable licensing body of the State Board of Medical Examiners, State Board of Dental Examiners, State Board of Podiatric Medicine or an appropriate licensing body for Allied Health Professionals those clinical privileges which he/she has been granted at Hospital shall likewise be limited or restricted, immediately and automatically. Any conditions imposed by these licensing authorities must be satisfied before such clinical privileges may be reinstated.

5. If the practitioner's suspended or expired license is reinstated, a copy of the reinstatement order must be submitted by the practitioner to the credentials physician liaison, requesting reinstatement of privileges. This statement will be reviewed by the MEC for action.

6. Whenever a practitioner's professional liability insurance lapses, falls below the required state minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the practitioner's clinical privileges shall immediately and automatically be suspended until adequate professional liability insurance coverage is restored and the practitioner's clinical privileges have been formally reinstated by the CEO.

7. Failure to abide by, or intentional breach of, the Hospital's privacy policies will result in disciplinary action against the practitioner. Such disciplinary action shall be determined by the Board of

Managers or its designee and may include suspension or termination of clinical privileges and/or Medical Staff membership.

8. It shall be the duty of the Medical Director to cooperate with the CEO in enforcing all automatic suspensions.

ARTICLE VIII:
HEARING AND APPELLATE REVIEW PROCEDURE

ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURE

A. RIGHT TO HEARING AND TO APPELLATE REVIEW

1. When any practitioner receives notice of a recommendation of the Medical Executive Committee that, if it were ratified by decision of the Board of Managers, will adversely affect his/her appointment to or status as a member of the Medical Staff or exercise of clinical privileges, he/she shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff comprised of medical staff members who are not in direct economic competition with the affected practitioner. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the affected practitioner, he/she shall be entitled to an appellate review by the Board of Managers before the Board of Managers makes a final decision on the matter.

2. When any practitioner receives notice of a decision by the Board of Managers that will affect his/her appointment to or status as a member of the Medical Staff or exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Medical Executive Committee of the Medical Staff with respect to which such practitioner is entitled to a hearing and appellate review, he/she shall be entitled to a hearing by a committee, the members of which are appointed by the Board of Managers, and are not in direct economic competition with the affected practitioner. If such hearing does not result in a favorable recommendation, the affected practitioner shall be entitled to an appellate review by the Board of Managers, before the Board of Managers makes a final decision on the matter.

3. All hearings and appellate reviews shall be in accordance with the procedure safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which he/she is are entitled.

4. All notices herein referred to shall be in writing and will be hand-delivered or delivered by certified mail, return receipt requested and shall state that an action or recommendation taken by the Medical Executive Committee or Board of Managers has been proposed that would adversely affect Medical Staff membership and/or privileges; inform the practitioner of the charges in detail sufficient to allow preparation of a defense; to inform the practitioner of the right to legal counsel; and, shall specify that the practitioner has thirty (30) days following the date of receipt of such notice to request a hearing and/or appellate review. If the practitioner does not request a hearing and/or appellate review within thirty (30) days, he/she will lose the right to do so.

B. REQUEST FOR HEARING

1. The CEO shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by hand delivery or certified mail, return receipt requested.

2. The failure of a practitioner to request a hearing to which such practitioner is entitled by these bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her r right to such hearing and to any appellate review. The failure of a practitioner to request an appellate

review to which he/she is are entitled by these bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such appellate review on the matter.

3. When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Board of Managers, the same shall thereupon become and remain effective against the practitioner pending the Board of Managers' decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board of Managers, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board of Managers provided for in Article VIII. In either of such events, the CEO shall promptly notify the affected practitioner of his/her status by hand delivery or certified mail, return receipt requested.

C. NOTICE OF HEARING

1. Within thirty (30) days after receipt of a request for hearing from a practitioner entitled to the same, the Medical Executive Committee or the Board of Managers, whichever is appropriate, shall schedule and arrange for such hearing and shall, through the CEO, notify the practitioner of the time, place and date so scheduled, by hand delivery or certified mail, return receipt requested. Notice of the hearing date will be given to the practitioner at least thirty (30) days prior to the hearing.

2. The affected practitioner shall be notified, no less than thirty (30) days before the hearing of the time, date, and place of the hearing; shall state in concise language the acts or omissions with which the practitioner is charged, a list of exhibits expected to be used and of witnesses expected to be called, and of their right to legal counsel.

D. COMPOSITION OF HEARING COMMITTEE

When a hearing relates to an adverse recommendation of the Medical Executive Committee, such hearing shall be conducted by an Ad Hoc Committee of not less than three (3) members of the Medical Staff who are not in direct economic competition or association with the affected practitioner and who are appointed by the Medical Director in consultation with the Medical Executive Committee, and one of the members so appointed shall be designated as chairman. No medical staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

When a hearing relates to an adverse decision of the Board of Managers that is contrary to the recommendation of the Medical Executive Committee, the Board of Managers shall appoint a hearing committee to conduct such hearing and shall designate one of the members of this committee as chairman. At least one representative from the Medical Staff who is not in direct economic competition with the affected practitioner shall be included on this committee when feasible.

E. CONDUCT OF HEARING

1. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

2. An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by use of a court reporter and/or electronic recording unit.

3. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Article VIII and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Article VIII, Request for Hearing (2).

4. Postponement of the hearing beyond the time set forth in these bylaws shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

5. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by legal counsel or a member of the Medical Staff in good standing or by a member of his/her local professional society.

6. The chairman of the hearing committee or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

7. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing record.

8. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its physician members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendations, and to examine witnesses. The Board of Managers, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that

the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

9. The affected practitioner shall have the following rights: to be represented by legal counsel at any stage of the proceedings; to call and examine witnesses; to introduce written evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; to challenge any witness and to rebut any evidence; and to have a record made of the proceedings, copies of which can be obtained upon payment of reasonable fees. If the practitioner does not testify on their behalf, they may be called and examined as if under cross-examination.

10. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

11. Within fifteen (15) days after adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the Board of Managers, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Board of Managers. Thereafter, the procedure to be followed shall be as provided in Article V of these bylaws.

F. APPEAL TO THE BOARD OF MANAGERS

1. Within 30 days after the practitioner's receipt of the notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, an affected practitioner may, by written notice to the Board of Managers delivered through the CEO by personal delivery or certified mail, return receipt requested, request an appellate review by the Board of Managers. Such notice must contain a brief statement as to the reason for the appeal and may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

2. If such appellate review is not requested within 30 days, the affected practitioner shall be deemed to have waived their right to same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately.

3. Within 30 days after receipt of such notice of request for appellate review, the Board of Managers shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the CEO, by hand delivery or written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same no less than 30 days prior to the hearing. The date of the appellate review shall not be less than 14 days nor more than 60 days from the date of the receipt of the request for appellate review; provided however, that when a request for

appellate review is made by a Member who is under a suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 30 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Board for good cause.

4. The appellate review shall be conducted by the Board of Managers or by a duly appointed appellate review committee of the Board of Managers of not less than three members; none of the physician member(s) shall be in direct economic competition with the affected practitioner.

5. The affected practitioner shall have access to the report and record (and transcription, if any) of the Ad Hoc Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. The practitioner shall have ten (10) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with he/she disagrees, and the reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board of Managers through the CEO by hand delivery or certified mail, return receipt requested, at least ten (10) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Executive Committee or by the chairman of the hearing committee appointed by the Board of Managers, and if submitted, the CEO shall provide a copy thereof to the practitioner at least five (5) days prior to the date of such appellate review by certified mail, return receipt requested.

