

**MEDICAL STAFF BYLAWS
AND
RULES AND REGULATIONS
OF
ELKHORN VALLEY REHABILITATION HOSPITAL**

**5715 E. 2nd Street,
Casper, Wyoming
82609**

August 30, 2011

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**BYLAWS OF THE MEDICAL STAFF
ELKHORN VALLEY REHABILITATION HOSPITAL**

PREAMBLE

WHEREAS, Elkhorn Valley Rehabilitation Hospital (EVRH) is an acute rehabilitation hospital organized under the laws of the State of Delaware; and

WHEREAS, its purpose is to provide safe patient care, treatment, and services, education, in the acute rehabilitation hospital;

WHEREAS, it is recognized that the Medical staff is responsible to the Medical Executive Committee and the Governing Body for the quality of professional care performed in the Hospital.

THEREFORE, the physicians, dentists, podiatrists, and clinical psychologists who practice in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

ARTICLE 1
NAME AND PURPOSES

1.1 NAME

The name of the organization shall be the Medical Staff of Elkhorn Valley Rehabilitation Hospital (EVRH).

1.2 PURPOSE

The purposes of the Medical Staff of the Hospital are:

- A. To strive to ensure that all patients admitted to, or treated in, the Hospital shall receive patient focused quality care without regard to race, religion, color, ancestry, economic status, educational background, marital status, disability, sex, age, sexual orientation, national origin, or source of payment.
- B. To develop and maintain rules of self-governance and conduct of the Medical Staff that assure the quality of professional care performed within the Hospital, including recommendations for appointment and reappointment to the Medical Staff.
- C. To provide a forum whereby issues concerning the Medical Staff may be discussed by the Medical Staff with the Governing Body and the CEO of the Hospital or their designees:
- D. To supervise and ensure compliance with these Bylaws, Rules and Regulations of the Medical Staff, and the Hospital policies approved by the Governing Body;
- E. To provide oversight of care, treatment, and services provided by practitioners with privileges; provide for a uniform quality of safe patient care, treatment, and services; report to, and be accountable to, the Governing Body;
- F. To provide a means for effective communication among the Medical Staff, Governing Body, and Administration on issues of mutual concern; and
- G. To maintain professional, collegial relationships within the Medical Staff.

ARTICLE 2
DEFINITIONS

2.1 ACCESS

Terms used to refer to the granting of permission under the limited or controlled access policy of the Governing Body for community physicians to utilize certain hospital-based services or laboratories. A physician must have Hospital privileges as a member of the Medical Staff and be credentialed as having the necessary professional qualifications to perform specialized procedures in the service or laboratory where access is sought.

2.2 ADMITTING PRIVILEGES

The right of members of the Medical Staff to admit patients to the Hospital.

2.3 ALLIED HEALTH PRACTITIONERS (AHP)

Individuals who hold a valid license, certificate, or other legal credential is required by State law that authorizes the provision of complex clinical services to patients, while

working collaboratively with a member of the Medical Staff. AHPs must provide safe patient care, treatment, and services under the terms and conditions recognized by these Medical Staff Bylaws and Rules and Regulations, and the Allied Health Practitioner Guidelines. AHPs may not be members of the Medical Staff, but are eligible for practice prerogatives. The practice prerogatives and scope are defined by State law and hospital policy and the Medical Staff Bylaws and Rules and Regulations.

2.4 ATTENDING PHYSICIAN

The Medical Staff member who is the physician of record for a given patient.

2.5 CHIEF EXECUTIVE OFFICER (CEO)

The individual appointed from time to time by the Governing Body to serve as the CEO of the Hospital, or his/her authorized representative, who shall direct the overall management of the Hospital.

2.6 CLINICAL PRIVILEGES (PRIVILEGES)

The permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, surgical, podiatric, or psychological services.

2.7 CONSTRUCTION OF TERMS AND HEADINGS

The captions or heading in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

2.8 DESIGNEE

Any reference to an individual holding a duly-authorized office under these Bylaws includes, unless otherwise indicated, the designee of that individual.

2.9 EMERGENCY

A condition in which serious harm could result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that harm or danger.

2.10 EX OFFICIO

A member of a committee or body by virtue of an office or position held, with voting rights unless otherwise expressly provided.

2.11 GOVERNING BODY

The Governing Body of the Hospital, is established by the Board of Directors of Ernest Health Incorporated, which serves as the Hospital Governing Body.

2.12 HIPAA PRIVACY REGULATIONS

The federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996.

2.13 HOSPITAL

Elkhorn Valley Rehabilitation Hospital (EVRH) including the associated ambulatory treatment areas, which are included in the hospital license.

2.14 IN GOOD STANDING

In good standing means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, Rules and Regulations, or policy of the medical staff.

2.15 INVESTIGATION

Investigation means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff.

2.16 LICENSED INDEPENDENT PRACTITIONERS

Licensed independent practitioners provide medical care to patients, in accordance with state licensure laws, without supervision by a physician.

2.17 MEDICAL EXECUTIVE COMMITTEE

The Executive Committee of the Medical Staff with the responsibilities set forth in these Bylaws.

