
Watertown Regional Medical Center
MEDICAL STAFF BYLAWS
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MEDICAL STAFF BYLAWS

OF

Watertown Regional Medical Center

PREAMBLE

WHEREAS, Watertown Regional Medical Center, hereinafter referred to as "Hospital", is operated by Watertown Medical Center, LLC hereinafter referred to as "Corporation", a private corporation organized under the laws of the state of Wisconsin and is lawfully doing business in Wisconsin, and is not an agency or instrumentality of any state, county or federal government; and

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

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

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

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

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

NOW, THEREFORE, the practitioners practicing in Watertown Regional Medical Center hereby organize themselves into a Medical Staff conforming to these bylaws.

DEFINITIONS

1. "Allied Health Professional" or "AHP" means an individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital, or without supervision in the case of CRNAs granted appropriate privileges and permitted by law and by the Hospital to practice independently. Such AHPs shall include, without limitation, physician assistants and nurse practitioners, and other such professionals. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.
2. "Board" means the Board of Trustees of the Watertown Regional Medical Center.
3. "Board Certification" shall mean certification in one of the Member Boards of the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).
4. "Chief Executive Officer" or "CEO" means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.
5. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.
6. "Clinical Privileges" means the Board's recognition of the practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.
7. "Corporation" means Watertown Medical Center, LLC.
8. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.
9. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these bylaws.
10. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.
11. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician's or dentist's clinical privileges are adversely affected by a determination based on the physician's or dentist's professional conduct or competence.
12. "Hospital" means Watertown Regional Medical Center.
13. "Licensed Independent Practitioner" means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.
14. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.
15. "Medical Staff" or "Organized Medical Staff" means the formal organization of practitioners who have been granted privileges by the Board to attend patients in the Hospital.

16. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan, policies and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.
17. "Medical Staff Year" means January – December.
18. "Member" means a practitioner who has been granted Medical Staff membership and clinical privileges pursuant to these bylaws.
19. "Peer Review Policy" means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix "E" hereto.
20. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Wisconsin.
21. "Practitioner" means a physician, dentist, or podiatrist who has been granted clinical privileges at the Hospital.
22. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these bylaws and in other hospital and Medical Staff policies.
23. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.
24. "Telemedicine" means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

ARTICLE I - NAME

The name of this organization shall be the Medical Staff of Watertown Regional Medical Center.

ARTICLE II - PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

- 2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of staff membership may be fulfilled;
- 2.1(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;
- 2.1(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other QAPI (Quality Assessment Performance Improvement) activities in accordance with the Hospital's QAPI program;
- 2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and AHPs authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHPs;
- 2.1(e) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill.
- 2.1(f) To promulgate, maintain and enforce bylaws, rules and regulations, and other policies and procedures related to medical care for the proper functioning of the Medical Staff;
- 2.1(g) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;
- 2.1(h) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;
- 2.1(i) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO; and
- 2.1(j) To accomplish its goals through appropriate committees.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

- 2.2(a) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and AHPs authorized to practice in the Hospital, by taking action to:

- (1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;
- (2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;
- (3) Participates in continuing medical education programs addressing issues of QAPI and including the types of care offered by the Hospital;
- (4) Implement a utilization management program, based on the requirements of the Hospital's utilization Management Plan;
- (5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPS;
- (6) Initiate and pursue corrective action with respect to practitioners, LIPs and AHPs, when warranted;
- (7) Develop, administer and enforce these bylaws, the rules and regulations of the staff and other hospital policies related to medical care;
- (8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment; and
- (9) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy, which is incorporated herein and attached as Appendix "D" hereto.

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

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff. Notwithstanding the foregoing OHCA relationship described in this policy, the Hospital shall not be liable to any third parties, whether under theories of apparent agency or any other theory of liability, for the acts and omissions of its Medical Staff members; and the members of the Medical Staff shall not be liable to any third parties, whether under theories of apparent agency or any other theory of liability, for the acts and omissions of the Hospital.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

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

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those practitioners legally licensed in Wisconsin, who continuously:

- (1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;
- (2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities;
- (3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;
- (4) Have professional liability insurance that meets the requirements of these Bylaws;
- (5) Are graduates of an approved educational institution holding appropriate degrees;
- (6) Have successfully completed an approved residency program or the equivalent where applicable;
 - (6) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;
- (8) Show evidence of the following educational achievements: CME or relevant documentation for additional training specific to their board certified specialty or the specialty they have been granted privileges to practice at the Hospital. The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital;
- (9) Meet one of the following requirements, in addition to those listed above:
 - (i) Board certification, sufficiently related to the privileges sought, demonstrated by proof of maintenance; or

- (ii) Adequate progress toward Board certification sufficiently related to the privileges sought, to be completed within five (5) years of appointment to the Medical Staff. The determination of adequacy shall be made by the MEC and must be approved by the Board of Trustees; or
- (iii) Demonstration to the satisfaction of the MEC and the Board of Trustees, competency and training equal or equivalent to that required for Board certification sufficiently related to the privileges sought.

The above requirement shall not apply to any practitioner already a member of the Medical Staff as of October 1, 2016.

- (10) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and
- (11) Practice in such a manner as not to interfere with the orderly and efficient rendering services by the Hospital or by other practitioners within the hospital.

3.2(b) Effects of Other Affiliations

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

3.2(c) Non-Discrimination

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

3.2(d) Ethics

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

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

- 3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;
- 3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;
- 3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff;

- 3.3(d) Discharge the staff, committee and hospital functions for which he/she is responsible by staff category assignment, appointment, election or otherwise;
- 3.3(e) Cooperate with other members of the Medical Staff, management, the Board of Trustees and employees of the Hospital;
- 3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;
- 3.3(g) Adequately enter all orders for treatment within the timeframe required by the applicable Medical Staff Rules, Regulations and Policies using Computerized Physician Order Entry as required by the Rules & Regulations;
- 3.3(h) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the hospital drug testing program;
- 3.3(i) Abide by the ethical principles of his/her profession and specialty;
- 3.3(j) Refuse to engage in improper inducements for patient referral;
- 3.3(k) Notify the CEO and Chief of Staff immediately if:
 - (1) His/Her professional licensure in any state is suspended or revoked;
 - (2) His/Her professional liability insurance is modified or terminated;
 - (3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;
 - (4) He/She is the subject of a successful or current pending challenge to, or the voluntary relinquishment of, any of the following:
 - (i) Specialty board certifications;
 - (ii) License to practice any profession in any jurisdiction;
 - (iii) National Drug Enforcement Agency (DEA) number or state licensure certificate issued by the state;
 - (iv) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges;
 - (v) The practitioner's management of patients which may have given rise to investigation by the state medical board;
 - (vi) Participation in federal or state health insurance, including Medicare or Medicaid; or
 - (vii) Voluntary or mandatory participation in a drug and/or alcohol rehabilitation program.
 - (5) He/she has had any criminal charges, other than minor traffic violations, brought/initiated against him/her.

Failure to provide any such notice, as required above, shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

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

3.3(m) Acknowledge and comply with the following standards concerning conflicts of interest:

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

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

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

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

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting.

The MEC Secretary will provide each MEC member with a copy of each member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

3.4 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented by a licensed practitioner who is credentialed and privileged by the Medical Staff to perform a history and physical examination for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care.

When the history and physical examination is conducted within thirty (30) days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff to perform a history and physical examination. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in Section 1861(r) of the Act) an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

The update must accompany an examination for any changes in the patient's condition since the patient's history and physical examination was performed that might be significant for the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient's condition since the history and physical examination was completed, he/she may indicate in the patient's medical record that the history and physical examination was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical examination was completed.

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

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

3.5 DURATION OF APPOINTMENT

3.5(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed 2 years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.5(b) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed 2 years.

3.5(c) Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member to be made in accordance with the procedures for initial appointment as outlined herein.

3.5(d) Declaration of Moratorium

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

3.6 LEAVE OF ABSENCE

3.6(a) Leave Status

A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year. If the leave is granted, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement. If the staff member's period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

3.6(b) Termination of Leave

- (1) At least sixty (60) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

- (2) If a member requests leave of absence for any reason and for any length of time, including but not limited to obtaining further medical training or an armed services commitment the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both.

Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall include Active, Courtesy, Honorary, and Affiliate categories.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

- (1) Meet the basic qualifications set forth in these bylaws;
- (2) Have an office and/or residence located within forty-five (45) minutes of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board; and
- (3) Regularly admit to, or are otherwise regularly involved in the care of at least twelve (12) patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

- (1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;
- (2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII;
- (3) To vote on all matters presented at general and special meetings of the Medical Staff;
- (4) To vote and hold office in the staff organization and on committees to which he/she is appointed; and
- (5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

- (1) Meet the basic responsibilities set forth in Section 3.3;
- (2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the

intensive care/critical care unit no later than 2 hours after admission or sooner if warranted by the patient's condition;

- (3) Actively participate:
 - (i) in the QAPI program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;
 - (ii) in supervision of other appointees where appropriate;
 - (iii) in the emergency department on-call rotation, for a minimum of ten (10) days per month, as more specifically described in the Medical Staff Rules and Regulations and *as recommended by the CEO and MEC and, approved by the Board*, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;
 - (iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and
 - (v) in discharging such other staff functions as may be required from time-to-time.
- (4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and
- (5) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

4.2(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of practitioners, who:

- (1) Meet the basic qualifications set forth in these bylaws;
- (2) Have an office and/or residence located within forty-five (45) minutes of the Hospital in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided;
- (3) Do not admit or participate in the care of more than eleven (11) patients in a calendar year. Courtesy members who admit or are involved in the care of more than eleven (11) patients in a calendar year must transfer to active staff. The requirement to transfer to active staff may be waived by the Board for practitioners who have their primary practice outside the community and provide services not otherwise available in the community; and
- (4) Are members of the Active Staff of another hospital where he/she actively participates in the QAPI program.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

- (1) Admit patients to the Hospital within the limitations provided in Section 4.3(a);
- (2) Exercise such clinical privileges as are granted to him/her pursuant to Article VII;
- (3) Attend meetings of the staff and any staff or hospital education programs;
- (4) Serve on any of the standing committees as a voting member on matters of policies and procedure, and vote as a member of the MEC or at a general Medical Staff meeting; and
- (5) Hold office, when the following conditions are met:
 - (i) annually attend at least 50 percent of the committee meetings to which they are assigned; and
 - (ii) if the combined total of the number of admissions and the number of referrals to the hospitalist program at Hospital or to a member of the Active Medical Staff for hospital inpatient or outpatient admissions exceeds 12 annually.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

- (1) Discharge the basic responsibilities specified in Section 3.3;
- (2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service;
- (3) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member; and
- (4) Take ER call if there are an inadequate number of Active Staff physicians to provide coverage within a specific specialty. The MEC shall make recommendations to the Board of Trustees regarding the determination of which specialties require coverage by Courtesy Staff members, and the Board shall have final authority for determining if such such requirement of Courtesy Staff members is necessary in order to provide quality care and meet the hospital's obligations under all applicable State and Federal laws.

4.4 HONORARY STAFF

4.4(a) Qualifications

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

- (1) Physicians who have retired from active hospital services, but continue to demonstrate a genuine concern for the Hospital; or
- (2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

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

4.4(b) Prerogatives

- (1) Prerogatives of an Honorary Staff member shall be:
 - (i) attending by invitation any such meetings that he/she may wish to attend as a non-voting visitor.
- (2) Honorary Staff members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Honorary Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.5 AFFILIATE STAFF

4.5(a) Qualifications

Appointees of the affiliate staff shall consist of those physicians who desire to be associated with the hospital, but who do not intend to care for or treat patients at this hospital. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing education endeavors. Affiliate Staff shall not be granted clinical privileges and shall not be subject to the requirements for ongoing professional practice evaluation or focused professional practice evaluation.

4.5(b) Prerogatives

Affiliate Staff Appointees:

- (1) May refer patients for outpatient diagnostic testing and specialty services provided by the hospital;
- (2) May refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment;
- (3) May visit their hospitalized patients, review their hospital medical records and provide advice and guidance to the attending physician, but shall **NOT** be permitted to admit patients, to attend patients, to exercise any clinical privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the hospital. They are encouraged to attend educational programs sponsored by the hospital or Medical Staff and attend meetings of the full Medical Staff; and
- (4) May serve and vote on Medical Staff Committees, if assigned.

4.5(c) Governance Prerogatives

- (1) Affiliate Staff members shall be entitled to vote at any level of the Medical Staff and to hold office when the following conditions are met:
 - (i) annually refer at least 12 patients to the hospitalist program at Hospital or to a member of the Active Medical Staff for hospital inpatient or outpatient admissions; and

- (ii) annually attend at least 50 percent of the committee meetings to which they are assigned.
- (2) Affiliate Staff members that do not meet the requirements of 4.5(c)(1) shall not be entitled to vote or hold office.

4.5(d) Responsibilities

Individuals requesting Affiliate Staff appointment shall be required to:

- (1) Submit an application for initial appointment, or for reappointment no less than every two years as prescribed by Article VI of these Bylaws;
- (2) Submit documentation of a current license, DEA certificate, malpractice insurance in the amounts required by Section 14.2 of these Bylaws, and shall not currently be ineligible as defined in Section 6.3(d)(5) of these Bylaws. Affiliate Staff members are not granted clinical privileges, therefore Board Certification is not required; and
- (3) Acknowledge that appointment and reappointment to the Affiliate Staff is a courtesy which may be terminated by the Board of Trustees upon recommendation of the Medical Executive Committee with sixty (60) days written notice, without right to a hearing or appeal as set forth in these Bylaws.

4.5(e) Reappointment Requirements

Individuals requesting re-appointment to the Affiliate Staff:

- (1) Shall provide evidence of a current license and Drug Enforcement Agency (DEA) registration;
- (2) Shall provide evidence of current malpractice insurance in the amounts required by Section 14.2
- (3) Shall not currently be an ineligible person as defined in Section 6.3(d)(5) of these Bylaws;
- (4) Shall provide peer references from Medical Staff members who are members of the Hospital's Medical Staff and are familiar with the Affiliate Staff member's competence.

ARTICLE V - ALLIED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

Allied Health Professionals (“AHPs”) shall be identified as any person(s) other than practitioners who are granted privileges to practice in the Hospital and are directly involved in patient care. Such persons may be employed by physicians on the staff; but whether or not so employed, must be under the direct supervision and direction of a staff physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations and may practice independently to the extent consistent with privileges granted, state and federal law, and Hospital policy) and not exceed the limitations of practice set forth by their respective licensure.

5.2 QUALIFICATIONS

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

5.2(a) AHPs must:

- (1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;
- (2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;
- (3) Have professional liability insurance in the amount required by these bylaws;
- (4) Provide a needed service within the Hospital; and
- (5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

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

- 5.3(a) To exercise judgment within the AHP’s area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;
- 5.3(b) To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff or without supervision in the case of CRNAs granted appropriate privileges and permitted by law and by the Hospital to practice independently; and
- 5.3(c) To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

5.4 CONDITIONS OF APPOINTMENT

- 5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of practitioners. The application fee for AHPs shall be \$250 at initial appointment, and AHP staff dues shall be \$100 per year. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.
- 5.4(b) Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity to be heard by the Committee concerning the AHP's grievance. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. A record of the appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP.
- 5.4(c) The AHP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.
- 5.4(d) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases. In the case of CRNAs who exercise privileges independently, as permitted by law and Hospital policy, such privileges shall be unaffected by the termination of any given practitioner's privileges.
- 5.4(e) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does

not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

- 5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;
- 5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;
- 5.5(c) Discharge any committee functions for which he/she is responsible;
- 5.5(d) Cooperate with members of the Medical Staff, administration, the Board of Trustees and employees of the Hospital;
- 5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;
- 5.5(f) Participate in performance improvement activities and in continuing professional education;
- 5.5(g) Abide by the ethical principles of his/her profession and specialty; and
- 5.5(h) Notify the CEO and the Chief of Staff immediately if:
 - (1) His/Her professional license in any state is suspended or revoked;
 - (2) His/Her professional liability insurance is modified or terminated;
 - (3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;
 - (4) He/she is the subject of a successful or current pending challenge to, or the voluntary relinquishment of, any of the following:
 - (i) Specialty board certifications;
 - (ii) License to practice any profession in any jurisdiction;
 - (iii) National Drug Enforcement Agency (DEA) number or state licensure certificate issued by the state;
 - (iv) Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges;
 - (v) The AHP's management of a patient which may have given rise to investigation by a state licensing board/agency;
 - (vi) Participation in federal or state health insurance program, including Medicare or Medicaid;or

(vii) Voluntary or mandatory participation in a drug and/or alcohol rehabilitation program.

(5) He/she has had any criminal charges, other than minor traffic violations, brought/initiated against him/her;

(6) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privilege;

Failure to provide any such notice, as required above, shall result in immediate loss of Allied Health membership and clinical privileges, without right of fair hearing procedures.