6. The Board of Managers shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to the preceding paragraph, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to them by any member of the appellate review body. The Medical Executive Committee or the Board of Managers, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

7. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board of Managers or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

8. If the appellate review is conducted by the Board of Managers, it may affirm, modify, or reverse its prior decision, or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specific disputed issues.

9. If the appellate review is conducted by a committee of the Board of Managers, such committee shall, within fifteen (15) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board of Managers affirm, modify or reverse its prior decision, or refer the matter back to the Medical Executive Committee for further review and recommendations within fifteen (15) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve disputed issues. Within fifteen (15) days after receipt of such recommendation after referral, the committee shall make its recommendations to the Board of Managers as above provided.

10. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital bylaws, all action required of the Board of Managers may be taken by a committee of the Board of Managers duly authorized to act.

G. FINAL DECISION BY BOARD OF MANAGERS

1. Within 30 days after the conclusion of the appellate review, the Board of Managers shall render its final decision in writing and shall send notice thereof to the MEC, and, through the CEO, to the affected practitioner, by personal delivery or certified mail, return receipt requested.

2. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee, or by the Board of Managers, or by a duly authorized committee of the Board of Managers, or both.

ARTICLE IX:
OFFICERS

ARTICLE IX: OFFICERS

A. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

a. A President elected by the Medical Staff; and
b. A Vice President elected by the Medical Staff
c. A Secretary elected by the Medical Staff
d. A Treasurer elected by the Medical Staff

B. QUALIFICATIONS OF OFFICERS

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

C. ELECTION OF OFFICERS

Nominations for officers are accepted up to 30 days before election of officers. The officers shall be elected by the majority vote of the voting Members of the Medical Staff present or represented by proxy and voting at the annual meeting of Members, or otherwise at a meeting duly called for such purpose in accordance with these Bylaws.

D. DUTIES OF OFFICERS

1. The President of the Medical Staff shall:

    - Act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;
    - Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
    - Serve as the Chairman of the Quality Council Committee;
    - Be responsible for the enforcement of Medical Staff Bylaws, including the section on Rules and Regulations; for implementation of sanctions where these are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
    - Appoint physician liaisons to all functional administrative and clinical areas;
    - Represent the views, policies, needs and grievances of the Medical Staff to the Board of Managers and to the CEO;
    - Receive, and interpret the policies of the Board of Managers to the Medical Staff and report to the Board of Managers on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
    - Be responsible for the educational activities of the Medical Staff; and
    - Be the spokesperson for the Medical Staff in its external professional and public relations.

2. In the absence of the President, the Vice President shall assume all duties and have the authority of the President. The Vice President shall be a member of the Quality Council Committee and shall

automatically succeed the President for the unexpired portion of the President's term of office if the President shall cease to serve for any reason.

E. REMOVAL OF OFFICERS

1. Any officer of the Medical Staff may be removed from office upon recommendation of two-thirds of the MEC, and approval of this recommendation by the Board of Managers. Any action regarding a reduction, suspension, or elimination of clinical privileges of such officer(s) shall follow the procedures as defined in these Bylaws.

2. Any practitioner whose engagement by the Hospital requires membership on the Medical Staff shall not have his/her Medical Staff membership or admitting and clinical privileges terminated without the same fair hearing provisions as must be provided for any other member of the Medical Staff, unless otherwise agreed to in the engagement contract.

3. Any decision regarding termination of a Medical Staff member in a medico-administrative position will be made by the Board of Managers. Any decision regarding suspension of clinical privileges of this person shall follow the procedures as defined in these bylaws unless otherwise stated on the engagement contract.

ARTICLE X:
COMMITTEES

ARTICLE X: COMMITTEES

A. MEDICAL EXECUTIVE COMMITTEE

1. Members. The MEC shall consist of the President of the Medical Staff, the Vice President, the Medical Director, and any Associate or Program Medical Directors appointed by the Medical Director, plus two additional representatives elected by the Active Medical Staff at a meeting duly called and approved by the Board of Managers. Administrative and clinical staff may attend MEC meetings as appropriate to the topics under discussion, and the CEO shall be an ex-officio member of the MEC. Notwithstanding the foregoing, only physician members of the MEC shall have the right to vote on matters presented to the MEC. MEC members who are Medical Staff officers shall be deemed removed from the MEC when they cease to be such officers. Other members of the MEC may be removed from the MEC upon a two-thirds vote of the voting Medical Staff at a meeting duly called for such purpose.

2. MEC Chairman. The President of the Medical Staff shall serve as chairman of the Medical MEC.

3. Duties. The duties of the MEC shall be as follows:

    a. The MEC shall exercise authority over activities related to the functions of self-governance of the Medical Staff and over activities related to the functions of performance improvement of the professional services provided by individuals with clinical privileges.
    b. The MEC shall be empowered to act for the Medical Staff on all matters in the intervals between Medical Staff meetings, so long as its actions are not inconsistent with these Bylaws.
    c. The MEC shall be responsible for making Medical Staff recommendations directly to the Quality Council Committee or the Board of Managers.
    d. The MEC shall be responsible for making recommendations to the Board of Managers in matters of corrective action.
    e. The MEC shall be responsible for the following matters relating to practitioner credentialing:
        - review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles V and VI of these Bylaws;
        - make a report to the MEC on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the reports from the departments in which such applicant requests privileges;
        - obtain the assistance of one or more physician liaisons appointed by the Medical Director to assist in the credentialing function;
        - investigate purported practitioner impairment and to report their findings to the CEO and Medical Director;
        - monitor a practitioner's compliance with a recovery program, when requested by the CEO and/or Medical Director;
        - advise the Medical Director and MEC on policies and procedures related to any impaired practitioner; and

- review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for granting of privileges, reappointments, and the assignments of practitioners to the Medical Staff or services as provided in Articles V and VI of these Bylaws.

f. The MEC shall investigate any breach of ethics that is reported;
g. The MEC shall fulfill the following functions with respect to these Medical Staff Bylaws:
   - making recommendations relating to revisions to and updating of the Bylaws, including the section on rules and regulations of the Medical Staff;
   - representing and acting on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
   - coordinating the activities and general policies of the various clinical specialties; and implementing policies of the Medical Staff.

4. Meetings

a. The Medical Staff shall meet at least annually. The date and time will be set by the President of the Medical Staff. The Medical Staff will be given at least two weeks' notice of event. Minutes for these meetings will be taken by MEC Secretary and kept in binder in administration. A quorum of 50% of the voting members of the MEC must be present to conduct business.
b. The President shall designate the time and place of any special meeting

B. FUNCTIONS OF THE MEDICAL EXECUTIVE COMMITTEE

1. Utilization Management Function - These functions may include, but are not limited to, the following:

a. Admission review of patient records for the purpose of determining appropriate level of care, certifying admissions and making initial assignment of appropriate lengths of stay using established criteria.
b. Continued stay reviews to determine the ongoing need for continued hospitalization and assure ongoing discharge planning.
c. Review and assessment of aspects of the quality of care being provided.
d. Maintaining close communication with the Hospital's quality improvement activities to assure coordination of the Hospital's evaluation programs and to evaluate potential areas of improvement.
e. Recommending a plan of action, as indicated from the analysis of review and study findings, to facilitate programs for improvement.
f. Work with Case Management in providing a mechanism for the initiation of discharge planning as soon as a patient is admitted to the Hospital.
g. Identifying utilization-related problems through the analysis of admission review, continued stay, and support service appropriateness.
h. Analysis of delays in the provisions of support services.

i. Examination of the related findings of quality improvement activities, profile analysis, infection control activities, medical care evaluation, medication use reviews, focus studies and QIO studies and other current relevant data.
j. Conducting ongoing retrospective monitoring of the Hospital's utilization of resources for the purpose of identifying problems and documenting the results of actions taken.
k. Reporting findings to appropriate committees and programs of the Medical Staff, the CEO, and the Board of Managers.
l. Evaluate QIO studies for potential areas of improvements and profile reports.
m. Evaluate other comparative studies for improvement.
n. In making such evaluations, the MEC shall be guided by the following criteria:
    - No physician shall have responsibilities for approving any extended stay cases in which he/she is professionally involved.
    - All decisions related to extended stays shall be made by physician members of the Committee, only after opportunity for consultation has been given the attending physician, and after full consideration has been given to the availability of out-of-Hospital facilities and services.
    - Where there is sufficient divergence in opinion following such consultation regarding the medical necessity for continued Hospital services for the patient, the judgment of the attending physician shall be given greater weight.
    - All decisions indicating that further inpatient stay is not medically necessary shall be given by written notice to the Medical Director, to the CEO and to the attending physician for such action, if any, as may be warranted.