2.18 MEDICAL DIRECTOR

A Medical Staff physician member employed by or under a contractual agreement or otherwise servicing the Hospital to provide medical direction in a specific clinical unit or function of the Hospital. Responsibilities may include both administrative and clinical duties.

2.19 MEDICAL STAFF

The formal organization of all licensed physicians, dentists, clinical psychologists, and podiatrists who may practice independently are granted recognition as members under the terms of these Bylaws.

2.20 MEDICAL STAFF YEAR

The period from January 1 to December 31.

2.21 ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

A clinically integrated care setting in which individuals typically receive health care from more than one health care provider.

2.22 PHYSICIAN

An individual with an M.D. or D.O. degree, who is licensed to practice in the State.

2.23 PRACTITIONER

Unless otherwise expressly limited, any physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership and/or clinical privileges or who is a Medical Staff member and/or who exercises clinical privileges at the Hospital.

2.24 PREROGATIVE

The participatory right granted, by virtue of Staff category or otherwise, to a Medical Staff member or an Allied Health Professional, which is exercisable, subject to, and in accordance with, the conditions imposed by these Bylaws and by other Hospital, or Medical Staff Rules, Regulations, or policies.

2.25 PRESIDENT OF THE MEDICAL STAFF

The principal, elected physician officer of the Medical Staff who serves a two (2) year term.

2.26 FOCUSED PROFESSIONAL PRACTICE EVALUATOR

A practitioner with expertise or knowledge within a focus area under review by the Medical Staff. In some circumstances, this evaluator may not be a member of the Medical Staff, but an external practitioner. The criteria for an external focused professional practice are outlined by policy.

2.27 PROTECTED HEALTH INFORMATION

Any information, whether oral or recorded in any form or medium:

- a) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- b) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2.28 HOSPITAL POLICIES

Policies concerning the operation of the Hospital are adopted by the CEO or Medical Executive Committee and approved by the Governing Body.

2.29 STANDING COMMITTEE OF THE MEDICAL EXECUTIVE COMMITTEE

A duly-authorized Committee of the Medical Staff reporting to the Medical Executive Committee.

2.30 VICE PRESIDENT OF THE MEDICAL STAFF

An elected physician officer of the Medical Staff will serve as Vice President for a two (2) year term of office.

ARTICLE 3
MEDICAL STAFF MEMBERSHIP AND CLASSIFICATION

3.1 MEMBERSHIP

Membership on the Medical Staff shall be extended to physicians, dentists, podiatrists, and clinical psychologists who continuously meet the requirements, qualification, and responsibilities set forth in these Bylaws and who are appointed by the Governing Body. Membership on the Medical Staff or clinical privileges shall not be granted or denied on the basis of race, religion, color, age, sex, national origin, ancestry, economic status, marital status, disability, or sexual orientation, provided the individual is competent to render care of the generally-recognized professional level of quality established by the Medical Executive Committee and the Governing Body, and provided the Hospital provides the services within the proposed setting. No physician, dentist, clinical psychologist, or podiatrist shall admit or provide services to patients in the Hospital unless he/she is a member of the Medical Staff or has been granted temporary, disaster, or emergency privileges in accordance with the procedures set forth in these Bylaws. The President of the Medical Staff may request privileges for trainees of an affiliated medical school to perform clinical work in the medical discipline for which they have had previous training if the privilege requested is unrelated to the area of their current training. Such applicants must meet all requirements, qualifications, and responsibilities of the Medical Staff, and are subject to such policies as may be established.

3.2 EFFECT OF OTHER AFFILIATIONS

No physician, dentist, clinical psychologist, or podiatrist shall be automatically entitled to Medical Staff membership or to exercise any particular clinical privilege merely because he/she holds a certain degree; is licensed to practice in State or any other state; is a member of any professional organization; is certified by any clinical board; previously had membership or privileges at the Hospital or had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or nonparticipation in a particular medical group, payer group, hospital-sponsored foundation, or on a practitioner's opting in or out of Medicare and Medicaid participation.

3.3 CLASSIFICATION

The Medical Staff shall constitute an open, unified staff consisting of appointed practitioners.

A. Qualifications

1. The Medical Staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who:
 - a. Meet the Membership Criteria set forth in Section 3.4;
 - b. Are able to provide continuous care, treatment, and services to their patients in the Hospital, as defined in the relevant Department's Policies and Rules and Regulations; and

- c. Regularly admit or care for patients to the Hospital each calendar year or are regularly involved in medical staff functions, as determined by the Medical Staff.
2. Prerogatives
- The prerogatives of the Medical Staff members shall be to:
- a. Admit or perform services on Hospital patients.
 - b. Exercise such clinical privileges as granted to them pursuant to Article Five (5). Medical Staff members in this category may admit patients to the Hospital. Non-physician members must exercise their privileges subject to a physician member's having the responsibility for the basic medical appraisal of the patients and for the care of any medical problem beyond the scope of the non-physician's license that may be present or may arise during hospitalization. Non-physician members may write orders to the extent allowed in the Rules and Regulations of the Medical Staff, but not beyond the scope of their license.
 - c. Vote on all matters presented at general and special meetings of the Medical Staff and in the committees of which they are a member.
 - d. Hold office in the Medical Staff organization and in the committees of which they are a member.
3. Responsibilities
- a. Meet the basic responsibilities of Staff membership defined in Section 3.4.
 - b. Actively participate in staff committees, performance improvement functions, quality assurance, and quality improvement activities, in supervising and performing focused and ongoing professional practice evaluation activities, in evaluating and monitoring Medical Staff members, and in discharging such other Staff functions as may from time to time be required. This participation is a duty derived from the privilege of the Medical Staff membership.
 - c. Satisfy the requirement set forth in Article Twelve (12) for attendance at meetings and committees of which he/she is a member.