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

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

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

ARTICLE VI - PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

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

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all practitioners except pathologists), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. The application fee shall be \$250 at initial appointment, and Medical Staff dues shall be \$150 per year. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

- 6.2(a) Acknowledgment & Agreement: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:
- (1) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and
 - (2) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.
- 6.2(b) Administrative Remedies: A statement indicating that the practitioner agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges;
- 6.2(c) Criminal Charges: Any current criminal charges, except minor traffic violations, pending against the applicant and any past convictions or pleas. The practitioner shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;
- 6.2(d) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;
- 6.2(e) Health Status. Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board. Applicant agrees to be bound by the hospital drug testing policy;
- 6.2(f) Program Participation: Information concerning the applicant's current participation and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

- 6.2(g) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The practitioner shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of a professional liability action against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions;
- 6.2(h) Education: Detailed information concerning the applicant's education and training.
- 6.2(i) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage;
- 6.2(j) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions;
- 6.2(k) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:
- (1) membership/fellowship in local, state or national professional organizations;
 - (2) specialty board certifications;
 - (3) license to practice any profession in any jurisdiction;
 - (4) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists);
 - (5) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or
 - (6) the practitioner's management of patients which may have given rise to investigation by the state medical board; or
 - (7) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The practitioner shall have a continuing duty to notify the MEC, in writing through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions.

- 6.2(l) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;
- 6.2(m) References: The names of at least three (3) practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience,

clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

- 6.2(n) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;
- 6.2(o) Request: Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;
- 6.2(p) Photograph: A recent, wallet sized government issued photograph of the applicant;
- 6.2(q) Citizenship Status: Proof of United States citizenship or legal residency;
- 6.2(r) Professional Practice Review Data: For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner's professional practice review, volumes and outcomes from organization(s) that current privilege the applicant; and
- 6.2(s) Continuing Education: Evidence of satisfactory completion of continuing education requirements.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

A practitioner wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her written request for an application form to the CEO or his/her designee.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

- (1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and clinical privileges;
- (2) Authorizes hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;
- (3) Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;
- (4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights;
- (5) Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall be deemed to have immediately relinquished his/her appointment and clinical privileges, without fair hearing rights;

- (6) Pledges to provide continuous care for his/her patients treated in the Hospital; and
- (7) Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights.

6.3(c) Statement of Release & Immunity from Liability

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

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

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

If granted appointment, I accept the following conditions:

- (1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:
 - (i) applications for appointment or clinical privileges, including temporary privileges;
 - (ii) periodic reappraisals;
 - (iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;
 - (iv) summary suspension;

- (v) hearings and appellate reviews;
 - (vi) medical care evaluations;
 - (vii) utilization reviews;
 - (viii) any other Hospital, Medical Staff, department, service or committee activities;
 - (ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and
 - (x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.
- (2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.
- (3) The term “Hospital” and “its authorized representatives” means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital’s attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term “third parties” means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

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

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff, including these Bylaws and Rules & Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in

force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise clinical privileges at the Hospital.

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

6.3(d) Submission of Application & Verification of Information

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the CEO or his/her designee. The application shall be returned to the practitioner and shall not be processed further if one (1) or more of the following applies:

- (1) Not Licensed. The practitioner is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or
- (2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the practitioner has had his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or
- (3) Exclusive Contract or Moratorium. The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicant's specialty; or
- (4) Inadequate Insurance. The practitioner does not meet the liability insurance coverage requirements of these bylaws; or
- (5) Ineligible for Medicare Provider Status. The practitioner has been excluded, suspended or debarred from any government payer program or is currently the subject of a pending investigation by any government payer program; or
- (6) No DEA number. The practitioner's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists); or
- (7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within the geographical area required by these bylaws; or
- (8) Application Incomplete. The practitioner has failed to provide any information required by these bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application.

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

In the event that none of the above apply to the application, the CEO or his/her designee shall promptly seek to collect or verify the references, licensure and other evidence submitted. The CEO or his/her designee shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) Description of Initial Clinical Privileges

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

6.3(f) Credentials Committee Action

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

6.3(g) Medical Executive Committee Action

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

6.3(h) Effect of Medical Executive Committee Action

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

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

- (2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Credentials Committee. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.
- (3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the practitioner by special notice which shall specify the reason or reasons for denial and the practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan, or for AHPS, the procedure outlined in 5.4(b). The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b).

6.3(i) Board Action

- (1) Decision; Deadline. The Board of Trustees may accept, reject or modify the MEC recommendation. The Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the MEC. If the committee returns a positive decision concerning the application, the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board.

The expedited process may not be used in the following circumstances:

- (i) The applicant submits an incomplete application;
- (ii) The MEC makes a recommendation that is adverse or with limitation;
- (iii) There is a current challenge or a previously successful challenge to licensure or registration;
- (iv) The applicant has received an involuntary termination of Medical Staff membership at another organization;

- (v) The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or
- (vi) There has been a final judgment adverse to the applicant in a professional liability action.

Any of the above circumstances will require review and consideration by the full Board.

In either case, and in situations in which no committee has been appointed, the Secretary of the Board shall reduce the full Board's decision to writing and shall set forth therein the reasons for the decision. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(n). The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Trustees shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

- (2) Favorable Action. In the event that the Board of Trustees' decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been granted. The CEO or his/her designee shall also keep each patient care area adequately informed concerning the current clinical privileges granted to each newly approved applicant as well as existing members of the medical staff. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of QAPI that does not materially restrict the applicant's ability to exercise the requested clinical privileges.
- (3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Board of Trustees' action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b). The CEO or his/her designee shall immediately deliver to the applicant by special notice, a letter enclosing the Board of Trustees' written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b).

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

6.3(j) Interview

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

6.3(k) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's

provision of false or misleading information on, or the omission of information from, the application materials.

6.3(l) Time Periods for Processing

Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the Credentials Committee upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the practitioner has failed to provide requested information needed to complete the verification process.

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

A decision by the Board to deny staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

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

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

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

6.3(n) Appointment Considerations

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

- (1) **Patient Care** with the expectation that practitioners provide patient care that is compassionate, appropriate and effective;
- (2) **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;
- (3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

- (4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients' families, members of the Medical Staff, Hospital Administration and employees, and others;
- (5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and
- (6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 **REAPPOINTMENT PROCESS**

6.4(a) **Information Form for Reappointment**

At least ninety (90) days prior to the expiration date of a practitioner's present staff appointment, the CEO or his/her designee shall provide the practitioner a reapplication form for use in considering reappointment. The staff member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the member's current term.

6.4(b) **Content of Reapplication Form**

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

- (1) **Education**: Continuing training, education, and experience during the preceding appointment period that qualifies the staff member for the privileges sought on reappointment;
- (2) **License**: Current licensure;
- (3) **Health Status**: Current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of staff membership or to exercise the privileges requested;
- (4) **Program Participation**: Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;
- (5) **Previous Affiliations**: The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding appointment period;
- (6) **Professional Sanctions**: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:
 - (i) membership/fellowship in local, state or national professional organizations; or
 - (ii) specialty board certification; or
 - (iii) license to practice any profession in any jurisdiction; or

- (iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists); or
 - (v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or
 - (vi) the practitioner's management of patients which may have been given rise to investigation by the state medical board; or
 - (vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.
- (7) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;
 - (8) Criminal Charges: Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or pleas during the preceding appointment period;
 - (9) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage;
 - (10) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of evaluations of care, including, but not limited to an evaluation by one (1) other Medical Staff member who is not a partner, employer, employee or relative of the practitioner or two (2) Medical Staff members who are not partners, employers or employees, or relatives, and results from the QAPI process of the Medical Staff. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the practitioner's professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.

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

- (11) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations

during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period;

- (12) Notification of Release & Immunity Provisions: The acknowledgments and statement of release;
- (13) Information on Ethics/Qualifications: Such other specific information about the staff member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the hospital;
- (14) References: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others; and
- (15) Continuing Education: Evidence of satisfactory completion of continuing education requirements.

6.4(c) Verification of Information

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

6.4(d) Action on Application

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

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Section 6.3(n) as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners and with patients, results of the hospital monitoring and evaluation process, including practitioner-specific information compared to aggregate information from QAPI activities which consider criteria directly related to

quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the CEO. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No staff member may seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Notwithstanding the foregoing, a staff member may not request modification of his/her staff category more than once in any two year appointment term.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

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

6.6(b) Requirements for Service

In approving any such practitioners for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements and CMS Conditions of Participation, are subject to appropriate quality controls, and are evaluated as part of the overall hospital quality assessment and improvement program.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6 shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. The expiration or termination of an employment agreement or a non-exclusive contract for services shall automatically result in concurrent termination of Medical Staff membership and clinical privileges if the employment agreement or non-exclusive contract for services so provides. The Fair Hearing does not apply in either case.

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

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

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for medical staff membership, each practitioner must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a staff member for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from QAPI activities, when available. For practitioners who have not actively practiced in the hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(12) herein. In addition, those practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a staff member.

7.2(c) Procedure

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

7.2(d) Limitations on Privileges

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

7.2(e) Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period of not less than six (6) months. The evaluation period may be renewed for additional periods up to the conclusion of the member's period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner's evaluation for reappointment.

7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

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

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

7.4(a) Temporary Privileges

The CEO or his/her designee, upon recommendation of the Chief of Staff or Chairperson of the Credentials Committee, and upon proof of current licensure, appropriate malpractice insurance, and completion of the required Data Bank query; may grant temporary privileges for no more than 120 days in the following circumstances:

- (1) Pendency of Applications: The CEO or his/her designee, upon recommendation of the Chief of Staff may grant such privileges upon completion of the appropriate application, consent, and release; proof of current licensure, DEA certificate, and appropriate malpractice insurance; completion of the required Data Bank query; verification that there are no current or prior successful challenges to licensure or registration, that the physician has not been subject to involuntary termination of Medical Staff membership at another facility; and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility.
- (2) One-Case Privileges: Upon receipt of a written request, an appropriately licensed person who is not an applicant for membership may be granted temporary privileges for the care of one (1) or more, but no more than five (5), specific patients. Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual patient's best interest, and no practitioner shall be granted one-case privileges for more than five (5) patients in any given year. The letter approving such privileges shall include the name of the patient to be treated and the specific privileges granted. Practitioners granted one-case privileges shall attend the patient for whom privileges were granted within thirty (30) days of the request for

one-case privileges. If a given practitioner exceeds the five (5) case requirement, such person shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Prior to any award of one-case privileges, the practitioner must submit a copy of current license, DEA certificate, proof of appropriate malpractice insurance, the name of the physician designated to care for the patient in the event the practitioner is unavailable and curriculum vitae and the CEO or his/her designee must obtain telephone verification of the physician's privileges at his/her primary hospital and query the Data Bank.

- (3) **Locum Tenens**: Upon receipt of a written request, an appropriately licensed person who is serving as locum tenens for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed sixty (60) days. Such privileges may be renewed for successive consecutive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service as locum tenens within a calendar year. All physicians providing coverage through such locum tenens services must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of locum tenens privileges pursuant to this section. Further, prior to award of locum tenens privileges, the applicant must submit a completed application, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving locum tenens privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to provide coverage through locum tenens physicians shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(b) Conditions

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

7.4(c) Termination

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

7.4(d) Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary, one-case or locum tenens privileges or because of any termination or suspension of such privileges.

7.4(e) Term

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

7.5 EMERGENCY & DISASTER PRIVILEGES

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

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

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

In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner’s disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster volunteer practitioner for

purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

7.6 TELEMEDICINE

7.6(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.6(b) Telemedicine Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the “telemedicine physician”), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception is outlined below for those circumstances in which the practitioner’s distant-site entity or distant-site hospital is Joint Commission accredited and the Hospital places in the practitioner’s credentialing file a copy of written documentation confirming such accreditation.

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

- (1) The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity’s or distant-site hospital’s physicians and practitioners providing telemedicine services;
- (2) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;
- (3) The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation and the Joint Commission Medical Staff (MS) chapter for hospitals or ambulatory care organizations, as applicable;
- (4) The telemedicine physician is privileged at the distant-site entity or distant-site hospital providing the telemedicine services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the telemedicine physician’s privileges at the distant-site entity or distant-site hospital;
- (5) The telemedicine physician holds a license issued or recognized by the State of Wisconsin; and
- (6) The Hospital has evidence, or will collect evidence, of an internal review of the telemedicine physician’s performance of telemedicine privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the telemedicine physician and all

complaints the Hospital has received about the telemedicine physician) for use in the periodic appraisal of the telemedicine physician by the distant-site entity or distant-site hospital.

For the purposes of this Section 7.6, the term “distant-site entity” shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare-participating hospital; (3) is Joint Commission accredited; and (4) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of physicians providing telemedicine services. For the purposes of this Section 7.6, the term “distant-site hospital” shall mean a Medicare-participating and Joint Commission accredited hospital that provides telemedicine services.

If the telemedicine physician’s site is also accredited by Joint Commission, and the telemedicine physician is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telemedicine physician’s credentialing information from that site may be relied upon to credential the telemedicine physician in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

ARTICLE VIII - CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the CEO, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed in the event of corrective action against a physician or dentist with clinical privileges, and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The MEC may also initiate corrective action on its own initiative based on information received from other sources. The MEC shall reference the specific activities or conduct constituting the basis of the action. The Chief of Staff shall promptly notify the CEO or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital's impaired practitioner policy. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

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

- (1) Rejecting the request for corrective action;
- (2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;
- (3) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;
- (4) Recommending terms of probation or required consultation;
- (5) Recommending reduction, suspension or revocation of clinical privileges;
- (6) Recommending reduction of staff category or limitation of any staff prerogatives; or

(7) Recommending suspension or revocation of staff membership.

8.1(e) Procedural Rights

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

8.1(f) Other Action

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

8.1(g) Board Action

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

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these bylaws or other hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner.

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

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

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

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

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

8.3 AUTOMATIC SUSPENSION

8.3(a) License

A staff member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in Wisconsin is revoked relinquished, suspended or restricted shall immediately and automatically be suspended from the staff and practicing in the hospital. Suspensions based upon revocation, relinquishment, suspension or restriction of license shall require the practitioner to request reinstatement, rather than automatic reinstatement upon reestablishment of his/her full licensure.

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

Any practitioner (except a pathologist) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended, relinquished or expired shall immediately and automatically be suspended from the staff and practicing in the Hospital until such time as the registration is reinstated.

8.3(c) Medical Records

- (1) Automatic suspension of a practitioner's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.
- (2) Medical Records - Expulsion: Notwithstanding the provision of Section 8.3(c)(1), any staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.3(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

8.3(d) Malpractice Insurance Coverage

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

8.3(e) Failure to Appear/Cooperate

Failure of a practitioner or AHP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner or AHP's clinical privileges as the MEC may direct.

8.3(f) Exclusions/Suspension from Medicare

Any practitioner or AHP who is excluded from the Medicare program or any state government payor program will be automatically suspended. Suspensions based exclusion from the Medicare program or any state government payor program shall require the practitioner to request reinstatement, rather than automatic reinstatement upon reenrollment in the applicable program.

8.3(g) Automatic Suspension - Fair Hearing Plan Not Applicable

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

8.3(h) Chief of Staff

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

8.4 CONFIDENTIALITY

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

8.5 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 8.3(c) of these bylaws.

8.6 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the practitioner's privileges. Any of the following shall have the right to impose supervision: Chief of Staff, the Board and/or CEO.

8.7 REAPPLICATION AFTER ADVERSE ACTION

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

8.8 FALSE INFORMATION ON APPLICATION

Any practitioner who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.8 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner, permit the practitioner to appear before it and present information solely as to the issue of whether the practitioner made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented

by the practitioner and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX - INTERVIEWS & HEARINGS

9.1 INTERVIEWS

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

9.2 HEARINGS

9.2(a) Procedure

Whenever a practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

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

9.3 ADVERSE ACTION AFFECTING AHPs

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

ARTICLE X - OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

- (1) Chief of Staff;
- (2) Vice-Chief of Staff;
- (3) Secretary/Treasurer; and
- (4) Immediate Past Chief of Staff.

10.1(b) Qualifications

Officers must be members of the Medical Staff at the time of nomination and election with rights to hold office under Article IV and must remain members in good standing during their term of office. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

10.1(c) Nominations

- (1) The Nominating Committee shall consist of the Chief of Staff, the Past-Chief of Staff of the Medical Staff and the CEO. This committee shall offer one (1) or more nominees for each office (with the exception of the office of Immediate Past Chief of Staff) to the Medical Staff thirty (30) days before the annual meeting.
- (2) Nominations may also be made from the floor at the time of the annual meeting if willingness to serve is confirmed by the nominee.