2. Surgical, Invasive and Non-Invasive Procedures Function

    a. To study the agreement or disagreement among the procedure and pathological diagnosis.
    b. To study whether those procedures in which no tissue was removed and whether the procedures undertaken in the Hospital were justified.
    c. Patient categorization shall involve two major categories:
        - Procedure diagnosis was confirmed by pathology.
        - The pre-procedure diagnosis and the tissue findings are not appropriately interrelated, and from the record it appears that the procedure was not justified.

3. Blood Utilization Review Function – Blood Utilization Review at least four times per year for appropriateness of all transfusions, including the use of blood and blood components.

4. Infection Control Function

    a. Surveillance of inadvertent Hospital infection potential.
    b. Review and analysis of actual infection.
    c. Promotion of a preventive and corrective program designed to minimize infection hazard.
    d. Supervision of infection control in all phases of the Hospital's activities, including:
        - Isolation procedures;
        - Employee exposure prevention;
        - Prevention of cross-infection by any means;

- Testing of Hospital personnel for carrier status;
- Disposal of infectious material; and
- Other situations as requested by the Quality Council Committee

5. Pharmacy and Therapeutics Function

   a. Development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard.
   b. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, drug use evaluation, safety procedures and all other matters relating to drugs in the Hospital.
   c. Medication Use
      - Discontinuance and reorder of medications after minor and major surgical inpatient/outpatient procedures.
   d. Physician liaisons with the Quality Council Committee shall perform the following specific functions:

      - Serve as an advisory group to the Medical Staff and the pharmacist on matters pertaining to the list of available drugs;
      - Make recommendations concerning drugs to be stocked in the Hospital;
      - Develop and review periodically a formulary or drug list for use in the Hospital;
      - Approve and review periodically the Therapeutic Diet Manual;
      - Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
      - Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and,
      - Establish standards concerning the use and control of investigational drugs and/or research in the use of recognized drugs.

6. Environment of Care Function -
   The Quality Council Committee shall assist and make recommendations to the Board of Managers on matters which may include, but shall not be limited to, the following:

   a. The identification, development, implementation and review of safety policies and procedures for all of the Hospital's clinical services and departments.
   b. The promotion and maintenance of an ongoing Hospital-wide hazard surveillance program that includes a policy for responding to medical device recalls and hazard notices from government agencies or manufacturers.
   c. The reporting, investigating, documenting, and evaluating of accidents, injuries and safety hazards as well as any follow-up actions.
   d. The determination of the effectiveness of the Hospital's Safety Program and familiarity with safety publications.

e. The review of documentation of a safety education program that includes orientation of new employees to general Hospital-wide safety practices, as well as orientation and continuing in-service education regarding services and departments within the Hospital.
f. The initiation of action, through the Director of Quality Management, when conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment and/or the physical structure.
g. The evaluation of the Hospital's emergency preparedness plan.
h. The review of the Hospital's system that is designed to safely manage hazardous materials and wastes.
i. The identification and reduction of areas of potential risk in the clinical aspects of patient care and safety and the safety of employees, visitors and others who are on the Hospital premises.
j. The receipt and review of, and making recommendations with respect to, reports regarding risk management issues.
k. Timely submission of conclusions, recommendations and actions to the appropriate administrative directors of the areas affected, who shall evaluate such conclusions, recommendations and actions.

7. Health Information Function

a. Responsible parties: A physician liaison and one representative each from the patient care service area, Hospital management staff and the health information consultant or designee.
b. Duties: The responsible parties are responsible for assuring that all medical records meet the highest standards of patient care usefulness and of historical validity. The physician liaison(s) shall be responsible for ensuring the medical records reflect accurate documentation of medical events. The responsible parties shall conduct reviews of currently maintained medical records to determine whether they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of physician responsibility for patient care. The responsible parties shall also conduct a review of records of discharged patients to determine the promptness, pertinence, adequacy and completeness thereof. The responsible parties shall be accountable for assisting Hospital administration with the planning, selecting, and coordination of the implementation of policies, procedures, and computer-based technologies which deal with patient medical records.
c. The responsible parties shall make a quarterly report thereof to the Quality Council Committee.

8. Quality Improvement Function

a. Quality Council Committee members may be invited by project teams at regular intervals and key points in the performance improvement cycle for support, guidance and technical expertise.
b. The Quality Council Committee supports, guides and is a "trouble shooter" for project teams.
c. The Quality Council Committee will:
   - Ensure that each service or project team monitoring activities are ongoing and in accordance with the designed plan for carrying out the activity.
   - Set priorities for ongoing measurement of important processes.

- Oversee ongoing measurement, periodic assessment, and periodic improvement of these important processes.
- Convene performance improvement teams for specific improvement efforts, some of which may be triggered by the results of ongoing measurement, including feedback from patients/families, and staff.
- Communicate relevant activities, as necessary, throughout the organization.
- Interpret and evaluate pertinent findings that are beyond the authority or expertise of the service or project teams and make recommendations as a result of performance improvement activities that are beyond the authority or expertise of the service or project teams.
- Review quarterly each service or project team's monitoring and evaluation activities and quarterly status reports.
- Prepare quarterly and annual reports of pertinent findings and recommendations to the CEO and Board of Managers.

9. Peer Review Function

   a. Peer review is required by the Board of Managers and encompasses all physicians, dentists and AHPs practicing in the Hospital. The purpose of peer review is to review the professional practices within the Hospital in an effort to reduce morbidity/mortality and improve the care of the patients. Such review shall include the nature, quality and necessity of care provided and the preventability of complications in the hospital. Such review need not identify the patient or doctor by name but may use a case number or some other designation.

   b. Results of peer review findings are considered when reviewing a practitioner for reappointment to the Medical Staff, and a summary of findings becomes part of the credentials file.

CHANGES IN DELEGATED AUTHORITY

The authority delegated to the Medical Executive Committee hereunder may be modified, limited, expanded or revoked only pursuant to an amendment to these Bylaws adopted in accordance with Article XIV.

ARTICLE XI:
IMMUNITY FROM LIABILITY

ARTICLE XI: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this Hospital.

1. Any act, communication, report, recommendation or disclosure with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other healthcare facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

2. Such privilege shall extend to members of the Hospital's Medical Staff and of its Board of Managers, its other practitioners, its CEO and their representative(s), and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of Article XI, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Board of Managers or of the Medical Staff.

3. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

4. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare institution's activities related to credentialing and peer review activities, including, but not limited to: (1) applications for appointment or clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action, including summary suspension; (4) hearings and appellate reviews; (5) medical care evaluations; (6) utilization reviews; and (7) other Hospital, service or committee activities related to quality patient care and inter-professional conduct. The purposes of such quality reviews are to reduce morbidity and mortality, and all quality review information shall be kept confidential.

5. The facts, communications, reports, recommendations and disclosures referred to in this Article XI may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care and the orderly administration of the Hospital.

6. In furtherance of the foregoing, each practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article XI in favor of the individuals and organizations specific in paragraph 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

7. The consents, authorizations, releases, rights, privileges and immunities provided by Article V of these Bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel and third parties in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XI.

ARTICLE XII:
CONFLICT RESOLUATION BETWEEN MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE

ARTICLE XII: CONFLICT RESOLUTION BETWEEN MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE

In the event that there is a disagreement or conflict between the Medical Staff and the Medical Executive Committee (MEC) regarding a matter of significance, the conflict management process described in this section will be followed. Examples of significant issues include, but are not limited to, proposals to adopt or change these Bylaws, a rule, regulation, or policy; or amendment of these Bylaws, a rule, regulation or policy or matters that if not resolved could adversely affect patient safety or quality of care. The process of resolving such a conflict would be as follows:

1. The conflict or unresolved issue shall be articulated in writing for consideration in the form of a petition to the MEC.

2. At least 25% of the voting members of the Medical Staff must sign the petition stating the basis for the conflict or disagreement with the action taken or the decision made by the MEC.

3. Within 30 days of receipt of the petition from the Medical Staff, a meeting between two representatives of the MEC, as appointed by the President, and two of the Medical Staff representatives of the petitioners (as selected by the petitioners) shall be held.

4. The MEC representatives and the petitioners' representatives shall discuss the issues set forth in good faith, in an attempt to resolve the conflict or disagreement in the best interests of promoting safety and high quality of care.

5. If the representatives of the MEC and the Medical Staff petitioners reach agreement on a proposed resolution of the conflict, the proposed resolution shall be submitted to the voting members of the Medical Staff if such action is necessary. If approved by the voting members, the proposal shall be forwarded to the Board of Managers for review and consideration. The decision of the Board of Managers will be final. In the event that the proposed solution does not require a vote of the Medical Staff, the proposed solution will be forwarded to the Board for a final decision.

6. If the Board does not approve the proposed solution (after the vote of the Medical Staff, if necessary, as outlined above), the Board will have the option to request a Joint Conference with representatives of the Board, The MEC (appointed by the President of the Medical Staff) and the petitioners in an effort to seek a final resolution. After such a Joint Conference, the decision of the Board will be final.

7. In the event that representatives of the MEC and the petitioners cannot agree on a proposed solution, the petition will be forwarded to the Board for review and consideration. The decision of the Board will be final.

ARTICLE XIII:
RULES, REGULATIONS AND POLICIES

ARTICLE XIII - POLICIES

The Medical Staff shall develop and adopt such rules, regulations and policies as may be necessary to implement more specifically the general principles found within the Bylaws, subject to the approval of the Board of Managers. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. Changes to the Bylaws, Rules and Regulations and any amendments thereto, shall be made by the MEC and become effective when approved by the Board of Managers.

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the Hospital only by a rehabilitation physician member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital. 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 admitting office will notify the attending practitioner whenever such consent has not been obtained.

2. A physician member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

3. The practice of division of fees under any guise whatsoever is forbidden.

4. A patient to be admitted on a transfer basis who does not have a private physician may request any physician on Medical Staff to attend them. Where no such request is made, or if the requested physician not on call does not assume care of the patient, then a member of the active Physical Medicine & Rehabilitation physician on staff will be assigned to the patient. If the "on call" practitioner for good cause cannot assume care of the patient, then the practitioner who is next "on call" will be assigned to the patient. The Medical Director shall provide a schedule of "on call" assignments.

5. Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area who may be called to attend their patients in an emergency, or until they arrive. In case of failure to name such associate, the CEO of the Hospital or Medical Director of the Medical Staff shall have authority to call any member of the active staff in such event.

6. Each practitioner must assure timely, adequate professional care for their patients in the Hospital by being available or having available through their office eligible alternate practitioners with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements may result in loss of

clinical privileges. When a practitioner is out of town or not available, the on-call schedule shall indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during their absence.

7. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be approved by the Quality Council Committee.

8. Patients will be admitted on the basis of the following order of priorities.
    a. In the event that sufficient beds are unavailable when approved patients are ready for admission, the Clinical Liaisons will confer with the Area Director of Business Development and the CEO to determine the priority of admission for those patients.
    b. Factors to be considered in determining priority include:
        - Length of time the patient has been awaiting a bed;
        - Urgency of need for rehabilitative care, for example, patients whose care may be compromised if they remain in their current setting;
        - Special needs of the patient and our ability to accommodate those needs with the available beds; and
        - Medical stability

9. Patient Transfers
    a. No patient will be transferred without such transfer being approved by the responsible practitioners (transferring and receiving).
    b. Transferring physician shall retain responsibility for patient until receiving physician in this Hospital accepts patient.

10. Procedures for the referral and/or transfer of patients exhibiting severe psychiatric symptoms shall be as follows:

    a. As soon as it is recognized that a patient's behavior represents a hazard to their personal security and safety or the security and safety of their surroundings or other persons in the Hospital, they will be transferred to an appropriate facility.
    b. Although the responsibility for the referral and transfer of patients is the attending physician's, when an emergency arises and the physician is not immediately available, the order can be issued by the Medical Director or other member of the Medical Staff. The Chief Clinical Officer or Administrator on Call will be contacted and asked to provide assistance.
    c. Notification of the Psychologist will be routine and is the responsibility of the charge nurse. Upon the request of the attending physician or their representative, a Psychologist will provide assistance in family instruction, selection of facilities and resources and other matters relating to the transfer of the patient.
    d. If the patient's need for acute rehab care is so urgent as to mitigate against the patient's transfer, the attending physician will immediately notify the CEO or Chief Clinical Officer and apprise them of their recommendations and plans concerning the care of the patient. The ultimate disposition of the patient will then be determined by the attending physician in consultation with

representatives of the administration, nursing service and other members of the Medical Staff as indicated or requested.

11. Patients shall be discharged only on a written 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 event shall be made in the patient's medical record.

12. Patients may not be released from the Hospital for the purpose of receiving professional care, consultation or treatment in a doctor's office or another health care facility, or for leave of absence for any reason, unless they sign a Release of Responsibility.

13. Attending Physical Medicine & Rehabilitation physicians are responsible for knowledge and understanding of CMS requirements for physician documentation in an Inpatient Rehabilitation Facility level of care. This includes the timely completion of: (1) Review and Concurrence of the Pre-Admission Assessment (2) Timely and thorough completion of the History & Physical including the Post-Admission Physician Evaluation (PAPE) and (3) Timely and thorough completion of the Individual Interdisciplinary Plan of Care

B. USE OF RESTRAINTS

The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever their patients might be a source of danger from any cause whatever.

1. Use of Restraints - The safety of the patients admitted is of utmost concern; therefore, all patients admitted to Community Rehabilitation Hospital North will be cared for in a safe environment. A physician's order is necessary for the use of restraints. Generally speaking, restraints are to be utilized to enhance patient safety. Details about the use of restraints are found in the Provision of Care Manual, Restraints policy.

2. Notify Chief Clinical Officer or Medical Director of patient's condition and of actions taken and pending.

3. Notification of the patient's family will be accomplished by the Chief Clinical Officer or the charge nurse. Such notification will be in accordance with the attending physician's appraisal of the circumstances, if available, and if not available, in accordance with the appraisal of the Chief Clinical Officer.