3.4 REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP

A. BASIC REQUIREMENTS

In order to obtain and maintain membership on the Medical Staff or be granted clinical privileges, applicants must have and document:

- 1. Current, unrestricted certificate or license to practice medicine, dentistry, podiatry, or clinical psychology in the State.
- 2. Eligibility to participate in the Medicare, Medicaid and other federally sponsored health programs.
- 3. Each Medical Staff member granted clinical privileges at the Hospital shall maintain in force professional liability insurance which

covers all privileges requested, is not less than the minimum amounts, if any, as from time-to-time may be determined by, and with an insurance carrier acceptable to, the Governing Body.

4. A practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article Seven (7), but may submit comments and a request for reconsideration of the specific qualifications that adversely affect such practitioner. The comments and request shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have the sole discretion whether to consider any changes in the basic qualification or to grant a waiver pursuant to Section 3.7.

B. GENERAL REQUIREMENTS

In order to obtain or maintain membership on the Medical Staff or be granted clinical privileges, applicants must have and document:

1. Current competence in their respective fields, ability to perform the clinical privileges requested, and adherence to standards of character and ethics established in their respective professions; including:
 - a. The ability to work cooperatively with others in the provision of care, treatment, and services;
 - b. Relevant training and/or experience; and
 - c. Adequate physical and mental health, so as to demonstrate to the satisfaction of the Medical Executive Committee that they are competent to render to any patient, care of the generally recognized professional level of quality established by the Medical Executive Committee and the Governing Body.
 - d. Their ability to provide patients with continuous care that meets the professional standards established by the Medical Staff.
2. Their promise to make appropriate arrangements for coverage of that member's patients as determined by the Medical Staff.
3. Their promise to abide by all Federal and State Regulations with respect to professional billing practices; including not cooperating or participating in the division of any fee for professional services.
4. Their promise to abide by the decisions of all duly-appointed Medical Staff committees and cooperate in safe patient care, treatment, and services and Medical Staff activities, including performance improvement, utilization review, professional practice evaluation and attendance at Medical Staff meetings.
5. Their promise to prepare and complete, in a timely, accurate and legible manner, the medical record and other required records for all patients the member in any way provides care to while at the Hospital.

6. Their promise to notify the President of the Medical Staff in writing immediately of any accusation or adverse action by any health care entity or law enforcement agency including any conviction of a misdemeanor or felony; the filing or service of any professional liability suit against the member; a voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation or imposition of a monitoring requirement; reduction, loss or change of clinical privileges at another health care entity; contact by an investigator from a regulatory agency such as FDA, DEA, etc. regarding an investigation of the practitioner. Health care entity includes, but is not limited to, a State or Federal licensing or certification agency, another hospital, health care organization, professional society, health maintenance organization, independent practice association, or medical group (see also Section 16.3.B).
7. Their promise to notify the President of the Medical Staff in writing immediately of any change or termination of malpractice insurance coverage.
8. Their promise to provide to the President of the Medical Staff in writing immediately as to details of any prior or pending government agency or third party payer proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings and convictions.
9. Their promise to abide by the Medical Staff Bylaws, Rules and Regulations; the Bylaws of the Hospital, and other policies of the Medical Staff and the Hospital, including: policies regarding discrimination and harassment; and policies regarding the privacy, confidentiality and security of Protected Health Information.
10. Their promise to fulfill necessary continuing education requirements for licensure.
11. Their promise to participate in emergency or other coverage as specified by the Medical Executive Committee or any consultation panel responsibilities as may be determined by the Medical Executive Committee, or President of the Medical Staff.
12. Their promise to participate in quality assurance and quality improvement activities of the Medical Staff, and to hold knowledge of the content of these activities as strictly confidential.
13. Their promise to notify the President of the Medical Staff in writing of any geographical relocation of practice or any limitation or cessation of professional practice of thirty (30) days or more in duration.
14. Their promise to notify the President of the Medical Staff in writing within thirty (30) days of any change in clinical privileges at other hospitals, whether voluntary or involuntary.

C. PROFESSIONAL PRACTICE EVALUATION

All initial Medical Staff appointees require a focused professional practice evaluation as defined on the Delineation of Privileges form. An ongoing professional practice evaluation will be completed in preparation for the reappointment process.