10.1(d) Election

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

10.1(e) Removal

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

10.1(f) Term of Elected Officers

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(g) Vacancies in Elected Office

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

10.1(h) Duties of Elected Officers

- (1) Chief of Staff. The Chief of Staff shall serve as the principal official of the staff. As such he/she will:
 - (i) appoint multi-disciplinary Medical Staff committees;
 - (ii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;
 - (iii) in concert with the MEC and Credentials Committee, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;
 - (iv) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and hospital management committees;
 - (v) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;
 - (vi) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
 - (vii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;
 - (viii) serve as a voting member of the MEC and an ex-officio member of all other staff committees or functions;
 - (ix) assist in coordinating the educational activities of the Medical Staff;
 - (x) confer with the CEO, CFO, CNO and Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and
 - (xi) assist the Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.
- (2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief

of Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

- (3) Secretary/Treasurer: The duties of the Secretary/Treasurer shall be to:
 - (i) give proper notice of all staff meetings on order of the appropriate authority;
 - (ii) prepare accurate and complete minutes for MEC and Medical Staff meetings;
 - (iii) assure that an answer is rendered to all official Medical Staff correspondence;
 - (iv) be responsible for the preparation of financial statements and report status of Medical Staff funds, if any; and
 - (v) perform such other duties as ordinarily pertain to his/her office.
- (4) The Immediate Past Chief of Staff shall be a member of the MEC and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

10.1(i) Conflict of Interest of Medical Staff Leaders

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board of Trustees) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Annually, on or before March 15, each Medical Staff leader shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff leader, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

- (1) Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to member of the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;
- (2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;
- (3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

(4) Business practices that may adversely affect the hospital or community.

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical Staff leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

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

Medical Staff leaders with a direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly with the Hospital shall not be eligible for service on the Medical Executive Committee, Credentials Committee, Bylaws Committee, Quality Assurance Committee or the Board of Trustees. This prohibition may be waived by the Board of Trustees, in its sole discretion, for good cause shown.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI - CLINICAL SERVICES

11.1 CLINICAL SERVICES

There shall be the following clinical services: surgical service, diagnostic service, hospital medicine service, outpatient and referral service, women and children service, emergency medicine service, and such other services as may be established by unanimous vote of the MEC or added by the bylaws amendment procedures as described in Article XV of these bylaws. The various services within the Medical Staff shall not constitute departments without express designation by the MEC and the Board of Trustees. Each service shall be headed by a chief selected in the manner and having the authority and responsibilities set forth in these bylaws.

11.2 SERVICE FUNCTIONS

The primary function of each service is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care. To carry out this overall function, each service shall:

- 11.2(a) Require that patient care evaluations be performed and that appointees exercising privileges be reviewed on an ongoing basis and upon application for reappointment;
- 11.2(b) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;
- 11.2(c) Monitor on an ongoing basis the compliance of its members with these bylaws, and the rules and regulations, policies, procedures and other standards of the Hospital;
- 11.2(d) Monitor on an ongoing basis the compliance of its members with applicable professional standards;
- 11.2(e) Coordinate the patient care provided within the service with nursing, administrative, and other non-Medical Staff services;
- 11.2(f) Foster an atmosphere of professional decorum within the service;
- 11.2(g) Review all deaths occurring in the service and all unexpected patient care events, and report findings to the MEC;
- 11.2(h) Submit written reports to the MEC on a regular basis concerning:
 - (1) Findings of the service's review and evaluation activities, actions taken thereon, and the results thereof;
 - (2) Recommendations for maintaining and improving the quality of care provided in the service and in the Hospital; and
 - (3) Such other matters as may be requested from time to time by the MEC.
- 11.2(i) Make recommendations to the MEC, subject to Board approval, of the kinds, types, and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members.

11.3 SERVICE CHIEF

- 11.3(a) Chiefs of Service shall be selected by the Board in consultation with the Chief of Staff. Chiefs of Service may be removed by affirmative vote of two thirds (2/3) of the Board for those reasons

described in these Bylaws with respect to removal of Medical Staff officers. The chief of each service shall have the following duties with respect to his/her service:

- (1) Account to the MEC for all professional activities within the service;
- (2) Develop and implement service programs;
- (3) Maintain continuing review of the professional performance of all Medical Staff and AHP Staff appointees having clinical privileges in the service;
- (4) Implement within his/her service any actions or programs designated by the MEC;
- (5) Participate in every phase of administration of his/her service in cooperation with the MEC, the nursing service, other services, administration and the Board;
- (6) Assist in the preparation of such annual reports regarding the service as may be required by the MEC, the CEO or the Board of Trustees;
- (7) As applicable, establish a system for adequate professional coverage within the service, including an on-call system, which systems shall be fair and non-discriminatory; and
- (8) Perform such other duties as may reasonably be requested by the Chief of Staff, the MEC, or the Board of Trustees.

ARTICLE XII - COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

- 12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.
- 12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.
- 12.1(c) All information pertaining to activities performed by the Medical Staff and its committees shall be privileged and confidential to the full extent provided by law.
- 12.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) Composition

Members of the committee shall include the following:

- (1) The Chief of Staff, who shall act as Chairperson;
- (2) The Chief of Staff Elect;
- (3) The Immediate Past Chief of Staff;
- (4) The Chiefs of Services;
- (5) Secretary to the Medical Staff;
- (6) The CEO, ex-officio, or his/her designee;
- (7) One (1) at-large member of the Medical Staff, elected by a majority vote of the Medical Staff at its annual meeting after nomination as provided in Section 10.1(c); and
- (8) One (1) representative from AHP staff, as a non-voting member, whose appointment is to be confirmed by the Chief of Staff upon recommendation of a majority vote of the AHP staff.

12.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of leadership are delegated to the MEC, it shall represent to the Board the organized medical staff's views on issues of patient safety and quality of care. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 12.2(b) and additional functions may be delegated or removed through amendment of this Section 12.2(b). The functions and responsibilities of the MEC shall include, at least the following:

- (1) Receiving and acting upon committee reports;
- (2) Implementing the approved policies of the Medical Staff;
- (3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action;

- (4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital;
- (5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;
- (6) Assuring regular reporting of QAPI and other staff issues to the MEC and to the Board of Trustees and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate staff members;
- (7) Assuring an annual evaluation of the effectiveness of the Hospital's QAPI program is conducted;
- (8) Developing and monitoring compliance with these bylaws, the rules and regulations, policies and other Hospital standards;
- (9) Recommending action to the CEO on matters of a medico-administrative nature;
- (10) Developing and implementing programs to inform the staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;
- (11) Requesting evaluation of practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a practitioner to the Medical Staff may not be complying with the bylaws, may be rendering care below the standards established for practitioners to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards;
- (12) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated;
- (13) Developing and implementing programs for continuing medical education for the Medical Staff;
- (14) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;
- (15) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Hospital; and
- (16) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

12.2(c) Meetings

The MEC shall meet as needed, but at least ten times annually and maintain a permanent record of its proceedings and actions.

12.2(d) Special Meeting of the Medical Executive Committee

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

12.2(e) Removal of MEC Members

All members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions. Officers of the Medical Staff who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e). The at-large Medical Staff member may be removed by a two-thirds majority of the Medical Staff for those reasons described in Section 10.1(e) with respect to Medical Staff officers. The AHP member may be removed by a two-thirds (2/3) majority of the AHP staff for those reasons described in Section 10.1(e) with respect to Medical Staff officers.

12.3 MEDICAL STAFF FUNCTIONS

12.3(a) Composition of Committees

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

12.3(b) Functions

The functions of the staff are to:

- (1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;
- (2) Conduct or coordinate appropriate QAPI reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record, core measures and other appropriate reviews;
- (3) Conduct or coordinate utilization review activities;
- (4) Assist the Hospital in providing continuing education opportunities responsive to QAPI activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital's professional library services;
- (5) Develop and maintain surveillance over drug utilization policies and practices;
- (6) Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other hospital patient care and administrative services;
- (7) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner's competence;
- (8) Investigate and control nosocomial infections and monitor the Hospital's infection control program;
- (9) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;
- (10) Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

- (11) Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, the Medical Staff has adopted an Impaired Practitioner Policy;
- (12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:
- (i) medical assessment and treatment of patients;
 - (ii) use of medications, use of blood and blood components;
 - (iii) use of operative and other procedure(s);
 - (iv) efficiency of clinical practice patterns; and
 - (v) significant departure from established patterns of clinical practice.
- (13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:
- (i) education of patients and families;
 - (ii) coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care of an individual patient;
 - (iii) accurate, timely and legible completion of patients' medical records including history and physicals;
 - (iii) Patient satisfaction;
 - (iv) Sentinel events; and
 - (v) Patient safety.
- (14) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers;
- (15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;
- (16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;
- (17) Review, on a periodic basis, professional practice evaluations and applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;
- (18) Investigate any breach of ethics that is reported to it;
- (19) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and
- (20) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

12.3(c) Meetings

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

12.4 CONFLICT RESOLUTION COMMITTEE

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two members of the Organized Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two non-physician Board members who are selected by the Board Chair, and the CEO. The CNO shall serve as a non-voting, ex-officio member of the Committee whose presence or absence will not be considered in determining a quorum. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

ARTICLE XIII - MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

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

13.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

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

13.2 REGULAR STAFF MEETINGS

13.2(a) Meeting Frequency & Time

The Medical Staff shall meet quarterly. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.2(b) Order of Business & Agenda

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

13.2(c) Special Meetings

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

13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4(a) General Staff Meeting

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

13.4(b) Committee Meetings

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

13.5 MANNER OF ACTION

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

13.6 MINUTES

Minutes of all meetings shall be prepared by the Secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

Complete and detailed minutes must be recorded and maintained.

13.7 ATTENDANCE

13.7(a) Regular Attendance

Members of the Active Staff are encouraged to attend at least one (1) meeting of the Medical Staff per year. Absence from all of the regular meetings for the year without acceptable excuse may be considered as a resignation from the Active Staff. Members must also attend at least one (1) of each of the committee meetings in which they are a member per year and at least fifty percent (50%) of Medical Executive Committee meetings, if they are a member.

13.7(b) Absence from Meetings

Any member who is compelled to be absent from any Medical Staff or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence.

Reinstatement of a staff member whose membership has been resigned because of absence from meetings shall be made only on application, and such application shall be processed in the same manner as an application for initial appointment.

13.7(c) Special Appearance; Cooperation with Medical Executive Committee

Any committee of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee is questioning the practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall

be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice shall and/or failure to comply with any reasonable directive of the MEC, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV - GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS AND POLICIES

Subject to approval by the Board, the Medical Staff hereby delegates authority to the MEC to adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular MEC meeting at which a quorum is present and without previous notice, or at any special MEC meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

14.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

14.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

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

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

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

14.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

14.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner or Allied Health Professional granted clinical privileges in the hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than \$1,000,000.00 per occurrence and \$3,000,000.00 in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the hospital, and shall be on an occurrence basis or, if on a claims made basis, the practitioner shall agree to obtain tail coverage covering his/her practice at the hospital. Each practitioner shall also inform the MEC and CEO of the details of such coverage annually in December. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

14.3 CONSTRUCTION OF TERMS & HEADINGS

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

14.4 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.4(a) Reports to be Confidential

Information with respect to any practitioner, including applicants, staff members or AHPs, submitted, collected or prepared by any representative of the hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

14.4(b) Release from Liability

No representative of the hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the hospital, provided such disclosure or representation is in good faith and without malice.

14.4(c) Action in Good Faith

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

ARTICLE XV - ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

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

15.2 ADOPTION, AMENDMENT & REVIEWS

The bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

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

15.2(b) Board

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

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these bylaws approved as set forth herein shall be documented by either:

15.3(a) Appending to these bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved by corporate legal counsel as to form; or

15.3(b) Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

Each member of the Medical Staff shall be given a copy of any amendments to these bylaws in a timely manner.

**MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____
Chairperson

Date

Watertown Regional Medical Center:

By: _____
Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for Watertown Medical Center, LLC

Date

APPROVED:

By: _____
Division President

Date

APPENDIX “A” – FAIR HEARING PLAN

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

DEFINITIONS

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

1. "Appellate Review Body" means the group designated pursuant to this Plan to hear a request for Appellate Review that has been properly filed and pursued by the practitioner.
2. "Corporation" shall mean Watertown Medical Center, LLC.
3. "Hearing Committee" means the committee appointed pursuant to this Plan to hear a request for an evidentiary hearing that has been properly filed and pursued by a practitioner.
4. "Parties" means the practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.
5. "Special Notice" means written notification sent by certified or registered mail, return receipt requested, or delivered by hand with a written acknowledgment of receipt.

ARTICLE I - INITIATION OF HEARING

1.1 RECOMMENDATION OR ACTIONS

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

- (1) Denial of initial staff appointment;
- (2) Denial of reappointment;
- (3) Suspension of staff membership in excess of fourteen (14) days, except for automatic suspensions pursuant to the Medical Staff Bylaws;
- (4) Revocation of staff membership;
- (5) Denial of requested advancement of staff category, if such denial materially limits the physician's exercise of privileges.
- (6) Reduction of staff category due to an adverse determination as to a practitioner's competence or professional conduct;
- (7) Limitation of the right to admit patients;
- (8) Denial of an initial request for particular clinical privileges;
- (9) Reduction of clinical privileges for a period in excess of thirty (30) days;
- (10) Permanent suspension of clinical privileges;
- (11) Revocation of clinical privileges;
- (12) Terms of probation, if such terms of probation materially restrict the physician's exercise of privileges for more than thirty (30) days; and
- (13) Summary suspension of privileges or staff membership for a period in excess of fourteen (14) days.

1.2 WHEN DEEMED ADVERSE

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

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

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

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

- (1) Advise the practitioner of the basis for the action and his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws of this Plan;
- (2) Specify that the practitioner has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;
- (3) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter;
- (4) State that upon receipt of this hearing request, the practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action;
- (5) Provide a summary of the practitioner's rights at the hearing; and
- (6) Inform the practitioner if the recommended action may be reportable to the National Practitioner Data Bank and appropriate licensing agencies.

1.4 REQUEST FOR HEARING

A practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Article I, Section 1.3 to file a written request for a hearing. Such request shall be delivered to the CEO either in person or by certified or registered mail.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

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

- (1) An adverse recommendation or action by the Board, CEO or their designees, shall constitute acceptance of that recommendation or action. (hereinafter, references to decisions by these entities or individuals shall be designated as decisions or actions of the Board); and
- (2) An adverse recommendation by the MEC or its designee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the MEC's recommendation at its next regular meeting following the waiver. In its deliberations, the Board shall review all relevant information and material considered by the MEC and may consider all other relevant information received from any source. The Board's action on the matter shall constitute a final decision of the Board. The CEO shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Article I, Section 1.5(2) and shall notify the Chief of Staff and the MEC of each such action.

ARTICLE II - HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

Upon receipt of a timely request for hearing, the CEO shall deliver such request to the Chief of Staff or to the Board, depending on whose recommendation or action prompted the request for hearing. The CEO shall send the practitioner special notice of the time, place and date of the hearing. The hearing date shall not be less than thirty (30) nor more than ninety (90) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect shall, at the practitioner's request, be held as soon as arrangements for it reasonably may be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

2.2 STATEMENT OF ISSUES & EVENTS

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

2.3 PRACTITIONER'S RESPONSE

Within ten (10) days of receipt of the notice of hearing under Section 2.2, the affected practitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the due process hearing.

2.4 EXAMINATION OF DOCUMENTS

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

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

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

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

determination. The Chief of Staff shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(b) By Board

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

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

2.5(c) Service on Hearing Committee

A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee solely because he/she has participated in investigating the action or matter at issue.

ARTICLE III - HEARING PROCEDURE

3.1 PERSONAL PRESENCE

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

3.2 PRESIDING OFFICER

Either the Hearing Officer, if one is appointed pursuant to Article VIII, Section 8.1, or the Chairperson of the Hearing Committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.

3.3 REPRESENTATION

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

3.4 RIGHTS OF THE PARTIES

During a hearing, each of the parties shall have the right to:

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

If any practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

3.5 PROCEDURE & EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence although these rules may be considered in determining the weight of the evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall

become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents in the state where the hearing is held.

3.6 OFFICIAL NOTICE

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

3.7 BURDEN OF PROOF

- (1) When a hearing relates to the matters listed in Article I, Sections 1.1(1), 1.1.(5) or 1.1(8), the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory.
- (2) For the other matters listed in Article I, Section 1.1, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

3.8 RECORD OF HEARING

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

3.9 POSTPONEMENT

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

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING

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

3.11 RECESSES & ADJOURNMENT

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

ARTICLE IV - HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

Within fourteen (14) days after the transcript of the proceedings has been delivered to the proper officer of the hearing, or if no transcript is ordered, then thirty (30) days after the hearing ends, the Hearing Committee shall make a written report of its findings and recommendations in the matter. The Hearing Committee shall forward the same, together with the hearing record and all other documentation considered by it, to the Board or the MEC, for action consistent with Section 4.2 below. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it. Recommendations must be made by a majority vote of the members and the committee may only consider the specific recommendations or actions of the Board or MEC. The practitioner who requested the hearing shall be entitled to receive the written recommendations of the Hearing Committee, including a statement of the basis for the recommendation.

4.2 ACTION ON HEARING COMMITTEE REPORT

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

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

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

4.3(b) Effect of Favorable Result

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

4.3(c) Effect of Adverse Result

At the conclusion of the process set forth in Section 4.2, if the result continues to be adverse to the practitioner in any of the respects listed in Article I, Section 1.1 of this Plan, the practitioner shall be informed, by special notice of his/her right to request an Appellate Review as provided in Article V, Section 5.1 of this Plan. Said notice shall be delivered to the practitioner no later than fourteen (14) days from the MEC action, or Hearing Committee report, as appropriate under Section 4.2.