4. Inform appropriate Hospital personnel of the patient's condition and instruct them in measures appropriate to the situation.

C. CODE OF CONDUCT FOR MEDICAL STAFF

A high degree of professionalism is expected in physician behavior and physician interaction with all Hospital co-workers, other Medical Staff members, patients and others. The Code of Conduct for Physicians is located below.

Reports of alleged violations of the Code of Conduct may be made by any member of Medical Staff or employee of the Hospital. Alleged violations should be reported within 24 hours to the employee's supervisor, or to the chair of the Medical Executive Committee, and the CEO. Information shall be handled in a professional and confidential manner. An investigation of the alleged violation will be conducted promptly as directed by the CEO or chair of the Medical Executive Committee.

Any person in good faith reporting a violation of this Code of Conduct will not be subject to retaliation of any kind.

1. PURPOSE

The purpose of the Medical Staff Code of Conduct is to promote a culture of safety and quality within Community Rehabilitation Hospital North. The Medical Staff Bylaws, of which this Code of Conduct is a part, shall be a means for review and disciplining Medical Staff members for inappropriate behaviors or behaviors that undermine a culture of safety.

2. APPLICABLE DEFINITIONS

- "Appropriate behavior" means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition with the Hospital. Appropriate behavior is not subject to discipline under these bylaws.

- "Behaviors that undermine a culture of safety" means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

- "Harassment" means conduct toward others based on their race, religion, gender, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

- "Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby undermine a culture of safety.

- "Sexual harassment" means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidating or otherwise hostile environment.

- "Medical Staff members" mean physicians and others granted membership on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

3. TYPES OF CONDUCT

A. Appropriate Behavior
Medical Staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:
- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient's care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means on communication
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Managers about patient care or safety provided by others;
- Active participation in Medical Staff and Hospital meetings (i.e., comments made during or resulting from such meetings cannot be used as the basis for a complaint under this Code of Conduct, referral to the Medical Executive Committee and Board of Managers. economic sanctions , or the filing of an action before a state or federal agency);
- Membership on other Medical Staffs; and
- Seeking legal advice or the initiation of legal action for cause.

B. Inappropriate Behavior
Inappropriate behavior by Medical Staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby undermine a culture of safety. Examples of inappropriate behavior include, but are not limited to, the following:
- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;

- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, Hospital personnel and/or the Hospital.

C. Behavior That Undermines A Culture Of Safety
Behavior that undermines a culture of safety by Medical Staff members is prohibited. Examples of behaviors that undermine a culture of safety include but are not limited to, the following:
- Physically threatening language directed at anyone in the Hospital including physicians, nurses, other Medical Staff members, or any Hospital co-worker, CEO or member of the Board of Managers ;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution;
- Sexual harassment; and,
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

4. INTERVENTIONS

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending Medical Staff member, and protecting patient care and safety. The Medical Staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the individual or Medical Director or his designee. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning, or corrective action pursuant to the Medical Staff Bylaws, if the behavior is inappropriate or undermines a culture of safety. The use of summary suspension should be considered only where the physician's behavior undermines a culture of safety and presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate behavior or behavior that undermines a culture of safety is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the Medical Executive Committee.

5. PROCEDURE

Complaints about a member of the Medical Staff regarding allegedly inappropriate behavior or behavior that undermines a culture of safety should be placed in writing by the complainant, signed and directed to the President of the Medical Staff or, if the President of the Medical Staff is the subject of the complaint, to the Vice President of the Medical Staff, and include to the extent feasible:
- the date(s), times(s) and the location of the inappropriate behavior that

- undermines a culture of safety;
- a factual description of the inappropriate behavior that undermines a culture of safety;
- the circumstances which precipitated the incident;
- the name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
- the names of other witnesses to the incident;
- the consequences, if any, of the inappropriate behavior that undermines a culture of safety as it relates to patient care or safety, or Hospital personnel or operations; and
- any action taken to intervene in, or remedy, the incident, including the names of those intervening.

At the discretion of the President of the Medical Staff (or Vice President if the President of the Medical Staff is the subject of the complaint), the duties here assigned to the President of the Medical Staff, can from time to time, be delegated to another elected member of the Medical Staff ("designee").

The complainant will be provided a written acknowledgement of the complaint.

In all cases, the Medical Staff member subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint in a timely fashion, as determined by the organized Medical Staff, but in no case more than 30 days from receipt of the complaint by the President or Vice President of the Medical Staff. The Medical Staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the Medical Staff member. An ad hoc committee, none of the members of which may be economic competitors of the Medical Staff member, consisting of the President or Vice President of the Medical Staff, or designee, and at least two additional members of the Medical Executive Committee, one of whom shall be the Medical Director, provided the Medical Director is not the subject of the complaint, shall make such investigation as appropriate in the circumstances which may include seeking to interview the complainant and any witnesses and the subject of the complaint. The subject Medical Staff member shall be provided an opportunity to respond in writing to the complaint.

The ad hoc committee will make a determination of the authenticity and severity of the complaint. The ad hoc committee shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the complainant and the subject of the decision reached.

If the ad hoc committee determines the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision, and the complaint will be addressed as follows:

a. If this is the first incident of inappropriate behavior or behavior that undermines a culture of safety, the Medical Director shall discuss the matter with the offending Medical Staff member, and emphasize that the behavior is inappropriate and undermines a culture of safety and must cease. The offending Medical Staff member may be asked to apologize

to the complainant. The approach during this initial intervention should be collegial and helpful.

b. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior that undermines a culture of safety will be handled by providing the offending Medical Staff member with notification of each incident and a reminder of the expectation of the individual comply with this Code of Conduct.

c. If the ad hoc committee determines the offending Medical Staff member has demonstrated persistent, repeated behavior, constituting harassment (a form of inappropriate behavior that undermines a culture of safety), or has engaged in inappropriate behavior that undermines a culture of safety on the first offense, a letter of admonition will be sent to the offending Medical Staff member, and, as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the Medical Executive Committee.

d. If, in spite of this admonition and intervention, inappropriate behavior that undermines a culture of safety recurs, the ad hoc committee shall meet with and advise the offending Medical Staff member that such behavior must immediately cease or corrective action will be initiated. This "final warning" shall be sent to the offending Medical Staff member in writing.

e. If after the "final warning" the inappropriate behavior that undermines a culture of safety recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the Medical Staff Bylaws of which this Code of Conduct is a part, and the offending Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws.

f. If a single incident of inappropriate behavior that undermines a culture of safety or repeated incidents of inappropriate behavior that undermines a culture of safety constitutes an imminent danger to the health of an individual or individuals, the offending Medical Staff member may be summarily suspended as provided in the Medical Staff Bylaws. The Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws.

g. If no corrective action is taken pursuant to the Medical Staff Bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending Medical Staff member, shall be retained in the Medical Staff member's credentials file for two (2) years, and then must be expunged if no related action is taken or pending. Informal rehabilitation, a written apology, issuance of a warning, or referral to the Medical Executive Committee will not constitute corrective action.

h. At any time during this procedure the Medical Staff member has a right to personally retain and be advised by legal counsel. However, the Medical Staff member does not

have the right to have counsel in attendance at any interview, meeting or similar preliminary proceeding. Such right shall only arise with respect to (a) a hearing or appellate review pursuant to Article VIII of the Medical Staff Bylaws, or (b) as may be determined in other circumstances by the Medical Executive Committee in its sole discretion.