D. FOCUSED PROFESSIONAL PRACTICE EVALUATION

1. The Medical Executive Committee shall require a focused professional practice evaluation to be completed for each initial appointee to the Medical Staff. Focused professional practice evaluation shall be in accordance with the parameters established on the Delineation of Privileges. Consideration shall be given to the practitioner's education, training, and experience and may include direct observation of performance and/or chart review. A Member shall remain subject to focused professional practice evaluation until the Medical Executive Committee has determined successful completed or is deemed no longer necessary.
2. Medical Staff members who change Medical Staff classification to one of greater clinical responsibility, or who are granted additional privileges, will complete a period of focused professional practice evaluation in accordance with Medical Staff policy.
3. A focused professional practice evaluation shall be performed by a member in good standing of the Medical Staff of the hospital, with similar privileges. If a sufficient amount of clinical activity has not occurred, the focused professional practice evaluation may be extended, as approved by the Medical Executive Committee.
2. The Medical Executive Committee may impose a focused professional evaluation if there is an insufficient amount of clinical activity during that appointment period to evaluate a practitioner's ongoing professional competence.
 - a. Such focused professional practice evaluation shall not entitle the practitioner to the procedures set forth in Article Seven (7), Hearing and Appellate Reviews.
3. If an initial appointee or a Medical Staff member refuses to participate in focused professional practice evaluation activities, the membership or particular clinical privileges may be terminated.
 - a. The President of the Medical Staff shall give the Staff members so affected written notice that he/she has a right to request a hearing pursuant to Section 7.3, Requests for Hearing.

D. ONGOING PROFESSIONAL PRACTICE EVALUATION

1. The Medical Executive Committee shall require an ongoing professional practice evaluation to be completed for each appointed Medical Staff member. Ongoing professional practice evaluation shall be in accordance with the parameters established on the Delineation of Privileges.

2. Medical Staff members who change Medical Staff classification to one of greater clinical responsibility, or who are granted additional privileges, will complete a period of focused professional practice evaluation followed by an ongoing professional practice evaluation in accordance with Medical Staff policy.
3. The ongoing professional practice will be reviewed every 6 months. The performance data will be reviewed by Medical Executive Committee at the next regularly scheduled meeting.
4. At the 2-year reappointment time, the aggregate of the previous 6-month reviews will be summarized and documented for the Medical Director recommendation to the Medical Executive Committee.
5. If a Medical Staff member refuses to participate in ongoing professional practice evaluation activities, the membership or particular clinical privileges may be terminated.
 - a. The President of the Medical Staff shall give the Staff members so affected written notice that he/she has a right to request a hearing pursuant to Section 7.3, Requests for Hearing.

3.5 DURATION OF APPOINTMENT TO THE MEDICAL STAFF

Appointment and reappointment to the Medical Staff shall be for a period of not more than two (2) years.

3.6 MEDICO-ADMINISTRATIVE APPOINTMENTS

A member of the Medical Staff who is appointed, employed, or under contract to perform administrative duties and who also renders clinical care (e.g., Medical Director), must meet the qualifications for the Medical Staff membership and all necessary clinical privileges.

3.7 WAIVER OF QUALIFICATIONS

Any qualification requirements in this Article or any of these Bylaws not required by law or governmental regulation may be waived at the discretion of the Governing Body upon recommendation of the Medical Executive Committee, upon determination that such waiver will serve the best interests of the patients of the Hospital.

3.8 HARASSMENT/DISRUPTIVE BEHAVIORS PROHIBITED

Harassment by a Medical Staff member against any individual (i.e., against another Medical Staff member, Hospital employee, patient, vendor or visitor) on the basis of race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation shall not be tolerated. "Harassment" is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of his/her race, religion, color, national origin, age, disability, sex, veteran status, or sexual orientation (or any other category protected by applicable Law). "Protected Category", and that has the purpose or effect of:
(1) creating an intimidating, hostile, or offensive working environment

(2) unreasonably interfering with an individual's work performance, or that otherwise adversely affects an individual's employment opportunities.

Harassing conduct includes:

- (1) epithets, slurs, negative stereotyping, or threatening, intimidating or hostile acts that relate to a Protected Category
- (2) written or graphic material that denigrates or shows hostility or aversion toward an individual or group because of a Protected Category and that is placed on walls, bulletin boards, or elsewhere on the employer's premises, or circulated in the workplace.

"Sexual Harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors or any other verbal, visual or physical conduct of a sexual nature when submission to or rejection of this conduct by an individual is used as a factor in decision affecting hiring, evaluation, retention, promotion, benefits or other aspects of employment; training and education or training and educational opportunities; medical treatment; referrals; purchases; etc.

"Disruptive Behavior" includes anything that interferes with the orderly conduct of hospital business. This includes behavior that interferes with the ability of others to effectively carry out their duties or that undermines the patients' confidence in the hospital or another member of the healthcare team. Specific examples include:

- Profane or disrespectful language
- Demeaning behavior, such as name calling
- Sexual comments or innuendos
- Inappropriate touching, sexual or otherwise
- Racial or ethnic jokes
- Outbursts of anger
- Throwing of instruments, charts, or other objects
- Criticizing other caregivers in front of patients or other staff
- Comments that undermine a patients' trust in other caregivers or the hospital
- Comments that undermine a caregiver's self confidence in caring for patients
- Failure to adequately address safety concerns or patient care needs
- Intimidating behavior that has the effect of suppressing input by other members of the healthcare team
- Deliberate failure to adhere to organizational policies without adequate evidence to support the alternative chosen
- Retaliation against any member of the healthcare team who has reported an instance of violation of the code of conduct or who has participated in the investigation of such an incident, regardless of the perceived veracity of the report.