ARTICLE V - INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

A practitioner shall have fourteen (14) days following his/her receipt of a notice pursuant to Article IV, Section 4.3(c) to file a written request for an Appellate Review. Such request shall be delivered to the CEO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in reaching the adverse result.

5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A practitioner who fails to request an Appellate Review within the time and manner specified in Article V, Section 5.1 shall be deemed to have waived any right to such review.

Such waiver shall have the same force and effect as that provided in Article I, Section 1.5 of this Plan.

5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

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

5.4 APPELLATE REVIEW BODY

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

ARTICLE VI - APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

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

6.2 WRITTEN STATEMENTS

The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, but may not raise new factual matters not presented at the hearing. The statement shall be submitted to the Appellate Review Body through the CEO at least seven (7) days prior to the scheduled date of the Appellate Review, except if such time limit is waived by the Appellate Body. A written statement in reply may be submitted by the MEC or by the Board, and if submitted, the CEO shall provide a copy thereof to the practitioner at least three (3) days prior to the scheduled date of the Appellate Review.

6.3 PRESIDING OFFICER

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

6.4 ORAL STATEMENT

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements supporting their positions. If the Appellate Review Body allows one of the parties to make an oral statement, the other party shall be allowed to do so. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, and not otherwise reflected in the record shall not be introduced at the Appellate Review, except by leave of the Appellate Review Body. The Appellate Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted, following establishment of good cause by the party requesting the consideration of such matter or evidence as to why it was not presented earlier. If such additional evidence is considered, it shall be subject to cross examination and rebuttal.

6.6 PRESENCE OF MEMBERS & VOTING

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

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of consultation. Upon the conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Body shall thereupon,

at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 ACTIONS TAKEN

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

6.9 CONCLUSION

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

ARTICLE VII - FINAL DECISION OF THE BOARD

7.1 No later than twenty-eight (28) days after receipt of the recommendation of the Appellate Review Body, or twenty-eight (28) days after waiver of Appellate Review, the Board shall consider the same and affirm, modify or reverse the recommendation. When a matter of hospital policy or potential liability is presented, the Board shall consult with Corporation prior to taking action. The decision made by the full Board after receipt of the written recommendation from the Appellate Review Body will be deemed final, subject to no further appeal under the provisions of this Fair Hearing Plan. The action of the Board will be promptly communicated to the practitioner in writing by certified mail.

ARTICLE VIII - GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

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

8.2 ATTORNEYS

If the affected practitioner desires to be represented by an attorney at any hearing or any Appellate Review appearance pursuant to Article VI, Section 6.4, his/her initial request for the hearing should state his/her wish to be so represented at either or both such proceedings in the event they are held. The MEC or the Board may also be represented by an attorney.

8.3 NUMBER OF HEARINGS & REVIEWS

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

8.4 RELEASE

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

8.5 WAIVER

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

**FAIR HEARING PLAN
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____
Chairperson

Date

Watertown Regional Medical Center:

By: _____
Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for Watertown Medical Center, LLC

Date

APPROVED:

By: _____
Division President

Date

APPENDIX “B” – RULES & REGULATIONS

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

ARTICLE I - ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

- 1.1(a) Excluding emergencies, all patients admitted to the hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.
- 1.1(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership.
- 1.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self harm.
- 1.1(d) Emergency Department Physicians, and physicians providing care in the Intensive Care Unit (ICU), shall be encouraged to maintain documentation regarding current ACLS certification. Physicians admitting to ICU without ACLS certification will be encouraged to co-manage the case with an ACLS certified physician.
- 1.1(e) The management and coordination of each patient’s care, treatment and services shall be the responsibility of a physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient to any referring practitioner and to relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician’s responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.
- 1.1(f) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician, the following should be contacted, in order of priority listed below:
 - (1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);
 - (2) The Chief of Staff, who may assume care for the patient or designate any appropriately trained member of the staff; or
 - (3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.
- 1.1(g) The physician certification must be completed, signed, dated and documented in the medical record prior to discharge unless otherwise permitted by law. This requires authentication of the order for inpatient admission prior to discharge.

1.2. ADMITTING POLICY

Priorities for admission are as follows:

1.2(a) Emergency Admissions

Within twenty-four (24) hours following all admissions, the Attending Physician shall have a history and physical dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b) Preoperative Admissions

This includes all patients scheduled for surgery. If it is not possible to handle all such admissions, the chief of the surgical service may decide the urgency of any specific admission.

1.2(c) Routine Admissions

This will include elective admissions involving all services.

1.3 PATIENT TRANSFERS

1.3(a) No patients will be transferred without notification to the Attending Physician.

1.3(b) If the intensive care unit is full and a patient requires ICU care; all physicians attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Chief of Staff may consult any appropriate specialist in making this determination, and shall make the decision.

1.4 SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staff, and the hospital, the care of the potentially suicidal patient shall be as follows:

1.4(a) A patient suspected to be suicidal shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or hospital policy. The patient will be afforded psychiatric consultation;

1.4(b) The hospital social worker should be consulted for assistance; and

1.4(c) If the patient presents to the emergency room, the steps set forth in Section 1.4(a) shall be followed, except that the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the hospital's EMTALA policy, that the benefits of transfer outweigh the risks.

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

1.5(a) Patients shall be discharged only on order of the Attending Physician. Should a patient leave the hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.

- 1.5(b) If any questions as to the validity of admission to or discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.
- 1.5(c) The Attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:
- (1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;
 - (2) Estimate of additional length of stay the patient will require; and
 - (3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

- 1.5(d) The Attending Physician shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:
- (1) Conditions that may result in the patient's transfer to another facility or level of care;
 - (2) Alternatives to transfer, if any;
 - (3) The clinical basis for the discharge;
 - (4) The anticipated need for continued care following discharge;
 - (5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and
 - (6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.6 DECEASED PATIENT

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

1.7 AUTOPSIES

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

1.8 UNANTICIPATED OUTCOMES

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

ARTICLE II - MEDICAL RECORDS

2.1 GENERAL REQUIREMENTS

- 2.1(a) The Hospital is a “paper light” organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically, and paper-based documentation will be scanned. Records will be accessed by physicians and others online, and the records will not be printed for internal use.
- 2.1(b) All medical record documents created after the patient is admitted will be created using Hospital-approved forms or Hospital electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes operative/invasive procedure reports, consultations, discharge summaries, and progress notes.
- 2.1(c) Access to patient information on the EMR will be made available to Medical Staff members and their staff and Allied Health Professionals. All access to electronic records is tracked, and unauthorized access to a patient’s record is not permitted. All Practitioners and Allied Health Professionals must maintain the confidentiality of passwords and may not disclose such passwords to anyone.
- 2.1(d) Medical Staff members and Allied Health Professionals who are appointed/granted privileges pending electronic medical record training and who have not completed this training within six (6) months of appointment will be considered to have voluntarily relinquished clinical privileges and/or to have voluntarily resigned from the Medical Staff. Practitioners and Allied Health Professional will be advised of the training requirement at or prior to appointment/granting of clinical privileges and reminded of the requirement at least twice after the date of appointment. Exceptions may be made for good cause shown as determined by the Chief of Staff.

2.2 PREPARATION/COMPLETION OF MEDICAL RECORDS

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

The Medical Record shall include Computerized Physician Order Entries as required by these Rules & Regulations in order to be considered complete.

2.3.1 ADMISSION HISTORY

- 2.3(a) Each patient admitted for inpatient care shall have a complete admission history and physical examination as required by the Medical Staff Bylaws.
- 2.3(b) An oral surgeon with appropriate privileges who admits or registers a patient without medical conditions may perform the history and physical examination and assess the medical risks of the procedure to the patient. Dentists and podiatrists with appropriate privileges are responsible for the

part of their patients' history and physical examination that relates to dentistry or podiatry, and podiatrists may perform the complete medical history and physical examination to the extent consistent with state law, scope of practice, training, and privileges granted.

2.3(c) For outpatients undergoing surgical procedures requiring general or regional anesthesia or monitored anesthesia care, a full history and physical report as described in the Medical Staff Bylaws must be completed within 24 hours after registration or prior to surgery or anesthesia, whichever is sooner (except in emergencies). For outpatients undergoing surgical or invasive procedures that do not require general or regional anesthesia or monitored anesthesia care, a short form history and physical report may be used. A short form history and physical report must include:

1. Indications/symptoms for the procedure;
2. A list of current medications and dosages;
3. Any known allergies including past medication reactions;
4. Existing co-morbid conditions;
5. Assessment of mental status;
6. Exam specific to the procedure performed.

2.3(d) For patients receiving IV moderate sedation, the completed short form history and physical report must include all of the above elements plus the following:

1. Examination of the heart and lungs by auscultation;
2. American Society of Anesthesia (ASA) status;
3. Documentation that patient is an appropriate candidate for IV moderate sedation.

2.4 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam must be recorded before all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such delay would be a threat to the patient's health.

2.5 PROGRESS NOTES

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

2.6 OPERATIVE/PROCEDURAL REPORTS

The responsible Practitioner should record and authenticate a pre-operative diagnosis prior to surgery. An operative report must be dictated or documented in the electronic medical record and dated and timed immediately following surgery for inpatients and outpatients, and the report must be promptly signed by the surgeon and made a part of the patient's current medical record within six (6) hours after completion of surgery. Operative reports shall include:

- (a) Name and hospital identification number of the patient;
- (b) Date and times of the surgery;

- (c) Name of the surgeon(s) and assistants or other providers who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific surgical tasks that were conducted by providers other than primary surgeon/practitioner;
- (d) Pre-operative and post-operative diagnosis;
- (e) Name of the specific surgical procedure(s) performed;
- (f) Type of anesthesia administered;
- (g) Complications, if any;
- (h) A description of techniques, findings, and tissues removed or altered;
- (i) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any; and
- (j) Estimated blood loss.

When there is a transcription or filing delay of the dictated operative report, an operative progress note must be entered in the medical record immediately after surgery to provide pertinent information to those attending the patient. The operative progress note must include the name(s) of the primary surgeon(s) and his/her assistant(s), the procedure performed, a description of each procedure finding, estimated blood loss, specimens removed, and post-operative diagnosis. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.7 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. Consultation reports shall be written or dictated within twenty-four (24) hours of seeing the patient. This report shall be dated, timed, authenticated and made a part of the patient's medical 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.

2.8 EMERGENCY DEPARTMENT RECORD

The following elements must be recorded for all patients receiving emergency care:

- (a) Adequate patient identification. When not obtainable, the reason shall be entered in the medical record;
- (b) Time of arrival, by what means and by whom transported;
- (c) Appropriate physical examination to include recording of vital signs. Date of last tetanus injection should be recorded in all cases where the skin is broken;
- (d) The pertinent history of the illness or injury including details relative to first aid or emergency care given prior to arrival;
- (e) Diagnostic and therapeutic orders;
- (f) Clinical observations, including results of treatment, if appropriate;
- (g) Reports of procedures, tests and results;
- (h) Diagnostic impression;
- (i) Condition of patient on discharge or transfer;
- (j) Final disposition, including instructions given to the patient and/or family for follow-up care;
- (k) A patient's leaving against medical advice, if applicable; and
- (l) Signature of responsible physician.

The Emergency Department record template contains all of the essential elements as outlined above.

2.9 OBSTETRICAL RECORD

The history for obstetrical patients, when adequately updated with progress notes setting forth the current history and changes in physical findings, shall be accepted as a valid and actual history and physical throughout the hospital for surgery and other procedures related to obstetrical patients. The current obstetrical record shall include a complete prenatal record. Orders for elective Caesarean Sections or induced labor(s) shall be entered at least twenty-four (24) hours prior to the scheduled procedure. The prenatal record may be supplied through the electronic medical record system or may be a legible hard copy of the attending Practitioner's office record transferred to the Hospital before admission and updated as necessary.

2.10 ANESTHESIA RECORD

2.10(a) The anesthesia record shall include:

1. Name and Hospital identification number of the patient;
2. Name of the anesthesiologist;
3. Name, dosage, route and time of administration of all drugs and agents used;
4. The monitoring of the patient;
5. The type and amount of all fluids administered, including blood and blood products;
6. Technique(s) used;
7. Oxygen flow rates;
8. Continuous recordings of patient status noting blood pressure, heart and respiration rate;
9. Any complications or problems occurring during the anesthesia period, including time and description of symptoms, vital signs, treatments rendered and patient's response to treatment; and
10. The status of the patient at the conclusion of anesthesia.

2.10(b) A pre-anesthetic note will be made on the patient's Hospital chart by the physician responsible for the anesthesia, and this will include pertinent information such as:

1. The results of the pre-operative evaluation,
2. Pre-op medication (amount and time given),
3. Physical status of patient,
4. Latest pre-op vital signs, and
5. Initial pulse and blood pressure readings taken in the O.R. suite.

The patient's medical record shall contain appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated.

2.10(c) The post-anesthesia records should include:

1. Vital signs and level of consciousness;
2. Intravenous fluids administered, including blood and blood products;
3. All drugs administered;
4. Post-anesthesia visits; and
5. Any unusual events or postoperative complications and the management of those events.

The post-anesthesia visits will be recorded, including at least one note describing the presence or absence of anesthesia-related complications. Post-anesthesia entries may be written in the doctor's progress notes, not necessarily on the anesthesia record sheet. A note made in the surgical or obstetrical suite, or in the post-anesthesia care unit, does not ordinarily constitute a visit. Complete recovery and readiness for discharge from the post-anesthesia care unit is determined by the clinical judgment of an anesthesiologist or another qualified physician. Each post-anesthesia note shall specify the date and time, cardiac status, level of consciousness (LOC), any complications and observations. While the number of visits by an anesthesiologist will be determined by the status of

the patient in relation to the procedure performed and anesthesia administered, a visit should be made early in the post-operative period and also after complete recovery from anesthesia.

2.11 CLINICAL ENTRIES/AUTHENTICATION

- 2.11(a) All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately and promptly dated, timed, authenticated and legible. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. The use of a rubber stamp signature is not acceptable.
- 2.11(b) Electronic signature authentication of medical records is standard practice at the Hospital. Each individual who makes entries in the medical record shall submit to Administration a signed statement to the effect that he/she is the only one who will use his/her electronic signature. There shall be no delegation of the use of such electronic signature to another individual.
- 2.11(c) The following medical record entries must be co-signed by a physician member of the Medical Staff:
- (1) Physical exam documenting, history taking, and writing of orders by audiologists;
 - (2) Physical exam documenting, history taking, and writing of orders by psychologists;
 - (3) Physical exam documenting, history taking, and writing of orders by nurse practitioners, unless otherwise permitted by applicable law and the Collaboration Agreement between the nurse practitioner and collaborating physician;
 - (4) Documentation of histories and physical exams and orders written for inpatients by physician assistants in the Hospital (co-signing physician must be physician assistant's supervising physician). Unless otherwise precluded by any third party payer's rules for payment, physician assistants (except those employed by temporary staffing agencies) may write orders without co-signature for laboratory services, diagnostic radiological services, audiology services, and physical, occupational, and speech therapy to be furnished for outpatients and Emergency Department patients at the Hospital, provided that the writing of each such order is within the scope of the physician assistant's license and Specified Services and written under the supervision of a physician member of the active Medical Staff; and
 - (5) Physical exam documenting, history taking, and writing of orders by certified nurse-midwives, unless otherwise permitted by applicable law and the Collaboration Agreement between the nurse-midwife and the collaborating physician.
 - (6) All medical record documentation by medical residents. The teaching physician must also indicate that he/she saw and evaluated the patient and agrees with the resident's documentation, if applicable, or has changes or additions to the resident's documentation and specify such changes or additions.

2.12 ABBREVIATIONS/SYMBOLS

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

2.13 FINAL DIAGNOSIS

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

2.14 DISCHARGE SUMMARY

A discharge summary shall be dictated or entered in the EMR and dated and timed for all inpatients. The discharge summary should recapitulate concisely the reason for hospitalization, significant findings, procedures performed, treatment rendered, condition of patient on discharge, and any specific instructions given to the patient and/or family. All discharge summaries shall be authenticated by the responsible Practitioner. For short stay observation patients, the responsible Practitioner must record a final note that includes the outcome of the hospital stay, disposition of the patient, and provisions for follow-up care. In the event of death, a summation statement should be added to the record as a final progress note. This final note should indicate the reasons for admission, findings and course in the Hospital and events leading to death.

2.15 REMOVAL OF MEDICAL RECORDS

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

2.16 ACCESS TO MEDICAL RECORDS

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

Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute, and require a signed release from the patient or a court order before being released to any person.

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.17 PERMANENTLY FILED MEDICAL RECORDS

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

2.18 STANDING ORDERS

In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed semi-annually by the physician, the Quality Department, the Pharmacy & Therapeutics Committee, and the Medical Executive Committee. Standing orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

2.19 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within twenty-two (22) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.20 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within twenty-two (22) days of discharge. The Health Information Management Department will provide each physician with a list of his/her incomplete medical records every seven (7) days. At the twenty-first (21st) day for any incomplete medical records, the letter will include a warning that the record(s) will be delinquent at twenty-two (22) days and the physician's privileges will be suspended if any records become delinquent.