6. INAPPROPRIATE BEHAVIOR OR BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY AGAINST A MEDICAL STAFF MEMBER

Inappropriate behavior or behavior that undermines a culture of safety, which is directed against the organized Medical Staff or directed against a Medical Staff member by a Hospital employee, CEO, board member, contractor, or other member of the Hospital community shall be reported by the Medical Staff member to the Hospital pursuant to Hospital policy or Code of Conduct, or directly to the Hospital Board of Managers, the state or federal government, or relevant accrediting, body as appropriate.

7. ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by Medical Staff members against complainants will give rise to corrective action pursuant to the Medical Staff Bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the Medical Staff Bylaws or Hospital employment policies, whichever applies to the individual.

8. PROMOTING AWARENESS OF CODE OF CONDUCT

The Medical Staff shall, in cooperation with the Hospital, promote continuing awareness of this Code of Conduct among the Medical Staff and the Hospital community, by:

a. Sponsoring or supporting education programs on inappropriate behaviors or behaviors that undermine a culture of safety to be offered to Medical Staff members and Hospital co-workers;
b. Disseminating this Code of Conduct to all current Medical Staff members upon its adoption and to all new applicants for membership to the Medical Staff;
c. Encouraging the Medical Executive Committee to assist members of the Medical Staff exhibiting inappropriate behaviors or behaviors that undermine a culture of safety to obtain education, behavior modification, or other treatment to prevent further infraction;
d. Informing the members and the Hospital staff of the procedures the Medical Staff and Hospital have put into place for effective communication to Hospital administration of any Medical Staff member's concerns, complaints and suggestions regarding Hospital personnel, equipment, and systems.

D. CONSULTATION

1. The patient's attending physician is primarily responsible for requesting consultation and is responsible for calling in a consultant. As such, except in an emergency, the patient's physician will authorize another practitioner to examine and attend the patient.

2. The patient's attending physician shall be responsible for advising the patient or next of kin of the feasibility of requesting consultation. The patient or next of kin shall have the right to decide whether a consultant shall be called, can select the consultant and shall be advised of the consultant's opinion.

3. Consultations requested by persons other than the attending physician should not be initiated prior to notification of the attending physician.

4. In circumstances of grave urgency, any practitioner may request consultation from an emergency physician(s) to assess and render emergency care to a patient. Such emergency care does not imply a prolonged period of care and does not alter the responsibility of the attending practitioner as defined in these rules and regulations.

5. If a nurse or anyone else entrusted with patient care responsibility has reason to doubt or question the care provided a patient or believes that consultation is needed and has not been obtained, they shall call this to the attention of the responsible practitioner. Failing to receive satisfaction, the concerned party should bring this to the attention of the appropriate supervisor(s) and if indicated, the Medical Director. Where circumstances are such as to justify such action, the Medical Director may request a consultation.

    a. A consultation may be indicated, if in the judgment of the attending physician or the Medical Director:
    b. The diagnosis is obscure or if the clinical situation is unusually complicated;
    c. Patient not responding to the treatment chosen.
    d. When the patient exhibits severe psychiatric symptoms;
    e. When requested by the patient or family.

6. It is the expectation of the medical staff that the consulting physician will have seen the patient and completed their consult within 72-hours of notification.

7. The Medical Staff may recommend the establishment of rules and regulations which shall require consultation for specific clinical situations. These rules and regulations shall become effective when approved by the Board of Managers.

8. The consultant must be a member of the Medical Staff and must have privileges in the field in which their opinion is sought. Privileges shall be determined by the Medical Executive Committee, and service on the basis of the individual's training, experience, and competence.

9. If a practitioner who is not a member of the Medical Staff is asked to render a consultation, they must obtain temporary privileges. They can request the temporary privileges or the practitioner requesting the consultation can request temporary privileges for the consultant.

10. If the patient's attending physician does not choose to follow the consultant's advice, they will discuss the reasons with the consultant, the patient, and if appropriate, with the family.

E. CALL RESPONSIBILITIES

1. Members of the active Medical Staff shall participate in call schedules as assigned. Members of the provisional staff shall participate in call schedules at the discretion of the Medical Director and after approval by the Medical Executive Committee.

2. Duties: The on call physician or dentist shall respond to calls by other practitioners who have patients that require consultation or care, or to the Medical Director and shall assist in the patient's care. The need to respond and assist will be determined by the requesting practitioner or staff member. If the on call physician or dentist, for good cause, cannot assist, then the practitioner next on call will be called and shall be expected to respond and assist. Questions or disputes regarding the call schedule shall be directed to the Medical Director.

F. MEDICAL RECORDS

1. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient.

2. The medical record contents shall be pertinent and current. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; anesthesia report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge notes; and autopsy report when performed.

3. A complete admission history and physical (H&P) examination shall be recorded within twenty four (24) hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body, as well as the applicable rehab impairment category and etiological diagnosis. If a complete physical and history has been performed within a week prior to admission, a durable, legible copy of this report may be used in a patient's record provided that there has been no change subsequent to the original exam or the changes have been recorded at the time of admission. When a patient is readmitted within thirty (30) days for the same or related problem, an interim history and physical reflecting subsequent changes may be used in the medical record providing the original questions are readily available. To be acceptable, outside records must be in a form approved by the Hospital and be compatible with its current Medical Records system. Failure

to comply with the twenty-four (24) hour rule for recording histories and physicals may result in suspension of all admitting privileges.

4. Procedure notes shall be entered in the medical record immediately after any procedure.

5. When the history and physical are not recorded before any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the practitioner states in writing that such delay would be detrimental to the patient or that he/she has dictated this information but it has not been transcribed. In such instances, the practitioner must write an interim note containing relevant information substantiating the patient's physical ability to undergo the procedure.

6. The Health Information Manager will monitor timeliness of recording H & P's by review of charts and/or records within the dictation system. If any physician is found to have a total of five (5) or more delinquent H & P's in a period of one month, he/she will be notified by certified letter that concurrent monitoring (all charts) will be performed the following month. The Medical Director will be notified as well. If during the month, following notification, the physician is found to have a total of five (5) or more delinquent H & P's, all admitting privileges will be suspended for one week (Monday-Monday) to begin the third Monday of the following month. This suspension will take place automatically whether or not the physician updates his/her records at that point. If, at the end of the week of suspension all medical records are complete, admitting privileges will be restored.

7. A second suspension within the same twelve (12) month period will result in automatic termination from the Medical Staff. Reapplication to the Medical Staff will be required. Exceptions may be made by the Medical Executive Committee.

8. 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 documented and authenticated.

9. The practitioner's dietetic order shall be recorded in the patient's medical record before the diet is served. Observations and information pertinent to diabetic treatment shall be recorded in the patient's medical record by the dietitian.

10. Each apparent transfusion reaction shall be reported immediately to the laboratory blood bank, and to the patient's physician, and a reaction report form shall be completed. The laboratory immediately shall perform necessary tests to determine whether a hemolytic reaction has occurred and, if so, attempt to find the cause. The results of all such tests shall become a permanent part of the patient's medical record. The pathologist shall direct the transfusion service and make recommendations to the appropriate clinical or medical audit committee regarding specific improvements in the use of blood.

11. Consultation shall show 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. This 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, except in emergency situations so verified on the record, be recorded prior to the operation.

12. All clinical entries in the patient's medical record including dictation and transcription shall be accurately dated, timed and authenticated.

13. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of do not use abbreviations should be kept on file in the Health Information Area. The list shall be reviewed and revised as needed, and then approved by the Medical Executive Committee and Board of Managers.

14. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner as of the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

15. A discharge clinical resume (summary) shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and include discharge instructions.

16. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

17. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the CEO or his/her designee. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner subject to the provisions of Article VII.

18. The Hospital considers its relationship with the Medical Staff to be an Organized Health Care Arrangement (as defined in regulations published under the Health Insurance Portability and Accountability Act (HIPAA) at 42 CFR 164.501) operating under a joint Notice of Privacy Practices that has been adopted by Hospital (and as may be amended from time to time). As a clinically integrated care setting where patients receive medical care from both the Hospital and its Medical Staff, the confidentiality of patients' records is the responsibility of the Hospital and all Medical Staff with privileges.

    Notwithstanding the foregoing, any record or other information created by the Medical Staff while not on Hospital's premises is not subject to the Hospital's Notice of Privacy Practices.

19. The patient's medical record should be completed at the time of discharge including progress notes, final diagnosis and (dictated) clinical resume. A medical record shall be deemed delinquent when not complete within thirty (30) days after patient discharge. A warning letter will be sent to the

Medical Staff member fifteen (15) days after patient discharge. A member of the Medical Staff is to be notified by the Health Information Manager at such time as a record is deemed delinquent. If the delinquent records are not completed within the stated time period, all privileges at the Hospital shall be suspended. If the records are not completed within seven (7) days from the date of the notification of suspension of all privileges by the CEO, the Medical Executive Committee shall be notified and may be requested to initiate further disciplinary action. A request for revocation of Medical Staff membership and/or privileges may be initiated by the Medical Director or CEO, as provided in these bylaws.

Suspension of privileges shall not apply to patients in the Hospital at the time the suspension goes into effect. The suspension shall be effective until the delinquent records are completed. No member shall have the right to hearing and/or appellate review as a result of such suspension.

20. Reinstatement of admitting privileges can be accomplished only through appropriate channels. The Medical Director may deem extenuating circumstances are applicable to an individual physician case and recommend reinstatement of admitting privileges and will notify appropriate parties. Administration, medical records and/or admitting personnel will not be allowed to approve individual patients to be admitted to a suspended physician while the physician is on suspension.

21. The Health Information Manager can only rescind suspension for delinquent records during regular business hours (8:00 a.m. - 4:30 p.m., Monday through Friday). Therefore, if records are not complete by 4:30 p.m. Friday, the Health Information Manager cannot reinstate admitting privileges until 8:00 a.m. Monday morning. If this situation should occur, and the physician needs to admit patients before the resuming of normal working hours, the Medical Director would then notify the appropriate parties in the Hospital to reinstate admitting privileges.

22. After a physician is placed on suspension, each admission during this period must be approved by the Medical Director until all delinquent records are completed in their entirety or until reinstatement.

23. The chain of command for notification would be as follows: Medical Director, Officers of the Medical Staff, and members of the Quality Council Committee.

24. For any anticipated absences, such as vacations, illnesses, etc., the physician should notify the Health Information office in advance and suspension will be delayed until seven (7) days after the return of the physician from absence.

G. IMPAIRED PHYSICIAN MANAGEMENT

The Medical Staff shall establish a Physician Well-Being Committee or a sub Committee of the MEC, devoted to the well-being of Licensed Independent Practitioners (LIP's) who are members of the medical staff. The purpose of this Committee shall include, but not necessarily be limited to, implementation of the

provisions noted in this policy. The particular composition of the Committee shall be determined by the Medical Executive Committee.

EDUCATION OF LIP's & STAFF ON ILLNESS & IMPAIRMENT ISSUES

The Committee (or other appropriate entity) shall educate the medical staff and hospital staff on illness and impairment issues that may affect LIP's. This education may take the form of any of the following:

- Written memoranda
- Discussion at meetings of the medical and other staff
- Continuing education and other in-service or training programs
- Provision of information at the time of appointment / reappointment

SELF-REFERRAL BY AN LIP

Any LIP may refer himself / herself to the committee for assistance. The LIP may contact any member of the Committee to request assistance..

REFERRAL OF AN LIP BY OTHERS

Other LIP's or staff may refer a LIP to the Committee. The person referring may contact any member of the Committee to request assistance.

EVALUATION OF A COMPLAINT OR CONCERN

If the Committee receives a complaint or concern regarding an LIP, the Committee shall first evaluate the credibility of the complaint before determining if any actions or assistance should be afforded to the LIP. If the compliant is of a nature that poses a serious and immediate risk to the safety and health of patients or others, the Committee may implement requirements/restrictions upon the LIP until such time as the credibility of the complaint can be ascertained.

CONFIDENTIALITY OF INFORMATION

Referral to the Committee shall be considered confidential. If the LIP is referred by another individual, that individual's identity will remain confidential and shall not be disclosed to the LIP. All investigations and actions taken by the Committee and the LIP shall be considered confidential except as limited by law, ethical obligation, or when the health and/or safety of the patient are threatened. In these situations, information will be shared with necessary entities as deemed appropriate by the Medical Executive Committee and the Chief Executive Officer of the organization.

REFFERAL OF AN LIP TO INTERNAL / EXTERNAL SOURCES

Depending on the particular issue and/or circumstances, the Committee may decide to refer an LIP to either internal and/or external sources for assistance. The decision to refer an LIP to sources for assistance shall be made by a majority vote of the Committee, and – when possible – should include the consent and agreement of the LIP.

MONITORING OF THE LIP

As appropriate to the specific needs, circumstances, and issues involving the LIP, the Committee shall determine the most appropriate and effective method to monitor the LIP and the safety of patients until any requirements placed upon the LIP by the Committee have been met. Monitoring of the LIP shall

continue until requirements are met, and thereafter as determined by the Committee. This includes, but is not necessarily limited to, the following:

- Monitored performance of the LIP clinical privileges
- Submission of reports by the LIP or internal / external sources on the progress / compliance with requirements
- Solicitation of feedback from individuals or entities affected by the LIP.

H. VERBAL AND TELEPHONE ORDERS

1. All orders for medications, treatments and diagnostic tests shall be in writing and shall be signed, timed and dated by a member of the Medical Staff. Verbal orders shall be accepted only when it is impractical to provide written orders. Verbal orders must be authenticated by the ordering practitioner according to Indiana State Law within forty eight (48) hours, unless a read back and verify process is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge. Verbal orders for physical or chemical restraints must be authenticated by the ordering practitioner within twenty four (24) hours. Verbal orders may be transcribed only by authorized persons functioning within their respective professional scopes of practice and within their respective Indiana state practice act, as follows:
    a. Registered Nurses;
    b. Licensed Practical Nurses;
    c. Pharmacists, who may transcribe verbal orders pertaining to drugs/medications;
    d. Physical Therapists, who may transcribe verbal orders pertaining to physical therapy evaluations and treatments, including topical medications to be used during physical therapy treatments;
    e. Occupational Therapists, who may transcribe verbal orders pertaining to occupational therapy evaluations and treatments, including topical medications to be used during occupational therapy treatments;
    f. Speech-Language Pathologists, who may transcribe verbal orders pertaining to speech-language pathology evaluations and treatments;
    g. Registered Dietitians, who may transcribe verbal orders pertaining to patient diets, enterals and supplements;
    h. Psychologists, who may transcribe verbal orders pertaining to psychological evaluations and treatments;
    i. Respiratory therapists, who may transcribe verbal orders pertaining to respiratory evaluations and treatments, including medications to be used during respiratory treatments.