All allegations of harassment or disruptive behavior by a Medical Staff member shall be investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action, including, but not limited to, reprimands, suspension, restriction or revocation of all or any part of the Medical Staff membership and/or clinical privileges as outlined in Article Six (6).

3.9 HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

A History and Physical (H&P) will be completed for all inpatients admitted to the hospital. The H&P will conform to the following requirements to ensure quality of care and comply with Joint Commission, CMS and State regulations:

- A. An H&P that is greater than thirty (30) days old is invalid.
- B. If a medical H&P exam has been done within thirty (30) days of inpatient admission, it must be updated with an interval note within 24 hours of admission, noting any changes in the patient's condition. If no changes have occurred, the absence of change must be documented.
- C. If the medical H&P has been done within thirty (30) days of the inpatient admission, it may be completed by another licensed independent practitioner that does not have privileges at the hospital.

An interval H&P will be completed within 24 hours of admission for all cases in which the H&P contained in the medical record is older than 24 hours. The interval H&P will contain an update to the patient's current medical history that may have changed since the original H&P or to address any areas where more current data is available. The patient's medical record will also reflect an update to the physical examination. The interval H&P must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred.

ARTICLE 4

APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

4.1 PROCEDURE FOR APPLICATION

Every applicant for appointment or reappointment to the Medical Staff shall:

- A. Be subject to the application and reappointment process reviewed and approved at the direction of the Medical Executive Committee;
- B. Submit a properly completed application, signed by the applicant, to the President of the Medical Staff, on the forms prescribed for the purpose of the Medical Executive Committee; properly completed means that all provisions have been completed or an explanation provided of any that are not, and all required supporting documentation has been submitted;
- C. Acknowledge that he/she will notify the President of the Medical Staff of any changes in the information provided in the application during the application period or at any subsequent time;
- D. Submit with the application for initial appointment such written recommendations as are required by the Medical Executive Committee and stated on the application;

- E. Submit any information requested pertaining to current competence, appropriate education and training in the applicant's field;
- F. Authorize the Hospital to consult with members of the Medical Staff of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's qualifications;
- G. Authorize the release of all records and documents that in the judgment of the President of the Medical Staff, the Medical Executive Committee, or the Governing Body, may be material to an evaluation of the applicant's qualifications;
- H. Submit information as to any action, including any past or pending investigation, which has been undertaken regarding the applicant's professional status or qualifications, including but not limited to, licensure, staff membership and/or clinical privileges, professional organizations, and related matters;
- I. Submit information satisfactory to the Medical Executive Committee pertaining to the applicant's professional liability insurance coverage, including appropriate amounts and coverage for all privileges requested, and any claim, professional liability suits, judgments, settlements, or arbitration proceedings against him and the status of such matters;
- J. Submit any information regarding any past, present or current exclusion from a federal health care program;
- K. Submit relevant information pertaining to the applicant's physician and mental health;
- L. Submit information pertaining to his/her voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges. A voluntary termination is considered a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.
- M. Acknowledge that he/she has received a copy (or has been given access to), and read the Medical Staff Bylaws and Rules and Regulation and that he/she agrees to be bound by the terms thereof, as they may be amended from time to time, if he/she is granted membership or clinical privileges, and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of this application; All practitioners are bound to amendments to the Bylaws.
- N. Agree to appear for such interviews and provide such additional information as may be requested by the President of the Medical Staff, Medical Executive Committee, or the Governing Body;
- O. Release from liability all representatives of the Hospital and the Medical Staff for their acts performed in good faith in evaluating the applicant's qualifications; and
- P. Release from liability all individuals and organizations who in good faith provide information to the hospital and its Medical Staff concerning the applicant, including otherwise privileged or confidential information.

4.2 APPLICANT'S BURDEN

The applicant for appointment, reappointment, or advancement, shall have the burden of producing complete, accurate and adequate information for a proper evaluation of his/her qualifications. This may include all requirements specified in the Medical Staff Bylaws and Rules and Regulations and for resolving any doubts about these matters, and of providing any additional information requested by the President of the Medical Staff or designee. This burden may include submission to a medical, psychiatric, or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee which may select the examining physician. The applicant's failure to sustain this burden and/or the provision of information containing any misrepresentations or omissions shall be grounds for denial of the application or subsequent termination, suspension or limitation of membership or privileges under Article Six (6) of these Bylaws. The President of the Medical Staff or designee shall notify the applicant of any areas of incompleteness and/or failure of others to respond to such information collection or verification efforts within forty-five (45) days of when the initial application is received, and it shall then be the applicant's obligation to obtain all required information. Failure to complete the application and/or to submit any additional requested information within thirty (30) days of a request by the President of the Medical Staff or designee may, in the sole discretion of the President of the Medical Staff, be deemed a voluntary withdrawal of the application and not subject to challenge under Article Seven (7) of these Bylaws. If interim membership and clinical privileges were granted pending the completion of the application, they will be deemed expired at this time.