- 2.20(a) Suspension. A chart which is not completed within twenty-two (22) days of discharge will trigger suspension of the responsible physician's privileges as described in this Section 2.20(a). When a staff member is notified of suspension, the staff member may not provide any hands-on patient care, whether inpatient or outpatient, unless covering Emergency Room call. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician may only exercise privileges for the purposes of covering Emergency Room call, and may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the Chief of Staff and the CEO.
- 2.20(b) The suspended staff member is obligated to provide to the hospital CEO and the Chief of Staff the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations and any other services that physician provides.
- 2.20(c) All hospital services shall be notified of a suspension to enable the enforcement of the suspension.
- 2.20(d) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.
- 2.20(e) If a vacation prevents the Practitioner from completing his/her medical records, the Practitioner must notify the Health Information Management Department in advance of the vacation; otherwise, the suspension/sanction will remain in effect until the documentation is completed. If there are extenuating circumstances (e.g., illness, extended absences) that prevent the Practitioner from completing his/her medical records, the Practitioner or the Practitioner's office must notify the Health Information Management Department. When an individual Practitioner has notified the Health Information Management Department regarding being out of town or ill prior to being placed on suspension, the suspension process may be waived. The Practitioner may be given one week after his/her return to complete any delinquent records.
- 2.20(f) Restoration of suspended privileges can be accomplished only by completion of all delinquent records assigned to the suspended physician. It shall be the responsibility of the Health Information Management Department to immediately notify appropriate parties upon completion of delinquent records so that the name of the Practitioner may be removed from the suspension list.

Allied Health Professionals are subject to the provisions above regarding incomplete medical records. The privileges of Allied Health Professionals shall be suspended in accordance with the policy above for incomplete records.

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

2.21 TREATMENT & CARE WRITTEN ORDERS

Orders for treatment and care of patients may not be written by Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician, as further specified by Section 2.11(c) of these Rules & Regulations.

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

2.22 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of “white-out”.

To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.23 COMPUTERIZED PHYSICIAN ORDER ENTRY

CPOEs shall be utilized by physicians and licensed independent practitioners to the extent available and operational.

ARTICLE III - GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

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

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing, dated, timed, authenticated and legible. Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists, occupational therapists, speech therapists, and CRNAs may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate, time and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than twenty-four (24) hours from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

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

Diagnostic and rehabilitative services may be ordered for nonhospitalized patients by licensed practitioners, within the legal scope of their license, who are not members of the Medical Staff. The Medical Staff shall determine, with Board approval, which services non-Medical Staff members may order and the criteria governing which licensed practitioners may order such services. An Emergency Department physician or hospitalist may order diagnostic tests for nonhospitalized patients, provided that the ordering of such tests is discussed with the patient's primary care physician or specialist and the primary care physician or specialist agrees to follow up with the patient regarding the test results.

3.3 ILLEGIBLE TREATMENT ORDERS

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

3.4 PREVIOUS ORDERS

All previous orders are canceled when patients go to surgery.

3.5 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Formulary of the American Society of Hospital Pharmacists. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC.

The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

3.6 ORDERING/DISPENSING OF DRUGS

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

3.7 QUESTIONING OF CARE

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

3.8 PATIENT CARE ROUNDS

Hospitalized patients shall be seen at least daily and more frequently if their status warrants. Patients in the Skilled Nursing Facility shall be seen weekly, and more frequently if their status warrants, by the Attending Physician or his/her designated alternate. Patients admitted to Intensive Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than six (6) hours after admission or sooner if warranted by the patient’s condition.

3.9 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.10 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by federal law, Joint Commission standards, and all hospital policies pertaining to restraints and seclusion.

3.11 PRACTITIONERS ORDERING TREATMENT

Licensure and Medicare/Medicaid eligibility will be verified for all practitioners ordering treatment (i.e. home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the practitioner’s Medical Staff status or lack thereof. Orders for outpatient services may only be made by practitioners who are (1) responsible for the care of the patient; (2) licensed in, or holds a license recognized in, the jurisdiction where he/she provides care to the patient; (3) acting within his/her scope of practice under State law; and (4) authorized by the Medical Staff to order the applicable outpatient services under a written hospital policy that is approved by the Board. This includes both practitioners who are on the Hospital Medical Staff, as well

as other practitioners who are not on the hospital Medical Staff, but who satisfy the Hospital's policies for ordering applicable outpatient services.

3.12 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

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

3.13 HOSPITALIST TRANSFER OF CARE

The hospitalist who comes on shift is responsible for the care of the patient, including documentation and answering clarification queries from coding or clinical documentation improvement specialists.

ARTICLE IV - GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

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

4.2 ADMISSION OF DENTAL CARE PATIENT

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

4.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

- (1) To provide a detailed dental history justifying hospital admission and that part of the patient's physical examination that relates to dentistry;
- (2) To provide a detailed description of the examination of the oral cavity and preoperative diagnosis;
- (3) To complete an operative report describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue shall be sent to the hospital pathologist for examination, subject to hospital policy regarding Surgical Pathology Tissue and Medical Device Exceptions & Specimens Exempt from Microscopic Examination;
- (4) To provide progress notes as are pertinent to the oral condition; and
- (5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

- (1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery;
- (2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
- (3) To supervise the patient's general health status while hospitalized.

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and the Attending Physician.

4.3 ADMISSION OF PODIATRIC PATIENTS

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist.

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

- (1) To provide a detailed podiatric history justifying hospital admission and that part of the patient's physical examination that relates to podiatry. The podiatrist may perform the complete medical history and physical examination to the extent consistent with state law, scope of practice, training, and privileges granted, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;
- (2) To provide a detailed description of the podiatric findings and a preoperative diagnosis;
- (3) To complete an operative report describing the findings and technique. A tissue shall be sent to the hospital pathologist for examination, subject to hospital policy regarding Surgical Pathology Tissue and Medical Device Exceptions & Specimens Exempt from Microscopic Examination;
- (4) To provide progress notes as are pertinent to the podiatric condition; and
- (5) To provide a clinical summary.

4.3(b) Physician's Responsibilities

The responsibilities of the physician are:

- (1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery, if not provided by the podiatrist;
- (2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery, if not performed by the podiatrist; and
- (3) To supervise the patient's general health status while hospitalized.

4.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and Physician.

4.4 INFORMED CONSENT

A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high risk treatments (as provided by hospital policy and/or state law) except in those situations wherein the patient's life and/or limb is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient, or any person to whom the patient has properly delegated representative authority, only after the risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of care, and other information necessary to make a fully informed consent has been explained to the patient by the responsible physician. After informed consent has been obtained by the surgeon, the physician or his/her designee shall obtain the patient's signature on the consent form and shall witness the signature. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

Each consent form shall include the name of the hospital where the procedure is to take place; the name of the specific procedure for which consent is being given; the name of the responsible practitioner who is

performing the procedure; a statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative; and the signature of the patient or the patient's legal representative. The form must also comply with the requirements of applicable state law.

4.5 PATIENT REQUESTS AND REFUSAL OF TREATMENT

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient's behalf, must be documented in the patient's permanent hospital record. Patients have the right to request any treatment at any time, and such requests shall be documented in the patient's permanent chart. However, such requests may be declined if determined to be medically unnecessary by the treating physician or his/her designee.

4.6 EXAMINATION OF SPECIMENS

Specimens shall be evaluated by a pathologist, subject to hospital policy regarding Surgical Pathology Tissue and Medical Device Exceptions & Specimens Exempt from Microscopic Examination. It is the responsibility of the scrub tech and registered nurse to process all specimens removed during surgery. (Refer to the OR policies and procedures for additional details.) Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff, and documented in writing.

Specimens for frozen section are received by the scrub nurse or surgical tech, who gives them to the circulating nurse to be sent immediately to the lab for pathology. (Refer to the OR policies and procedures for additional details.) Specimens are received and handled by the pathologist and laboratory according to the procedure defined in the Clinical Laboratory's Miscellaneous Procedure Manual.

4.7 ELECTIVE SURGERY SCHEDULING

In order to reduce patient anxiety resulting from a long wait, reduce staff overtime for elective work and allow time for possible emergencies, the following guidelines will be used for scheduling elective surgeries. Emergency procedures shall take priority above all other cases.

4.7(a) Standing Time:

7:30 a.m.

4.7(b) Priority Cases shall include:

- (1) Cesarean section;
- (2) Age 12 and under;
- (3) Open bone work;
- (4) Latex allergic patients; and
- (4) Contaminated cases last, if possible.
- (5) Priority for surgical cases shall be further determined in accordance with the policy developed by the Surgical Services Committee.
- (6) A surgical case may lose priority only in the following circumstances:

- a. When the patient is considered to be an unusual risk for anesthesia, who might be improved by further preparation and whose general condition will not deteriorate by the time spent in the preparation. Such decision must be made by the Medical Director of Anesthesiology, or his/her representative, in consultation with the attending physician.
- b. When a scheduled case is pre-empted by the occurrence of a life-threatening emergency requiring the use of the available anesthesia and surgical personnel.
- c. When a local factor, e.g., infection or power failure, renders an unnecessary risk attendant to beginning a case.

4.7(c) Scheduling of Cases:

- (1) Elective surgery should be scheduled by 3:00 p.m the previous day;
- (2) All cases must be scheduled with Operating Room Staff;
- (3) All cases must be taken in the order they are scheduled, whether general or local, inpatient or outpatient, except for pre-existing priority cases;
- (4) If a scheduled case is canceled, the schedule will be moved up to fill the vacancy. New cases will not replace the canceled case, unless the physicians with cases following the canceled case do not desire an earlier time, in which case the canceling surgeon can substitute another comparable length procedure . Otherwise, any other case scheduled by the same surgeon will be added to the end of the schedule;
- (5) If a surgeon desires to change the order of his/her scheduled cases, any other surgeon who will be affected by the change must be notified and consent to the change; and
- (6) The start time for a surgery shall be deemed to be the time of incision or invasion. If a surgeon is more than thirty (30) minutes late for a scheduled procedure, the case will then follow other scheduled cases. If the surgeon is more than fifteen (15) minutes late, the OR Supervisor will attempt to contact the surgeon and ascertain when he/she will be available. If the surgeon will not be available within a reasonable period of time, the next scheduled surgery shall commence and the case will be moved to the end of the schedule.
- (7) Reservations for elective surgery will be accepted for the schedule with the following information to be recorded:
 - a. The patient's name and age;
 - b. Name of the operation;
 - c. Duration of operation, as well as can be estimated;
 - d. Surgeon's name and assistant, if necessary;
 - e. The patient's address and phone number;
 - f. Room number if in-patient; and
 - g. Special equipment or implant requests.

4.7(d) Block Time:

Block time for scheduling elective surgery can be used by surgeons who have applied to the Chief of the Surgery Service and been granted a block of time for scheduled procedures requiring anesthesia. Block time usage will be evaluated quarterly by the Surgical Services Committee. Adjustments to block time allotments will be made as necessary by the Committee if usage falls below 70% of time blocked. For all other cases, standard priority in scheduling will be assigned on

a first-come, first-served basis. This original priority may be challenged by a life-threatening emergency or by consultation with the surgeon in charge of the first procedure. Surgical procedures scheduled after the first case will have priority in order of time as originally scheduled, or by time request by availability.

4.8 PREOPERATIVE WORKUP

4.8(a) Preoperative workup is as deemed appropriate. The requirements prior to surgery are outlined below and will be followed whenever possible prior to the induction of anesthesia. All diagnostic test results and history and physicals must be on the chart on the day of a scheduled elective surgery.

- (1) The medical record shall document a current, thorough medical history and physical examination prior to the performance of surgery, completed in accordance with the requirements set forth in the Medical Staff General Rules and Regulations.
- (2) Diagnostic tests and labwork will be determined for surgical patients using pre-op testing requirements and guidelines.
- (3) The responsible physician must record and authenticate a provisional diagnosis prior to surgery.
- (4) The physician performing the surgery must mark the surgical site with his/her initials using an indelible marker if the case has a right/left distinction, multiple structures (such as fingers and toes), or multiple levels. Except in emergencies, the preoperative diagnosis, the history and physical examination, and the required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded or if certification that the above is dictated is not made, the practitioner shall make at least a comprehensive note on the patient's record regarding the patient's condition prior to induction of anesthesia and start of surgery, if possible.

4.8(b) Before any surgical procedure will begin, the following must be consistent in regard to diagnosis and procedure: (1) history and physical; (2) operating consent form; and (3) surgical schedule. If there is any inconsistency in the above, the physician and/or surgeon must make the appropriate change and initial it.

4.9 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a post operative examination will be conducted by the surgeon.

4.10 ANESTHESIA SERVICES

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (MAC) including deep sedation, regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

4.10(a) Anesthesia services throughout the Hospital shall be organized into one anesthesia service under the direction of a qualified physician. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. The director of anesthesia services may be, but is not required to be, an anesthesiologist member of the Medical Staff. Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services.

- 4.10(b) The Hospital shall maintain policies and procedures governing anesthesia services provided in all Hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.
- 4.10(c) Only credentialed and qualified individuals as defined in the policies and procedures of the Hospital may provide anesthesia services. The surgical service and Credentials Committee shall approve credentialing guidelines consistent with federal regulations and Joint Commission standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations and the policies and procedures of the Hospital. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care (MAC) must be supervised by an anesthesiologist who is immediately available, except that CRNAs may administer anesthesia services independently to the extent consistent with privileges granted, state and federal law, and Hospital policy. An anesthesiologist is considered “immediately available” only if he/she is physically located within the same area as the CRNA and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

When supervision of CRNA administered anesthesia services by a practitioner other than an anesthesiologist is required, doctors of medicine or osteopathy with clinical privileges to perform invasive procedures may supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care (MAC). Dentists, oral surgeons, and podiatrists who are qualified to administer anesthesia under state law may supervise the qualified CRNA in the administration of regional anesthesia and monitored anesthesia care (MAC).

- 4.10(d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the Hospital and shall be consistent with the requirements of applicable state law, the Joint Commission and the CMS Hospital Conditions of Participation. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care (MAC), this record shall include a pre-anesthesia evaluation, an intraoperative record, and a postanesthesia evaluation.

Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the Hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthetist or anesthesiologist will reevaluate and document the patient’s condition immediately before administering moderate or deep sedation or anesthesia, as such terms are defined by The Joint Commission.

The individual who administered the patient’s anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the Hospital, must also perform a postanesthesia evaluation of the patient and document the results of the evaluation no later than forty-eight (48) hours after the patient’s surgery or procedure requiring anesthesia services. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than forty-eight (48) hours, as addressed in Hospital policies and procedures. For those patients who are unable to participate in the postanesthesia evaluation, a postanesthesia evaluation should be completed and documented within forty-eight (48) hours with notation that the patient was unable to participate, description of the reason(s) therefore, and expectations for recovery time, if applicable.

- 4.10(e) The anesthetist or anesthesiologist will be responsible to verify that informed consent for anesthesia is documented in the medical record and, if it is not documented, to obtain and document such informed consent. In order to ascertain the patient's wishes as they relate to the continuance of advanced directives, said advanced directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the attending physician prior to surgery. If the patient's wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.
- 4.10(f) The Hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary. Thus, the response time for arrival of the qualified anesthesia provider must not exceed twenty (20) minutes.

4.11 PREPARATION FOR ADMINISTERING ANESTHESIA

- 4.11(a) The anesthesiologist assigned to the case is responsible for checking and setting up anesthesiology equipment and supplies.
- 4.11(b) The surgical patient who is scheduled to receive anesthesia services (general, regional, or monitored anesthesia care) will be brought to the operating room when the O.R. suite is prepared for the procedure. Exceptions to this timing may be made at the O.R. Director's discretion.
- 4.11(c) In accordance with Hospital policy, the operating physician/surgeon shall mark the operative site, review and update the history and physical, and reassess the patient prior to the induction of anesthesia.
- 4.11(d) The patient's identity shall be checked in accordance with Hospital policy.
- 4.11(e) Prior to the start of any surgical procedure, a final "time out" verification process will be conducted in accordance with Hospital policy.

4.12 POST-ANESTHESIA CARE

- 4.12(a) At the conclusion of anesthesia, the patient will be evaluated for special post-anesthetic management. The patient will be transferred to the post-anesthesia care unit, where properly trained personnel will evaluate and document the following: (1) respiratory function, including respiratory rate, airway patency, and oxygen saturation; (2) cardiovascular function, including pulse rate and blood pressure; (3) mental status; (4) temperature; (5) pain level; (6) nausea and vomiting; and (7) postoperative hydration.
- 4.12(b) A post-anesthesia follow-up report must be written by the anesthesiologist within 48 hours after surgery. At a minimum, the post-anesthesia follow-up report must document (1) cardiopulmonary status; (2) level of consciousness; (3) any followup care and/or observations; and (4) any complications occurring during postanesthesia recovery.
- 4.12(c) The anesthesiologist is responsible for the patient from time of induction of anesthesia until the patient has recovered from the anesthetic. The anesthesiologist must be readily available until the patient has been discharged from the postanesthesia care unit.
- 4.12(d) The anesthesiologist or another qualified physician will sign the post-anesthesia care unit discharge order.