2. The individual transcribing the verbal and telephone orders shall sign, date and time the orders.

3. Read Back and Verify Process for Verbal Orders: The individual receiving the order shall immediately read back the order to the ordering practitioner who shall immediately verify that the read back order is correct. The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. When the read back and verify process is

followed, the order must be authenticated by the ordering practitioner not later than thirty (30) days after the patient's discharge.

4. 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 authorized person functioning within their sphere of competence.

5. Orders may be written, printed or copied and sent in with a patient provided they have been signed by the attending physician.

I. DRUGS AND MEDICATIONS

1. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations. Exceptions are those drugs used in clinical investigation; the latter can be used when in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and when used in accordance with the rules and regulations of the Food and Drug Administration.

2. All controlled medications classified as Schedule II drugs by federal or state laws; whether ordered orally, IV or rectally, shall be renewed or discontinued after seven (7) days. Exceptions to this rule are: (a) when day seven (7) occurs on a weekend or legal holiday (in this event the order must be renewed or discontinued on the first working day after the weekend or legal holiday); or (b) when the scheduled drug is part of an approved standing order to be used on an "as necessary" basis (Example: "Morphine Sulfate 2.0-4.0 mg. Intravenously PRN for chest pain not relieved by nitroglycerin" as part the unit standing orders.)

3. All open-ended antibiotic orders shall be renewed or discontinued after fourteen (14) days unless otherwise specified by the ordering physician.

4. As far as possible, the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, they will be secured and a special charge made to the patient. No medicines shall be brought into the Hospital by the patient without physician order and pharmacist confirmation of the identity of the drug. Medicines received by inpatients shall be ordered from the Hospital pharmacy.

J. AUTOPSY

1. It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever possible. An autopsy may be performed with a written consent signed in accordance with State law.

2. Possible criteria to be utilized as a guide to select meaningful autopsy cases are:

a. Deaths in which autopsy may help explain unknown and unanticipated complications to attending physician;
b. All deaths in which the cause of death is not known with certainty on clinical grounds;
c. Cases in which autopsy may help allay concerns of the family/public regarding the death, and to provide reassurance to them regarding same;
d. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedure/therapy;
e. Unexpected or unexplained deaths, which are apparently natural and not subject to a forensic medical jurisdiction;
f. Natural deaths, which are subject to, but waived by, a forensic medical jurisdiction such as:
   - A person dead on arrival at hospital;
   - Deaths occurring in hospital within 24 hours of admission; and
   - Deaths in which the patient sustained or apparently sustained an injury while hospitalized.
g. Deaths resulting from high-risk infectious and contagious diseases;
h. Death occurring within 48 hours after surgery or an invasive diagnostic procedure;
i. Death where the cause of death is sufficiently obscure to delay completion of the death certificate;
j. Any death from which an autopsy might contribute to the quality of medical care for a patient with the same condition in the future; and/or
k. Deaths associated with restraints.

3. In the event of a Hospital patient's death, the deceased shall be pronounced dead by the attending Practitioner or their designee within a reasonable time, and an entry shall be made and signed in the medical records of the deceased. Policies with respect to release of dead bodies shall conform to local law.

K. TREATMENTS AND CONSENTS

1. All orders, treatments, and/or consents which by federal or state law or TJC standards require periodic review shall be reviewed and renewed or discontinued after seven (7) days. An exception to this rule is when day seven (7) occurs on a weekend or legal holiday; in this event, the orders, treatments, and/or consents must be renewed or discontinued on the first working day after the weekend or legal holiday.

2. To simplify the renewal process (when technically feasible) and after the formulation of rules acceptable to both the Medical Staff and administration: on any one patient all orders and treatments will be combined and shall be renewed or discontinued every seven (7) days after the date of patient admission. Exceptions to this rule are: (a) when day seven (7) occurs on a weekend or legal holiday; in this event the order must be renewed or discontinued on the first working day after the weekend or legal holiday; and (b) when the order or treatment is part of an approved standing order.

L. EMERGENCY SERVICES

1. The Medical Staff shall establish policies and procedures governing the acceptance and care of emergency patients in the event that someone presents to the Hospital with a medical emergency, or in the event of community disaster situation.

2. The Medical Staff shall recommend and approve written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

3. The Hospital will ensure that the assigned "Nurse in Charge" on all shifts will be qualified to initiate immediate appropriate lifesaving measures after they have met the clinical qualifications for that designation.

4. The Medical Staff shall establish policies and procedures regarding the safe and timely transfer of patients to other facilities for definitive care pursuant to applicable state and federal laws, rules, regulations and procedures.

M. PEER REVIEW

In both focused and ongoing professional practice evaluation, Physicians evaluate their colleagues' performance to ensure it is consistent with the standard of high quality, safe care.

Cases for peer review may be selected via screening through Utilization Review activity, peer identification of adverse events or outcomes, or caregiver concerns.

When a performance issue is identified, the individual whose performance is being reviewed is allowed to participate in the review process which shall be determined by the Medical Executive Committee. Relevant information from the review process should be incorporated into performance improvement initiatives and be consistent with confidentiality and privilege of information.

Actions taken as a result of peer review may include changes in policy and procedure or processes, collegial intervention of informal discussions or counseling of a physician, educational letters, quality letters, or trending of occurrences. The Medical Executive Committee will determine in situations involving the safety of patients if adverse actions need to be taken and the type of reporting to occur. Physicians have the right to the fair hearing process set forth in the Medical Staff Bylaws.

1. Focused Professional Practice Evaluation. A period of focused professional practice evaluation is implemented for all physicians requesting initial privileges. Additionally, a focused review should be completed when a practitioner's performance raises issues affecting the provision of safe, high quality patient care.

   The MEC will determine:

   - Triggers that will require review

- Criteria to evaluate performance when issues affecting safe, high quality patient care are identified.
- Committee or physicians who will oversee and conduct evaluations.
- Duration of performance monitoring
- Circumstances requiring external review, if indicated

2. Ongoing Professional Practice Evaluation. Ongoing professional practice evaluation is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. Criteria used in the ongoing professional practice evaluation may include the following:

   - Blood and blood products usage
   - Pharmaceutical usage
   - Requests for tests and/or procedures
   - Length of stay patterns
   - Mortality and morbidity data
   - Medical Necessity review data
   - Other relevant criteria as determined by the MEC

ARTICLE XIV:
AMENDMENTS

ARTICLE XIII: AMENDMENTS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff, provided 30 days notice of the proposed amendments are given in writing to all voting staff members prior to said meeting. Any member of the active Medical Staff may propose an amendment to these Bylaws by submitting such amendment, in writing, to the President or his/her designee. A proposed amendment shall be referred to the MEC, which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require approval by two-thirds of the Active Medical Staff present and voting at the meeting. Amendments so made shall be effective when approved by the Board of Managers. These Bylaws may not be amended unilaterally by action of the Medical Staff, the Board of Managers or any other entity (including, but not limited to, the MEC), but may only be amended in accordance with this Article.

Amendments to the Medical Staff policies, Rules and Regulations may be proposed upon approval of a majority of the voting members of the Medical MEC, and forwarded to the Board for consideration. Amendments are effective when approved by the Board of Managers.

ARTICLE XV:
ADOPTION

ARTICLE XIV: ADOPTION

A. These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Board of Managers of the Hospital. Upon approval of these Bylaws, the Board of Managers and the Medical Staff agree that these Bylaws shall be binding upon the Medical Staff, its members and the Hospital (including any successor-in-interest to the Hospital).

B. These Bylaws shall be reviewed every 3 years.

ADOPTED by the Active Medical Staff on: 6/4/18

G. Williams
Medical Director

APPROVED by the Board of Managers on: 6/4/18

Chair, Board of Managers