4.3 CONSIDERATION OF APPLICATION

- A. The procedure for consideration for appointment to the Medical Staff shall be outlined in applicable credentialing policies.
- B. After an examination of the completed application, and all supporting material, the Medical Director shall present a written report to the Medical Executive Committee, along with supporting materials, which shall indicate, on the basis of his/her evaluation of the applicant's competence, ability to perform the clinical privileges requested, character, health, and ethics, his/her recommendations and the reasons therefore, as to:
 1. Whether the applicant should be appointed to the Medical Staff;
 2. What specifically-delineated clinical privileges should be granted to the applicant; and
 3. What focused professional practice evaluation is required per the granted Delineation of Privileges.
- C. Upon receipt of the recommendations of the Medical Director, the Medical Executive Committee shall review this information, conduct any further investigation regarding the applicant's character, competence, health, and ethics it deems appropriate, and:
 1. Provide the Governing Body with a recommendation that the applicant be appointed to the Medical Staff with the specific clinical privileges requested; or

2. Provide the Governing Body with a recommendation that the applicant be appointed to the Medical Staff, but not with all of the specific clinical privileges requested; or
 3. Provide the Governing Body with a recommendation that the applicant shall not be appointed to the Medical Staff.
 4. Action will be taken on the completed application no later than ninety (90) days after the date which the application is complete.
- D. In the event that the Medical Executive Committee takes action C.2 or C.3 above, the applicant shall be notified of the adverse recommendation and of his/her right to request a hearing under Article Seven (7). No final action shall be taken by the Governing Body until the applicant has waived or exhausted his/her hearing right.
- E. Upon receipt of the application, supporting information, and recommendation from the Medical Executive Committee, the Governing Body shall act upon the application and shall notify the applicant of its decision. The Governing Body may either adopt the Medical Executive Committee's decision or refer the matter back to the Medical Executive Committee for further proceedings. If the decision of the Governing Body is to appoint the applicant to the Medical Staff, the Governing Body shall approve the specific privileges to be granted the Medical Staff member. The Governing Body shall give great weight to the actions and recommendations of the Medical Executive Committee and, in no event, shall act in an arbitrary and capricious manner. When the Governing Body has adopted the decision, it shall be considered the final decision of the Hospital. The Governing Body will take this final action no later than sixty (60) days after the date which the Medical Executive Committee made their decision.
- F. All decision by the Governing Body approving or disapproving the appointment or reappointment of an applicant shall be forwarded in writing, to the applicant with a copy to the President of the Medical Staff. The notification will occur not later than twenty (20) days after the Governing Body decision.
- G. In the event of an unwarranted delay in the application process, the Governing Body may act on a properly completed application without the recommendation of the Medical Executive Committee upon the request of the applicant. For the purpose of this Section, unless specifically waived in writing by the applicant, unwarranted delay shall mean ninety one (91) days from the date that the properly completed application has been received. In all cases, the decision to appoint or reappoint shall be based upon the same information as is usually considered by the Medical Executive Committee.
- H. Should the Governing Body's preliminary decision be adverse to the applicant after either: (1) a favorable Medical Executive Committee recommendation; or (2) without benefit of a Medical Executive Committee recommendation in accordance with 4.3.G, above, the applicant shall be notified of the preliminary adverse decision and of his/her right to request a hearing under Article Seven (7). No final action shall be taken by the Governing Body until after the applicant has waived or exhausted his/her hearing rights.

- I. Any time periods specified in Section 4.3 are to assist those named in accomplishing their tasks and shall not be deemed to create any right of the applicant to have his/her application processed within those periods.
- J. A Medical Staff member who has been the subject of an adverse decision denying an application, an adverse corrective action decision, or a resignation in lieu of a medical disciplinary action, shall not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by such action for a period of at least two (2) years from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, which is applicable.

4.4 REAPPOINTMENT TO THE MEDICAL STAFF

- A. Reappointment to the Medical Staff shall occur biennially. Staff members whose appointments are scheduled to expire shall receive notification and shall submit a completed and signed reapplication form, as well as materials necessary to processing of the form as set forth in applicable credentialing policies.
- B. Candidates for reappointment will provide a list of Continuing Medical Education (CME) activities completed since the last appointment/ reappointment date in an amount equal to or greater than the amount required by the State Medical Board. CMEs will correspond in part to the privileges requested.
- C. The reapplication shall be processed in all respects in the same manner as applies under Section 4.1 through 4.3 for applications for initial appointment to the Medical Staff, and the applicant shall, in all respects, have the same rights and be subject to the same requirements. The Medical Executive Committee will require additional focused professional practice evaluation for any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency or may consider the results received from other hospitals' professional practice activities, when available. Additional focused professional practice evaluation requirements imposed for lack of activity or information from other hospitals shall not result in any hearing rights.
- D. The properly completed reapplication form and all necessary documentation shall be forwarded to the Medical Director for evaluation and recommendation as to whether or not the member should be reappointed to the Medical Staff and a recommendation on the specific clinical privileges requested. In making such recommendations, the Medical Director shall consider the member's results of quality assessment and professional practice evaluation activities, and recommendations from the member's peers. The Medical Director's recommendation and pertinent information within the reapplication file will be reviewed by the Medical Executive Committee with a resulting recommendation. The recommendations of the Medical Executive Committee shall be forwarded to the Governing Body.
- E. If a completed reappointment packet is not returned prior to the appointment or reappointment expiration date, the member will be processed as a voluntary resignation effective on the date his/her appointment expires. Voluntary

resignation does not apply in the event of: 1. An ongoing formal review related to conduct