- 4.12(e) The anesthesiologist will evaluate the patient's need for I.C.U. care. If the anesthesiologist feels I.C.U. care is appropriate, he/she will assess the patient, confer with and transfer patient care to the surgeon and primary care physician, if applicable.
- 4.12(f) Visitors are allowed in the post-anesthesia care unit only for professional observation or in emergent life-threatening situations, or to aid in the care of the patient, at the discretion of the physician involved and with the approval of the operating surgeon, anesthesiologist and the nurse in charge. Such visitors are to remain only for the period of time indicated and will leave on request of the nurse in charge.

4.13 SUPPORT PERSON IN SURGERY DURING C-SECTION

4.13(a) Upon the patient's request for the presence of a support person during her Caesarean Section, and at the discretion of the attending physician or anesthesiologist, the following must occur:

- (1) Physician's approval must be obtained.
- (2) Anesthesiologist's approval must be obtained.
- (3) All applicable protocols must be followed (see C-Section Support Person Policy and waiver form).

4.13(b) After the patient has received a regional anesthetic, skin prep of the abdomen and draping are completed, the support person, in proper O.R. attire, is ushered into the operating room. He/she must wash his/her hands prior to entering the operating suite. He/she leaves the operating room to accompany the infant to the nursery. The support person shall leave immediately if requested to do so by any member of the surgical team.

4.14 ORGAN & TISSUE DONATIONS

The hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

The attending physician shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient's medical record shall reflect the results of this notification.

ARTICLE V - GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

Only by those physicians who have training in high risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

5.1(a) All cesarean sections;

5.1(b) Premature infants less than thirty-five (35) weeks gestation, with or without complications;

5.1(c) Premature infants less than four (4) pounds eight (8) ounces (2.0 kilograms), with or without complications;

5.1(d) All premature infants with complications; and

5.1(e) Full term infants with complications requiring invasive intervention.

5.2 LABOR AND DELIVERY

Physicians providing pediatric care for newborns delivered via cesarean section or other high risk newborns are required to arrive at the Emergency Department or Labor and Delivery Unit, as applicable, within thirty (30) minutes of initial contact regarding a cesarean delivery or other emergency condition which requires specialized pediatric or neonatal care.

During the use of IV pitocin, the attending physician should be available to assist within 15 minutes, if necessary.

When Caesarean Sections are performed or when requested by the delivering physician, there should be at least one person present whose primary responsibility is the neonate and who is capable of initiating resuscitation. Either that person or another individual who is immediately available should have the skills to perform a complete resuscitation, including ventilation with bag and mask, endotracheal intubation, chest compressions, and the use of medications. Further, responsibility for identification of a distressed neonate should be assigned to a qualified individual, who may be a physician, a certified nurse-midwife, advanced practice neonatal nurse, labor and delivery nurse, certified registered nurse anesthetist, nursery nurse, or respiratory therapist.

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents unscheduled to the hospital requesting medical evaluation, regardless of the location to which the female presents, this presentation is considered a presentation for medical screening evaluation (MSE) pursuant to the facility's EMTALA policy. An MSE is required to be conducted face-to-face by a licensed independent provider. In late pregnancy, defined as gestation greater than twenty (20) weeks, the initial triage nurse will consider best location for the MSE to occur. Pregnancy related complaints in late pregnancy may be evaluated in the hospital's Labor and Delivery Unit, considered an extension of the emergency department for purposes of compliance with EMTALA. The decision regarding best location for the MSE is based upon the patient's gestational age and presenting condition. For those patients who are referred to the Labor and Delivery Unit for MSE, an RN trained in obstetrics, as defined by Hospital policy, will initiate the order of the obstetric provider to determine the onset of labor or obstetrical conditions that may require immediate medical intervention. For the patient who is determined not to be in active labor, a face-to-face medical screening exam by a LIP is required to determine the diagnosis and the disposition.

5.4 PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating physician or otherwise shall undergo the screening described in Section 5.2, above. The nurse shall contact the admitting physician upon any change in the patient's condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital within thirty minutes upon being contacted by the nurse and requested to come to the Hospital due to a change in condition or deviation from the standard course of progress. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician at any time that her condition warrants, but in any event no later than twelve (12) hours after admission.

**ARTICLE VI - EMERGENCY MEDICAL SCREENING,
TREATMENT, TRANSFER & ON-CALL ROSTER POLICY**

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

- (1) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an “emergency medical condition” is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.
- (2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual’s method of payment or insurance status, nor denied on account of the patient’s inability to pay.
- (3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician, or in the case of a woman in labor, a registered nurse trained in obstetric nursing, where permitted under state law and Hospital policy, who may determine true, false or no labor but may not make a medical diagnosis.
- (4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

6.1(b) Stabilization

- (1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.
- (2) A patient is Stable for Discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or, the patient requires no further treatment and the treating physician has provided written documentation of his/her findings.
- (3) A patient Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient’s medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.
- (4) A patient does not have to be stabilized when:
 - (i) the patient, after being informed of the risks of transfer and of the hospital’s treatment obligations, requests the transfer and signs a transfer request form; or
 - (ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification which includes a summary of risks and benefits to this effect.
- (5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual’s refusal of the proposed treatment, shall take all reasonable

steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1(c) Transfer

- (1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.
- (2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.
- (3) Upon transfer, the Emergency Department shall provide *a copy of* appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.
- (4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

- 6.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient's medical record.
- 6.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department and that person will document the time of the contact in the patient's medical record.
- 6.2(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:
 - (1) Attempted to reach the physician in the hospital;
 - (2) Called the physician at home;
 - (3) Called the physician at his/her office; and
 - (4) Called once on the physician's pager.

Twenty minutes will be considered a reasonable time to carry out this procedure.

- 6.2(d) The rotation call list, containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient's request to come to the Emergency Department, or the

physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the rotation list may not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the CEO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

- 6.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the physician's office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.
- 6.2(f) All members of the Active Staff shall participate in the on-call backup to the Emergency Department as required by the Board, upon recommendation of the MEC. The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or specialty represented on the Active Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital's ability to fulfill its obligations as outlined above.

Physicians called are required to respond to Emergency Department call by telephone within fifteen (15) minutes. If requested to come in, they are required to do so within thirty (30) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within thirty (30) minutes of initial contact.

- 6.2(g) The system for providing on-call coverage shall be approved by the Board of Trustees and documented by written policy.

6.3 REVIEW OF EMERGENCY DEPARTMENT PATIENT RECORDS

A patient's Personal Physician, if any, will receive copies of the Emergency Department report, lab results, EKG reports, and x-ray reports within 24 hours after completion. In the event that a patient treated in the Emergency Department by an Emergency Medicine Physician has no Personal Physician and is not admitted to the Hospital, the Emergency Medicine Physician will be the only physician listed on the Emergency Department record, and associated reports and test results will be reviewed by the Emergency Medicine Physician.

6.4 REVIEW OF EMERGENCY CARE

The review of care provided in the Emergency Department shall be performed according to the Emergency Service's approved procedure. Quarterly Reports at the Emergency Services Committee on the management of trauma and other aspects of emergency care are conducted for pertinent Medical Staff and nursing service personnel to identify and review any areas that may require improvement in the emergency team effort.

6.5 DISPENSING MEDICATIONS IN THE EMERGENCY DEPARTMENT

- 6.5(a) Prescriptions for Emergency Department patients are filled using the InstyMeds machine. Emergency Department physicians do not dispense drugs to Emergency Department patients.

6.5(b) Prescriptions for patients in the Emergency Department may be filled by the Hospital pharmacy, at a patient's request, during the hours of 8:00 am to 7:00 pm Monday through Friday.

ARTICLE VII – AHP QUALIFICATIONS, RESPONSIBILITIES AND CLINICAL DUTIES

7.1 AUDIOLOGIST

The audiology staff shall consist of individuals who are legally licensed to practice as audiologists in the State of Wisconsin. They shall exercise Specified Services as may be determined in conformity with the Medical Staff Bylaws.

Within the limits specified in Article V of the Bylaws, the audiologist shall perform specified patient care services and will record the interpretation of reports and progress notes pertinent to the auditory condition of the patient.

All patients attended by the audiology staff shall be admitted and discharged by a physician Medical Staff member who has the primary responsibility for the care of the patient. Physical exam documenting, history taking and writing of orders are the dual responsibility of the Medical Staff member and the audiologist and must be signed by the physician Medical Staff members.

Audiology staff members shall not be eligible to admit patients to the Hospital, to vote on matters related to the Medical Staff, nor to hold office in the Medical Staff organization. They may vote on matters related to committees or services to which they are assigned.

7.2 PSYCHOLOGIST

The psychology staff shall consist of individuals with a doctorate in psychology or its equivalent from an accredited college or university and legally licensed to practice psychology in the State of Wisconsin. They shall exercise Specified Services as may be determined in conformity with the Medical Staff Bylaws.

Within the limits specified in Article V of the Bylaws, psychologists shall limit their practices to their demonstrated areas of professional competency including, as appropriate:

- (a) Evaluation, diagnosis, and assessment of the functioning of individuals.
- (b) Interventions to facilitate the functioning of individuals. Such interventions may include psychological counseling, psychotherapy, and process consultation.
- (c) Consultations relating to (a) and (b) above.

All patients attended by the psychology staff shall be admitted and discharged by a physician member of the Medical Staff who has the primary responsibility for the care of the patient.

Psychologists shall not be eligible to admit patients to the Hospital, to vote on matters related to the Medical Staff, nor to hold office in the Medical Staff organization. They may vote on matters related to committees or services to which they are assigned.

The psychologist will record reports and progress notes pertinent to the psychological condition of the patient. Physical exam documenting, history taking and writing of orders are the dual responsibility of the Medical Staff member and the psychologist and must be signed by a physician Medical Staff member.

7.3 NURSE PRACTITIONER

The nurse practitioner staff shall consist of individuals who are appropriately certified and legally licensed to practice as advance practice nurse prescribers in the State of Wisconsin. Each nurse practitioner caring for Emergency Department patients must maintain evidence of current ACLS certification and evidence of CPR competency. Nurse practitioners shall exercise Specified Services as may be determined in conformity with the Medical Staff Bylaws.

The nurse practitioner shall be sponsored by, and work in collaboration with, a physician on the active Staff at the Hospital.

Within the limits specified in Article V of the Bylaws, the nurse practitioner shall perform specified patient care services and will record reports and progress notes as to the condition of the patient.

All patients attended by the nurse practitioner will be admitted and discharged by a physician Medical Staff member who has the primary responsibility for the care of the patient. Physical exam documenting, history taking, and writing of orders must be co-signed by the physician Medical Staff member, unless otherwise permitted by applicable law and the Collaboration Agreement between the nurse practitioner and the collaborating physician. Unless otherwise precluded by any third party payer's rules for payment, nurse practitioners may write orders without co-signature by a physician for laboratory services, diagnostic radiological services, audiology services, and physical, occupational, and speech therapy to be furnished to outpatients at the Hospital, provided that the writing of each such order is within the scope of the nurse practitioner's license and Specified Services granted by the Hospital's Medical Staff.

Nurse practitioners shall not be eligible to admit patients to the Hospital, to vote on matters related to the Medical Staff, nor to hold office in the Medical Staff organization. They may vote on matters related to committees or services to which they are assigned.

7.4 PHYSICIAN ASSISTANT

The physician assistant staff shall consist of individuals who are appropriately certified and legally licensed to practice as physician assistants in the State of Wisconsin. Each physician assistant caring for Emergency Department patients must maintain evidence of current ACLS certification and evidence of CPR competency. Physician assistants shall exercise Specified Services as may be determined in conformity with the Medical Staff Bylaws.

The entire practice of a physician assistant shall be sponsored and supervised by a physician on the active staff at the Hospital. The physician assistant's practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the supervising physician. A medical care task assigned by the supervising physician to a physician assistant may not be delegated by the physician assistant to another person.

Within the limits specified in Article V of the Bylaws, the physician assistant shall perform specified patient care services and will record reports and progress notes as to the condition of the patient.

All patients attended by the physician assistant will be admitted and discharged by a physician Medical Staff member who has the primary responsibility for the care of the patient. Documentation of histories and physical exams and orders written for inpatients by physician assistants in the Hospital must be co-signed by the physician Medical Staff member supervising the physician assistant. Unless otherwise precluded by any third party payer's rules for payment, physician assistants (except those employed by a temporary staffing agency) may write orders without co-signature by a physician for laboratory services, diagnostic radiological services, audiology services, and physical, occupational, and speech therapy to be furnished for outpatients and Emergency Department patients at the Hospital, provided that the writing of each such order is within the scope of the physician assistant's license and Specified Services granted by the Hospital's Medical Staff and that the order is written under the supervision of a duly licensed physician who is on the active Medical Staff of the Hospital.

Physician assistants shall not be eligible to admit patients to the Hospital, to vote on matters related to the Medical Staff, nor to hold office in the Medical Staff organization. They may vote on matters related to committees or services to which they are assigned.

As required by Wisconsin law, a physician must supervise the prescribing practice of a physician assistant and must conduct a periodic review of the prescription orders prepared by the physician assistant to ensure quality of care. In conducting the periodic review of the prescriptive practice of a physician assistant, the supervising physician must:

1. Review a selection of the prescription orders prepared by the physician assistant; and/or

2. Review a selection of the patient records prepared by the physician assistant practicing in the office of the supervising physician or at a facility or a hospital in which the supervising physician has staff privileges.

The supervising physician must determine the method and frequency of the periodic review based upon the nature of the prescriptive practice, the experience of the physician assistant, and the welfare of the patients. The supervising physician must document the process and schedule for review in writing and must indicate the minimum frequency of review and identify the selection of prescriptive orders or patient records to be reviewed.

7.5 SURGICAL ASSISTANT

The surgical assistant shall consist of professional support personnel employed by members of the Staff or by the Hospital. They may be approved to provide services upon the receipt of a completed Surgical Assistant Scope of Practice Request Form, including required documents.

Within the limits specified in Article V of the Bylaws, the surgical assistant may assist in operative procedures in the Operating Room Suite under the direct supervision of the supervising surgeon.

Surgical assistants shall not be eligible to admit patients to the Hospital, to vote on matters related to the Medical Staff, nor to hold office in the Medical Staff organization. They may vote on matters related to committees or services to which they are assigned.

ARTICLE VIII - ADOPTION & AMENDMENT OF RULES & REGULATIONS

8.1 DEVELOPMENT

The Medical Staff hereby delegates to the MEC the initial responsibility to bring before the Board formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

8.2 ADOPTION, AMENDMENT & REVIEWS

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular MEC meeting at which a quorum present and without previous notice, or at any special MEC meeting on notice, by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

8.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

- 8.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel; or
- 8.3(b) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last restatement, which restated Rules & Regulations shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel.

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner.

8.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the MEC at the next regular meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 8.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well being of patients, employees or staff.

**MEDICAL STAFF RULES & REGULATIONS
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____
Chairperson

Date

Watertown Regional Medical Center:

By: _____
Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for Watertown Medical Center, LLC

Date

APPROVED:

By: _____
Division President

Date

APPENDIX “C” – POLICY REGARDING BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

1.1 PURPOSE AND OBJECTIVE

It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy, and dignity, and to conduct ourselves in a professional, cooperative manner, and in compliance with the Code of Conduct of LifePoint Hospitals. This policy, which replaces the Disruptive Practitioner Policy, sets forth the requirement that all physicians and allied health professionals who work in the Hospital will act in a professional and respectful manner at all times. Further, this policy defines behavior or behaviors that undermine a culture of safety, and outlines how to report and address it.

The objectives of this policy are to ensure quality patient care by promoting a safe, cooperative, and professional health care environment, and to provide Hospital employees with a work environment based on respect and one that encourages personal and professional growth.

This policy is applicable to all medical staff members and all allied health professionals (collectively referred to in this policy as “Practitioners”).

Conduct of a criminal nature by a Practitioner, including but not limited to assault, battery, rape, or theft shall be handled through local law enforcement officials in accordance with local and State laws, in addition to application of this policy to address Practitioner’s medical staff or allied health membership.

Any employee who engages in behavior or behaviors that undermine a culture of safety, including employed Practitioners, may be dealt with in accordance with the Hospital’s human resource policies. Practitioners or Hospital employees who observe undermining behavior on the part of a Hospital employee shall follow the reporting mechanisms set forth in the human resource policies.

2.1 BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

For purposes of this policy, behavior that undermines the culture of safety (herein referred to as "Undermining Behavior") is any behavior that substantially intimidates others; affects morale or staff turnover; disrupts the smooth operation of the Hospital; adversely affects the ability of others to perform their jobs appropriately; poses a threat or potential threat to safe quality patient care; or exposes the Hospital or Medical Staff to potential liability. Behavior that does not substantially impact a culture of safety is behavior that is outside the scope of this policy. Behavior which may rise to the level of Undermining Behavior may include, but is not limited to, behavior such as:

- 2.1(a) Rude, abusive or intimidating behavior or comments to Hospital personnel, other Practitioners, Hospital visitors, patients or their families, or other behavior that negatively affects the ability of others to do their jobs. Such behavior can include the failure to cooperate, the refusal to return calls, or other passive activities when such substantially impacts the culture of safety.
- 2.1(b) Attacks, verbal or physical, directed at other Practitioners, Hospital personnel, patients or visitors, that are personal, inappropriate, irrelevant, or beyond the bounds of fair professional conduct.
- 2.1(c) Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the Hospital, or attacking particular Practitioners, nurses, other Hospital employees, or Hospital policies.
- 2.1(d) Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

- 2.1(e) Refusal to accept, or causing a disturbance of, medical staff assignments or participation in committee affairs.
- 2.1(f) Interference with Hospital operations, Hospital or Medical Staff committees, or placing quality care at the Hospital in jeopardy.
- 2.1(g) Knowingly making false accusations or falsifying any patient medical records or Hospital documents.
- 2.1(h) Verbal or physical maltreatment of another individual, including physical or sexual assault or battery, or retaliation of any kind for making a report under this policy.
- 2.1(i) Sexual, racial, or other harassment, including words, gestures and actions, verbal or physical, that interferes with a person's ability to perform his or her job.
- 2.1(j) Behavior that adversely affects or impacts the community's confidence in the Hospital's ability to provide quality patient care.