1. An extension agreed upon by the Medical Executive Committee, subject to Governing Body approval,
 2. Other penalties as may be imposed by the Medical Executive Committee, and subject to Governing Body approval.
- F. A subsequent request for Medical Staff membership received from a member who has voluntarily resigned in this manner shall be submitted and processed in accordance with the procedure specified for applications for initial appointments. The procedural rights set forth in Article Seven (7) of the Medical Staff Bylaws shall not apply to a voluntary resignation under this section.
- G. The Medical Executive Committee and the Governing Body reserve the right to decline reappointment based on practitioner inactivity in the Hospital throughout the previous 2-year period.

4.5 AUTHORITY FOR DOCUMENTATION AND VERIFICATION SERVICES

The Medical Executive Committee and the Governing Body may designate a verification service to serve as a designee of the Medical Staff, the President of the Medical Staff or designee, the CEO and the Governing Body under this Article, to provide documentation and verification services with respect to applicants for appointment and reappointment. The documentation and verification services shall be limited to collecting verified, objective data, and the Medical Staff and Governing Body remain responsible for evaluation and making recommendations with respect to applications for appointment and reappointment for membership and/or clinical privileges. By applying for membership and/or clinical privileges, each applicant for appointment or reappointment authorizes the Medical Staff, the President of the Medical Staff or designee, the CEO and/or Governing Body to use the services of a verification service for the documentation and verification of appointment/reappointment information for the limited purpose described in this Section.

The Medical Executive Committee and the Governing Body may also rely upon credentialing and privileging information from a distant site facility for telemedicine practitioners if that distant facility is a Medicare certified hospital or a distant-site telemedicine entity. The distant site must meet all the standards set forth in 42 CFR 482 regarding credentialing and privileging processes. The documentation regarding the individual practitioner's current privileges, current list of privileges, current license in the State in which the patients are receiving care, and the Medical Executive Committee received information regarding the individual's performance including, at a minimum, all adverse events that occur as a result of the telemedicine services provided.

4.6 LEAVE OF ABSENCE

- A. A Medical Staff member who wishes a leave of absence must, unless excused by the President of the Medical Staff for good cause, submit a written request for the leave to the President of the Medical Staff at least thirty (30) days prior to the commencement of leave. The President of the Medical Staff shall determine,

subject to the approval of the Medical Executive Committee, whether or not to grant the leave. A leave of absence may not be less than three (3) or more than twelve (12) consecutive months. An approved leave is renewable once (1) for a total not to exceed twenty-four (24) consecutive months from the initial date of the leave. Renewals shall be processed following the same procedures as for an initial leave, except that the Member must request a renewal of the leave thirty (30) days prior to the end of the initial leave. Failure, without good cause to submit a timely request for a leave or renewal of leave to the President of the Medical Staff shall be deemed a voluntary resignation from the Medical Staff and the member shall not, as a result, be entitled to the procedural rights of Article Seven (7). If a leave of absence is granted or renewed, a written report stating the reasons for the leave or renewal shall be forwarded to the Medical Executive Committee.

- B. While on an approved leave, a Medical Staff member shall not have privileges to admit or treat patients, nor have any other of the prerogatives or responsibilities of Medical Staff membership.
- C. At least thirty (30) days prior to termination of leave, the member shall submit a written request for the reinstatement of membership and clinical privileges to the President of the Medical Staff. At the request of the President of the Medical Staff, the member shall submit a summary of relevant activities while on leave including, if requested, information relevant to current competency and health. Thereafter, the President of the Medical Staff, subject to the approval of the Medical Executive Committee and the Governing Body, shall make a recommendation regarding reinstatement of the member's privileges. A determination that a member be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to the Article Seven (7) of these Bylaws.
- D. Failure, without good cause, to request reinstatement or submit a requested summary of activities shall be deemed a voluntary resignation from the Medical Staff. In such a case, the procedural rights of Article Seven (7) shall apply solely for determining whether there was good cause to excuse the failure to request reinstatement or submit the requested summary of activities.

E. MEDICAL LEAVE OF ABSENCE

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

F. MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted, upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Section 4.6, but may be granted

subject to focused professional practice evaluation as determined by the Medical Executive Committee.