3.1 REPORTING OF UNDERMINING BEHAVIOR

- 3.1(a) Hospital employees who observe, or are subjected to, Undermining Behavior by a Practitioner shall notify their supervisor about the incident. If the supervisor's behavior is at issue, the employee shall notify the Chief Executive Officer (or his or her designee) or the Hospital Human Resources Director. Any Practitioner who observes Undermining Behavior of another Practitioner shall notify the Chief Executive Officer directly. Supervisors who have received a report of Undermining Behavior shall report the same to the Chief Executive Officer.
- 3.1(b) If a reporting individual is uncomfortable with reporting Undermining Behavior directly, then a report of the incident must be made to the Hospital's Ethics & Compliance Officer or the LifePoint Ethics Line at 1-877-508-LIFE (5433).

4.1 DOCUMENTATION

- 4.1(a) Documentation of Undermining Behavior is critical since it is ordinarily a pattern of conduct, rather than one incident, which justifies disciplinary action. Practitioners, nurses and other Hospital employees who observe and report Undermining Behavior by a Practitioner must document the behavior or in the alternative, the supervisor/Chief Executive Officer shall document the incident as reported. That documentation shall include:
 - (1) The date and time of the questionable behavior;
 - (2) A statement of whether the behavior affected or involved a patient in any way; and if so, the medical record number of the patient;
 - (3) Known circumstances which precipitated the situation;
 - (4) A description of the questionable behavior limited to factual, objective language;
 - (5) Known consequences, if any, of the Undermining Behavior as it relates to patient care or Hospital operations;
 - (6) The names of other witnesses to the incident; and
 - (7) A record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

- 4.1(b) The report shall be submitted to the Chief Executive Officer, who shall provide the report to the Chief of Staff. In performing all functions hereunder, the Chief Executive Officer and Chief of Staff, and their designees, shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.
- 4.1(c) After a report of Undermining Behavior, the Chief Executive Officer or his or her designee shall insure those making the report are aware of the Hospital's standards of behavior and process for assuring professional and appropriate behavior in the Hospital. Individuals that reported the potentially undermining behavior will be advised of policies preventing retaliation and will be requested to report any perceived acts of retaliation to the CEO or his or her designee. This follow-up discussion with individuals that made a report will occur as soon as practical after each report of Undermining Behavior.

5.1 INVESTIGATION

Once received, a report will be investigated by the Chief Executive Officer and/or the Chief of Staff. The Chief Executive Officer may delegate this investigation to the Hospital's Human Resources Director, Chief Nursing Officer, or other individual who may have applicable expertise or skill. This investigation may include meeting with the individual who reported the behavior and any other witnesses to the incident. If the Chief Executive Officer and Chief of Staff determine after investigation that the report lacks merit, this conclusion shall be documented and no further action is necessary. Those reports considered accurate will be addressed through the procedure set out below. This documentation shall be placed in the Practitioner's confidential peer review file. If at any time it appears to the Chief of Staff, the Chief Executive Officer, or any committee charged with implementation of this policy that a physician's behavior may result from impairment, the procedure set forth in the Practitioner Wellness Policy shall be followed.

6.1 MEETING WITH THE PRACTITIONER

- 6.1(a) A first confirmed incident requires a discussion with the offending Practitioner. The Chief of Staff and Chief Executive Officer **shall** initiate a meeting with the Practitioner and emphasize that such behavior is inappropriate and violates Hospital policy and the Medical Staff bylaws.
- 6.1(b) These individuals shall discuss the matter informally with the Practitioner, emphasizing that if the behavior continues, more formal action will be taken to stop it. The identity of the individual who made the report of Undermining Behavior shall not be disclosed at this time, unless the Chief Executive Officer and Chief of Staff, after consulting with legal counsel, agree in advance that legal requirements or unusual circumstances make it appropriate to do so. The following guidelines shall be followed regarding the meeting:
- (1) The initial approach should be collegial and designed to be helpful to the physician;
 - (2) The parties should emphasize that if the behavior continues, more formal action will be taken to stop it;
 - (3) Informal meetings shall be documented with a written summary of the meeting. This documentation shall be maintained in a confidential peer review file of the Practitioner;
 - (4) A follow-up letter to the physician shall state that the physician is required to behave professionally and cooperatively, along with a copy of this Hospital policy on Undermining Behavior; and
 - (5) Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident should the Chief of Staff and/or the Chief Executive Officer determine that the seriousness of the incident justifies such action.

- 6.1(c) If an additional incident of Undermining Behavior occurs, or if the Chief of Staff or the Chief Executive Officer determines it to be necessary, the Chief Executive Officer and the Chief of Staff, **shall** meet with and advise the physician that such behavior is intolerable and must stop. This meeting constitutes the physician's final warning. It shall be followed with a letter reiterating the warning and summarizing the meeting. The Practitioner may prepare a written response to the letter. This documentation shall be maintained in the Practitioner's confidential peer review file. More formal corrective action may be pursued at this juncture if deemed warranted by the Chief of Staff and/or Chief Executive Officer.
- 6.1(d) Every meeting with the Practitioner shall include a review of the Hospital's policy against retaliation. Such discussions shall be explicitly documented
- 6.1(e) All meetings with the Practitioner shall be documented.
- 6.1(f) After each meeting with the Practitioner, a letter shall be sent to the Practitioner confirming the Hospital's and medical staff leadership's position - that the Practitioner is required to behave professionally and cooperatively, and which also shall include the potential consequences of continued non-compliance or retaliation against individuals the Practitioner believes to have reported the behavior in question.

7.1 DISCIPLINARY ACTION PURSUANT TO BYLAWS

- 7.1(a) A single additional incident of behavior that undermines a culture of safety, after the above process has been completed, shall result in initiation of formal disciplinary action pursuant to the medical staff bylaws. The Chief Executive Officer and Chief of Staff shall be responsible for presenting the history of behavior to the Medical Executive Committee.
- 7.1(b) Summary suspension may be appropriate pending this process, depending upon the seriousness of the offense, and after consultation with operations counsel.
 - 7.1(c) The Medical Executive Committee must be fully advised of all of the previous meetings and warnings, if any, and must take them into account, so that it may pursue whatever action is necessary to cease the Undermining Behavior.
- 7.1(d) The Medical Executive Committee must take action or refer the matter to the Board with a recommendation as to action. This recommendation shall be processed as provided in the administrative corrective action section of the Medical Staff Bylaws. The Board will review and may initiate action if the Medical Executive Committee fails to take action, refer the matter or make a recommendation as to action regarding the matter.
- 7.1(e) Although the above outline is a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, damaging Hospital property or jeopardizing patient care may result in immediate corrective action. As such, if they deem it appropriate based upon the circumstances, the Hospital's Chief Executive Officer, Chief of Staff or Board Chairperson may initiate formal disciplinary action under the Bylaws for a single incident of Undermining Behavior without first resorting to the progressive disciplinary approach set forth herein.
- 7.1(f) In the minutes of the deliberative meetings of any peer review committee addressing Undermining Behavior of a Practitioner, the Hospital's Human Resource Director shall be formally included as an ex-officio member of the committee without vote, and to the extent possible, the Hospital's Human Resource Director shall be advised of the action taken against a Practitioner resulting from a report of Undermining Behavior by a Hospital employee.

**BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY POLICY
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

_____ Date

BOARD OF TRUSTEES:

By: _____
Chairperson

_____ Date

Watertown Regional Medical Center:

By: _____
Chief Executive Officer

_____ Date

APPENDIX “D” –PRACTITIONER WELLNESS POLICY

It is the policy of this hospital to properly review and act upon concerns that a licensed independent practitioner, as defined in the Medical Staff Bylaws, is suffering from an illness or impairment. The hospital will conduct its review and act in accordance with pertinent state and federal law, including, but not limited to, the Americans With Disabilities Act. For purposes of this policy, impaired shall mean acute and ongoing physical, psychiatric, and emotional illness or injury, as well as health issues due to alcohol and drugs.

As part of the hospital’s commitment to the safe and effective delivery of care to patients, the Hospital and Medical Staff shall conduct education sessions concerning practitioner health and impairment issues, including illness and impairment recognition issues specific to practitioners (“at-risk” criteria).

1.1 Report & Review

If any individual in the hospital has a reasonable suspicion that a licensed independent practitioner (hereinafter “LIP”) appointed to the Medical Staff is impaired, the following steps shall be taken:

- 1.1(a) An oral or, preferably, a written report shall be given to the Chief Executive Officer or the Chief of Staff. The reporting individual shall otherwise keep the report and the facts related thereto confidential. The report shall include a description of the incident(s) that led to the belief that the LIP may be impaired. The report must be factual. The individual making the report need not have proof of the impairment, but must state the facts leading to the suspicions. A LIP who feels that he/she may be suffering from impairment may also make a confidential self-report.
- 1.1(b) Notwithstanding the foregoing, in the event that any person observes a LIP who appears to be currently impaired by drugs or alcohol, that person shall report the events to the Chief of Staff and/or CEO immediately. The Chief of Staff and CEO may order an immediate drug or alcohol screen if, in their opinion, circumstances so warrant.
- 1.1(c) If, after discussing the incidents with the individual who filed the report, the Chief Executive Officer and Chief of Staff believe there is sufficient information to warrant further inquiry, the Chief Executive Officer and Chief of Staff may:
 - (1) Meet personally with the LIP or designate another appropriate person to do so; and/or
 - (2) Direct in writing that a review be instituted and a report thereof be rendered by the Provider Development Committee or an ad hoc committee to be appointed by the MEC for this purpose. The MEC shall appoint an ad hoc committee of three (3) physicians to review the issue within five (5) days of receipt of the request.
- 1.1(d) In performing all functions hereunder, the Chief Executive Officer and Chief of Staff shall be deemed authorized agents of the MEC and the Provider Development Committee or ad hoc committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.
- 1.1(e) Following a written request to review, the Provider Development Committee or ad hoc committee shall review the concerns raised and any and all incidents that led to the belief that the LIP may be impaired. The committee's review may include, but is not limited to, any of the following:
 - (1) A review of any and all documents or other materials relevant to the review;
 - (2) Interviews with any and all individuals involved in the incidents or who may have information relevant to the review, provided that any specific inquiries made regarding the

LIP's health status are related to the performance of the LIP's clinical privileges and Medical Staff duties and are consistent with proper patient care or effective operation of the hospital;

- (3) A requirement that the LIP undergo a complete medical examination as directed by the committee, so long as the exam is related to the performance of the LIP's clinical privileges and Medical Staff duties and is consistent with proper patient care or the effective operation of the hospital; and
 - (4) A requirement that the LIP take a drug test to determine if the LIP is currently using drugs illegally or abusing legal drugs.
- 1.1(f) The Provider Development Committee or ad hoc committee shall meet informally with the LIP as part of its review. This meeting does not constitute a hearing under the due process provisions of the hospital's Medical Staff Bylaws or pertinent credentialing policy and is not part of a disciplinary action. At this meeting, the committee may ask the LIP health-related questions so long as they are related to the performance of the LIP's clinical privileges and Medical Staff duties, and are consistent with proper patient care and the effective operation of the hospital. In addition, the Committee may discuss with the LIP whether a reasonable accommodation is needed or could be made so that the LIP could competently and safely exercise his or her clinical privileges and the duties and responsibilities of Medical Staff appointment.
- 1.1(g) Based on all of the information reviewed, the Provider Development Committee or ad hoc committee shall determine:
- (1) Whether the LIP is impaired, or what other problem, if any, is affecting the LIP;
 - (2) Whether the LIP would benefit from professional resources, such as counseling, medical treatment or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and if so, what services would be appropriate;
 - (3) If the LIP is impaired, the nature of the impairment and whether it is classified as a disability under the ADA;
 - (4) If the LIP's impairment is a disability, whether a reasonable accommodation can be made for the LIP's impairment such that, with the reasonable accommodation, the LIP would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of Medical Staff appointment;
 - (5) Whether a reasonable accommodation would create an undue hardship upon the hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the hospital's operations or the provision of patient care; and
 - (6) Whether the impairment constitutes a "direct threat" to the health or safety of the LIP, patients, hospital employees, physicians or others within the hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the LIP appears to pose a direct threat because of a disability, the Committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.
- 1.1(h) If the review produces sufficient evidence that the LIP is impaired, the CEO shall meet personally with the LIP or designate another appropriate individual to do so. The LIP shall be told that the results of a review indicate that the LIP suffers from an impairment that affects his/her practice. The LIP should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

- 1.1(i) If the Provider Development Committee or ad hoc committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the LIP, so long as that arrangement would neither constitute an undue hardship upon the hospital or create a direct threat, also as described above. The Chief Executive Officer and Chief of Staff shall be kept informed of attempts to work out a voluntary agreement between the Committee and the LIP, and shall approve any agreement before it becomes final and effective.
- 1.1(j) If the Provider Development Committee or ad hoc committee determines that there is no reasonable accommodation that can be made as described above, or if the committee cannot reach a voluntary agreement with the LIP, the committee shall make a recommendation and report to the MEC, through the Chief of Staff, for appropriate corrective action pursuant to the Bylaws. If the MEC's action would provide the LIP with a right to a hearing as described in the hospital's Medical Staff Bylaws or credentialing policy, all action shall be taken in accordance with the Fair Hearing Plan, and strict adherence to all state and federal reporting requirements will be required. The Chief Executive Officer shall promptly notify the LIP of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the hospital's Medical Staff Bylaws or credentialing policy.
- 1.1(k) The original report and a description of the actions taken by the Provider Development Committee or ad hoc committee shall be included in the LIP's confidential file. If the initial or follow-up review reveals that there is no merit to the report, the same shall be noted on the report and no further action shall be taken. If the initial or follow-up review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the LIP's file and the LIP's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.
- 1.1(l) The Chief Executive Officer shall inform the individual who filed the report that follow-up action was taken, but shall not disclose confidential peer review information or specific actions implemented.
- 1.1(m) All parties shall maintain confidentiality of any LIP referred for assistance, except as limited by law, ethical obligation, or when safety of a patient is threatened. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.
- 1.1(n) In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the hospital or its Medical Staff, including the due process sections of those bylaws and policies, the provisions of this policy shall control.
- 1.1(o) Nothing herein shall preclude commencement of corrective action, including summary suspension under the Medical Staff Bylaws, or termination of any contractual agreements between the Hospital and the LIP, including any employment agreement, in the event that the LIP's continued practice constitutes a threat to the health or safety of patients or any person.

2.1 Rehabilitation & Reinstatement Guidelines

A. Substance Abuse

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

1. Hospital and Medical Staff leadership shall assist the LIP in locating a suitable rehabilitation program. A LIP who may benefit from counseling or rehabilitative services, but who is not believed to be impaired in his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the hospital. In cases where the LIP's ability is believed to be impaired, the LIP shall be allowed a leave of absence if necessary. A LIP who is determined to have an impairment which requires a leave of absence for rehabilitation shall not be reinstated until it is established, to the satisfaction of the Provider Development Committee or ad hoc committee, the MEC and the Board, that the LIP has successfully completed a program in which the hospital has confidence.
2. Upon sufficient proof that a LIP who has been found to be suffering from an impairment has successfully completed a rehabilitation program that LIP may be considered for reinstatement to the Medical Staff.
3. In considering an impaired LIP for reinstatement, the hospital and Medical Staff leadership must consider patient care interests paramount.
4. The Provider Development Committee or ad hoc committee must first obtain a letter from the physician director of the rehabilitation program where the LIP was treated. The LIP must authorize the release of this information. That letter shall state:
 - (a) Whether the LIP is participating in the program;
 - (b) Whether the LIP is in compliance with all of the terms of the program;
 - (c) Whether the LIP attends AA meetings or other appropriate meetings regularly (if appropriate);
 - (d) To what extent the LIP's behavior and conduct are monitored;
 - (e) Whether, in the opinion of the director, the LIP is rehabilitated;
 - (f) Whether an after-care program has been recommended to the LIP and, if so, a description of the after-care program; and
 - (g) Whether, in the director's opinion, the LIP is capable of resuming medical practice and providing continuous, competent care to patients.
4. The LIP must inform the Provider Development Committee or ad hoc committee of the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.
5. From the primary care physician the Provider Development Committee or ad hoc committee needs to know the precise nature of the LIP's condition, and the course of treatment as well as the answers to the questions posed above in (4)(e) and (g).
6. Assuming all of the information received indicates that the LIP is rehabilitated and capable of resuming care of patients, the Provider Development Committee or ad hoc committee, MEC and the Board shall take the following additional precautions when restoring clinical privileges:
 - (a) The LIP must identify a another LIP who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and

- (b) The LIP shall be required to obtain periodic reports for the Provider Development Committee or ad hoc committee from his or her primary physician-for a period of time specified by the Chief Executive Officer-stating that the LIP is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.
- 7. The LIP's exercise of clinical privileges in the hospital shall be monitored by the Provider Development Committee chairperson or by a physician appointed by the Provider Development Committee chairperson. The nature of that monitoring shall be determined by the Provider Development Committee or ad hoc committee after its review of all of the circumstances.
- 8. The LIP must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chairperson of the ad hoc committee or the Provider Development Committee chair.
- 9. All requests for information concerning the impaired LIP shall be forwarded to the Chief Executive Officer for response.

B. Physical, Psychiatric or Emotional Illness

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

- 1. If applicable, the Hospital and Medical Staff leadership shall assist the LIP in locating a suitable rehabilitation program or treatment plan. A LIP who may benefit from counseling or rehabilitative services, but whose illness or injury is not believed to interfere with his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the hospital. In cases where the LIP's ability is believed to be undermined, the LIP shall be allowed a leave of absence if necessary. A LIP who is determined to have an illness or injury which requires a leave of absence for rehabilitation or treatment shall not be reinstated until it is established, to the satisfaction of the committee, the MEC and the Board, that the LIP has successfully completed any necessary rehabilitation or treatment in which the hospital has confidence.
- 2. Upon sufficient proof that a LIP who has been found to be suffering from an illness has successfully completed treatment or has been cleared for return to practice by his/her treating physician (as applicable), that LIP may be considered for reinstatement to the Medical Staff.
- 3. In considering a LIP for reinstatement, the hospital and Medical Staff leadership must consider patient care interests paramount.
- 4. If requested by the committee, the LIP must provide the name and address of his or her primary care physician, and must authorize that physician to provide the hospital with information regarding his or her condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.
- 5. Assuming all of the information received indicates that the LIP is rehabilitated or recovered and capable of resuming care of patients, the committee, MEC and the Board may take the following additional precautions when restoring clinical privileges:
 - (a) The LIP must identify another LIP who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and
 - (b) The LIP may be required to obtain periodic reports for the committee from his or her primary physician, for a period of time specified by the Committee, stating that the LIP is continuing

treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

6. The LIP's exercise of clinical privileges in the hospital shall be monitored by the Provider Development Committee chairperson or by a physician appointed by the Provider Development Committee chairperson. The nature of that monitoring shall be determined by the committee after its review of all of the circumstances.
7. All requests for information concerning the impaired LIP shall be forwarded to the Chief Executive Officer for response.

**IMPAIRED PHYSICIAN POLICY
ADOPTED & APPROVED:**

MEDICAL STAFF:

By: _____
Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____
Chairperson

Date

Watertown Regional Medical Center:

By: _____
Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____
Legal Counsel for Watertown Medical Center, LLC

Date

APPROVED:

By: _____
Division President

Date

APPENDIX “E” – PROFESSIONAL PERFORMANCE REVIEW POLICY

I. PURPOSE

- To define the process for conducting performance evaluations, establish the method and duration of monitoring, and circumstances under which monitoring by an external source or focused review may be required;
- To define the type of data (criteria/indicators), outlined in Addendum A, to be collected for the ongoing and focused professional practice evaluation and ensure this information is integrated into performance improvement initiatives and used to determine whether to continue, limit or revoke any existing privilege(s);
- To ensure reported concerns regarding a privileged practitioner’s professional practice are uniformly investigated and addressed as defined by the organization and applicable laws;
- To measure, assess, and resolve clinical performance issues on an organization-wide basis and to promote high quality patient care; and
- To conduct an effective peer review process that is evidence-based, consistent, timely defensible, balanced, useful, and ongoing.

II. SCOPE

This policy applies to all Medical Staff and Allied Health Professionals privileged through the medical staff credentialing process of the hospital. However, providers who have no volume at the facility are exempt from the OPPE and FPPE requirements contained herein.

III. DEFINITIONS

- Focused Professional Practice Evaluation (FPPE) – A time-limited (for a specific period of time OR a specific volume/number of procedures, admissions, encounters, etc.) evaluation of practitioner or AHP’s competence in performing a specific privilege. This process is implemented for (1) all newly requested privileges, and (2) whenever recommended by the applicable committee when a question arises regarding a practitioner’s ability to provide safe, high quality patient care, or a “trigger” event, as outlined in Addendum A, occurs.
- Ongoing Professional Practice Evaluation (OPPE) – A documented summary of ongoing data collected for the purpose of assessing a practitioner or AHP’s clinical competence and professional behavior. The information gathered during this process factors into the decision to maintain, revise or revoke existing privilege(s).
- Peer – An individual who possesses the same or similar medical specialty knowledge and training as the individual being reviewed. *Note that an individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants that were involved in the patient’s case.*

- Practitioner – The definition of “practitioner” shall be the same as in the Medical Staff Bylaws.

IV. POLICY

The Medical Staff, through the activities of committee review, will monitor and evaluate the quality and appropriateness of patient care provided by all medical staff licensed independent practitioners and allied health professionals with delineated clinical privileges and/or scopes of practices..

The review process involves monitoring, analyzing, and understanding those special circumstances of practitioner performance which require further evaluation. If there is uncertainty regarding the practitioner’s professional performance, the course of action defined in the Medical Staff Bylaws for further evaluation should be followed. It is not intended that this Policy supersede any provisions of the Medical Staff Bylaws. If the performance of the practitioner is sufficiently egregious, the Chief of Staff or CEO shall determine, within his/her sole discretion, whether the provisions of this Policy need not be followed, whereupon the provisions of the Medical Staff Bylaws, and not this Policy, shall govern.

If behavior that undermines a culture of safety or practitioner wellness is identified as a potential concern, the Behavior that Undermines a Culture of Safety Policy or Practitioner Wellness Policy, as appropriate, may be implemented in conjunction with this Policy.

However, nothing herein limits the appropriate committee, MEC or Board’s obligations or authority under either Policy.

When findings of this process are relevant to an individual’s performance the Medical Staff is responsible for determining their use in ongoing evaluation of a practitioner’s competence, in accordance with Joint Commission standards on renewing or revising clinical privileges.

V. SCREENING

The Quality Director or his/her designee will perform concurrent and retrospective chart reviews as part of the routine peer review process, which shall not be considered an “investigation” as that term is contemplated by the Medical Staff Bylaws. Any individual (including patients/family, medical staff, allied health professional or hospital staff) may report any concerns regarding the professional performance of a practitioner. If a case meets the screening indicator criteria, the screener will refer the case to an appropriate physician peer reviewer for evaluation and scoring.

VI. RESPONSIBILITIES

The Quality Director or his/her designee is responsible for coordinating and facilitating review activities, forwarding cases to the designated committee chairperson or his/her designee, as appropriate, per the criteria/indicators for review identified in Addendum A, trending data related to individual practitioner performance, and providing periodic summary reports for review by applicable peer review committees and MEC of patterns/trends identified.

Each committee chairman responsible for the ongoing review of patient care may, at his/her discretion, designate other members of the committee to collaborate with him/her or conduct FPPE as appropriate.

The chairman, or his/her designee peer review screener, will review the medical record, score the case using the rating scale contained herein, identify opportunities for improvement and make recommendations whether any further intervention/action is needed. All cases scored as 3, 4 or 5 will be referred for a higher level of review or by a special panel of peers assigned by the committee chairperson, Chief of Staff, applicable peer review committee or MEC.

The MEC will serve as the oversight committee for all medical staff performance improvement activities, review findings of ongoing and focused practice evaluations, and take action as appropriate. The MEC will consider all documented cases which meet the criteria for review at the time of renewing, revising, limiting or revoking existing privileges, and make recommendations to the Board of Trustees regarding ongoing and focused professional practice reviews, as appropriate.

The MEC reviews and modifies this Policy at least every two (2) years and peer review indicators as needed, but at least annually, with input from the individual services and the Quality Department.

VII. CRITERIA/INDICATORS FOR REVIEW

The following are six areas of general competence that may be considered in review:

- Patient care;
- Medical/clinical knowledge;
- Practice-based learning and improvement;
- Interpersonal and communication skills;
- Professionalism; and
- Systems-based practice

The Medical Staff will develop and update the criteria/indicators to be collected for OPPE and the “triggers” for FPPE, attached hereto as Addendum A.

VIII. REVIEW PROCESS

Professional performance reviews, which include OPPE and FPPE, may include, but shall not be limited to:

- Periodic chart reviews;
- Use of external peer review;
- Simulation;
- Proctoring by direct observation;
- Extension of monitoring period to further evaluate competency and/or performance evaluation;
- Evaluation of medical assessment and treatment of patients;
- Consultations/discussions with other individuals involved in the care of the patient;
- Adverse privileging decisions;
- Use of medications;
- Use of blood and blood components;
- Operative and other procedures;
- Appropriateness of clinical practice patterns;

- Significant departures from established patterns of clinical practice;
- Use of developed criteria for autopsies;
- Monitoring of diagnostic and treatment techniques;
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing and administrative personnel.

Evaluation is accomplished through a review of various data sources, which may include, but are not limited to the following:

- Monitoring clinical practice patterns
- Complications
- Complaints/Compliments
- Volume
- Length of stay patterns
- Morbidity and mortality data
- Peer review cases/chart reviews
- Suspensions
- Medical record deficiencies
- Patient, peer, family, staff complaints
- Pharmacy, Therapeutics/Infection Control Committee
- Medical Records/Utilization Review Committee
- Patient Care Conferences
- Blood and Tissue Reviews
- Patient Safety data
- Quality Core Measures
- Occurrence reports
- Sentinel event data
- Mortality Reviews
- Other relevant criteria as determined by the organized medical staff

IX. OPPE

OPPE is used to assess the competence of those practitioners privileged through the medical staff process. All OPPE data will be reviewed by the applicable service chairperson or his/her designee/reported for review/action at least every nine (9) months for overall performance and comparison purposes or to determine whether there are any performance improvement initiatives that need to be addressed further, which are related to organizational processes or clinical practices.

All reviews shall be considered a part of the confidential peer review activity of the medical staff, and the written results of OPPE shall become part of the practitioner or AHP's quality file and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke existing privileges prior to or at the time of renewal. Results of OPPE shall be communicated in writing to the practitioner or AHP at least every nine (9) months.

X. FPPE

FPPE is implemented (1) for all newly requested privileges, and (2) whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care, or a "trigger" event

occurs. The Credentials Committee, a Service Chairperson, any peer review committee, the MEC, or the Board may recommend FPPE.

Periods of FPPE implemented for reasons other than for a newly requested privilege must be time-limited (for a specific period of time OR a specific volume/number of procedures, admissions, encounters, etc.). The terms of the FPPE must be communicated to the affected practitioner or AHP in writing, which shall include the reasons for the FPPE; the specific period of time or specific volume/number of procedures, admissions, encounters, etc.; and the method for monitoring specific to the privileges giving rise to the review.

Cases reviewed pursuant to an FPPE may be selected either by ongoing monitoring of clinical practice patterns using the criteria/indicator “triggers” outlined in Addendum A, attached, or when there is an unexpected patient outcome. Such FPPE may be accomplished through:

1. Review of certain cases/procedures (e.g., all laparoscopic cholecystectomy cases; or all cesarean sections) during an identified period of time;
2. Review of an identified number of cases or procedures performed; or
3. Review of a randomly selected percentage of cases during a specified time period.

All reviews shall be considered a part of the confidential peer review activity of the medical staff, and the written results of FPPE shall become part of the practitioner or AHP’s quality file and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke existing privileges prior to or at the time of renewal.

Results of FPPE shall be communicated in writing to the practitioner or AHP upon conclusion of review.

XI. RATING SCALE

The peer reviewer uses the following rating scale to assess the cases:

Rating Score	Definition
0	Quality of care, treatment, or services meet or exceeds medical standards of practice
1	Medical management in variance with acceptable standards of practice but it is <u>without</u> potential for: <ul style="list-style-type: none"> • Anatomical or physiological impairment, disability or death • Unnecessary prolonged treatment, complications, or readmissions
2	Medical management in variance with standards of medical practice and it is <u>with</u> the potential for adverse consequence: <ul style="list-style-type: none"> • Anatomical or physiological impairment, disability or death • Unnecessary prolonged treatment, complications, or readmissions
3	Medical management does not meet acceptable standards of practice (disease, or symptoms caused, exacerbated or allowed to progress) resulting in: <ul style="list-style-type: none"> • Anatomical or physiological impairment or disability • Unnecessary prolonged treatment, complications or readmissions

4	Medical management does not meet acceptable standards of practice resulting in: <ul style="list-style-type: none"> • Adverse Outcome
5	Medical management does not meet acceptable standards of practice resulting in: <ul style="list-style-type: none"> • Death

XII. ACTIONS BASED ON THE RATINGS

The criteria utilized to determine the type of action/intervention imposed are based on severity, frequency of occurrence, and trigger threshold parameters. The following actions/interventions are taken based upon the rating assigned:

LEVEL 1—SERVICE CHAIR REVIEW (or designated initial peer reviewer)

RATING	ACTION
0, 1	Case approved. <ul style="list-style-type: none"> • Results used for trending only • Case review sheet to Medical Staff Coordinator for physician’s reappointment file

LEVEL 2—REVIEW BY APPROPRIATE COMMITTEE

2, 3	Further review indicated <ul style="list-style-type: none"> • Committee may decide to track and trend • Presented at appropriate committee meeting <p><u>Recommendation of the committee may include</u></p> <p>A. Case found to be acceptable – No further action needed</p> <ul style="list-style-type: none"> • Results used for trending only • Case review sheet to Medical Staff Coordinator for physician’s reappointment profile <p>B. Further review indicated—Refer to MEC</p> <ul style="list-style-type: none"> • A focus review plan is proposed
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LEVEL 3—MEDICAL EXECUTIVE COMMITTEE REVIEW

2, 3, 4, 5	Further review indicated by the committee. <ul style="list-style-type: none"> • Responsible physician notified case to be reviewed by MEC and given notice of the meeting <p><u>Recommendation of the MEC may include:</u></p> <p>A. Require additional education</p> <p>B. A review of additional cases</p> <p>C. Assignment of proctor for certain procedures</p> <p>D. Require consultation for specific diagnoses</p> <p>E. Institute a focused professional practice evaluation (FPPE) or specified scope and duration</p>
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	<p>F. Limit, modify, restrict, suspend, or revoke existing privilege(s)</p> <ul style="list-style-type: none"> • MEC notifies responsible physician by certified mail of recommendation(s) made • Case review sheet to Medical Staff Coordinator for physician’s reappointment file
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XIII. EXTERNAL PEER REVIEW

The Board of Trustees, the Medical Executive Committee, the Chief of Staff, or a peer review committee chairperson has the authority to request external peer review. Circumstances that may indicate an external review may include, but are not limited to:

- There is no member who qualifies as a “peer”, or expertise is lacking;
- Conflict of interest exists that cannot be appropriately resolved by the MEC or Board;
- Professional standards are not clear, non-existent, or inconsistent;
- Need for opinion from an impartial, expert outsider due to confusing, ambiguous, or conflicting internal review opinion;
- There is potential for medical malpractice suit or significant compliance issue, legal counsel or risk management may recommend external review;
- When a matter has the potential to lead to an action that would require a hearing pursuant to the Health Care Quality Improvement Act of 1986.

Practitioners or AHPs may request the Hospital to obtain external peer review; however, the determination as to whether to grant said requests rests solely with the Board of Trustees, the Medical Executive Committee, and the Chief of Staff.

An external reviewer may, but is not required to, be appointed to the reviewing committee as an ad hoc member for the purpose of completing a case review. The decision to appoint an external reviewer to a committee shall be in the sole discretion of the Board of Trustees, the Peer Review Committee, or the MEC.

XIV. DOCUMENTATION

Cases presented at meetings will be referred to, and referenced by the medical record number/patient account number and not by the patient’s name. The physician’s ID# will be used rather than the name of the physician. The reason the case is being reviewed (i.e., mortality review, blood criteria not met, complications, etc.), and results of peer review findings, recommendations to continue, limit, modify or restrict privileges, will be recorded in meeting minutes.

XV. REPORTING

Composite case review ratings for all services are presented to the Medical Executive Committee and Board quarterly.

XVI. CONFIDENTIALITY AND MAINTENANCE OF FILES

No copies of peer review documents will be created or distributed, unless required and authorized by applicable law or allowed the Medical Staff Bylaws or Fair Hearing Plan. A practitioner or AHP may review his/her quality file by making an appointment with the

Medical Staff Office and Chief of Staff, provided that the Chief of Staff and CEO may, in their sole discretion, redact any personal information (e.g., reviewer, patient, or employee identities) from the file before the practitioner or AHP reviews the file.

Practitioners or AHPs shall be permitted to submit written responses to any peer review matter for which he/she is being reviewed for placement in his/her peer review/quality file.