ARTICLE 5 **CLINICAL PRIVILEGES**

5.1 PRIVILEGES EXTENDED TO THE MEDICAL STAFF

- A. Members of the Medical Staff shall be entitled to exercise only those delineated clinical privileges specifically granted to them by the Medical Executive Committee and the Governing Body in accordance with these Bylaws. All clinical privileges shall be requested and processed pursuant to the procedures outlined in Article Five (5). A mechanism is in place that allows assessment of whether an individual with clinical privileges provides services within the scope of those privileges granted.
- B. The Medical Executive Committee shall define the privileges delineation and criteria it shall use for recommending privileges in the initial appointment, reappointment, and evaluation of Staff members. If privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges.

5.2 ADDITIONAL CLINICAL PRIVILEGES

A member of the Medical Staff may apply for additional clinical privileges in writing. The application shall, in all respects, be processed in the same manner as applies under Article Four (4) to an application for appointment or reappointment to the Medical Staff, and the applicant shall, in all respects, have the same rights and be subject to the same requirements as apply under Article Four (4) to an application for appointment or reappointment to the Medical Staff.

5.3 TEMPORARY CLINICAL PRIVILEGES

There is no right to temporary privileges. When appropriate, the President of the Medical Staff shall make a recommendation with the concurrence of the CEO, to grant temporary clinical privileges to a qualified practitioner for no more than one hundred and twenty (120) days under the circumstances and subject to the conditions stated below. The President of the Medical Staff will designate those practitioners providing focused professional practice evaluation, if appropriate.

- A. **IMPORTANT CARE NEED PRIVILEGES:** Upon receipt of a written application for specific temporary privileges, an individual otherwise eligible for Medical Staff privileges, but who is not an applicant for membership, may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than three (3) patients in any one year by any such individual. Validation of current licensure and current competence shall occur prior to granting privileges.
- B. **NEW APPLICANT WITH COMPLETE APPLICATION:** A qualified practitioner that has completed the application for privileges may be granted privileges while

awaiting review and approval by the Medical Executive Committee and Governing Body. Verification of current licensure, relevant training or experience, current competence, ability to perform requested privileges, and a report by NDPB must be completed. Additionally, the application must have no current or previously successful challenge to licensure or registration, no involuntary termination of medical staff membership at another organization, and no involuntary limitation, reduction, denial, or loss of clinical privileges at another health care institution or provider.

- C. Unless excused for good cause by the President of the Medical Staff or in a disaster situation, temporary privileges may be granted only when the practitioner has submitted a written request for temporary privileges and the information available reasonably supports a favorable determination regarding the requesting practitioner's licensure, qualifications, ability, and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement of Section 3.4., regarding professional liability insurance. The President of the Medical Staff shall be responsible for monitoring the performance of the practitioner granted temporary privileges, or for designating a member who shall assume this responsibility. Special requirements of consultation and reporting may be imposed. Before temporary privileges are granted, the practitioner must acknowledge, in writing, that he/she has received, or has been given access to, and read the Medical Staff Bylaws and Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

5.4 DENIAL OR TERMINATION OF TEMPORARY PRIVILEGES

On the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any interim or temporary privileges granted, or compliance with these Bylaws, Rules and Regulations, or other requirements, the President of the Medical Staff may deny or terminate any or all of such individual's interim or temporary privileges. The denial or termination of interim or temporary privileges shall not be reviewable according to the procedures set forth in Article Seven (7) of the Medical Staff Bylaws unless required to be reported pursuant to applicable law. In the event of any such denial or termination, the practitioner's patients in the Hospital shall be assigned to another practitioner by the President of the Medical Staff. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner. An applicant whose temporary appointment and interim clinical privileges were terminated for administrative purposes, shall remain eligible to apply for Medical Staff membership and clinical privileges.

5.5 EMERGENCY CLINICAL PRIVILEGES

A. PATIENT EMERGENCY

For the purposes of this Section, an emergency is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and

regardless of Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by the Hospital personnel in doing everything possible to save a patient from such danger. When the emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient.

B. EMERGENCY OPERATIONS PLAN

Emergency privileges of licensed independent practitioners may be granted when the Hospital's Emergency Operations Plan is activated and the organization is unable to handle immediate patient needs. The Chief Executive Officer or designee may grant emergency temporary privileges to a physician based upon presentation of valid government-issued photo identification and upon obtaining at least one of the following:

1. Current picture identification from a health care organization that clearly identifies professional designation
2. A current license to practice
3. Primary source verification of licensure
4. Identification indicating that the individual is a member of a recognized state or federal response organization or group
5. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in a disaster
6. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

The facility will provide each volunteer licensed independent practitioner with a photo identification that clearly identifies him/her as a volunteer practitioner. The Medical Staff will oversee the performance of licensed independent practitioners through the focused professional practice evaluation process. This may be accomplished through such methods as direct observation, mentoring, and/or medical record review by the Medical Director or his/her designee. Formal verification of credentials and privileges will begin as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer practitioner presents at the hospital, whichever comes first. If primary source verification cannot be completed within 72 hours due to extraordinary circumstances relating to the disaster, documentation will be kept substantiating why this was not possible, as well as the attempts made by the hospital to do so. Documented evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, and services will also be maintained.

5.6 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

A. ADMISSIONS

1. Limited License practitioners, (to include Dentist (DDS), non-physician oral surgeon (DMD), clinical psychologists (PhD), and podiatrist (DPM) may not admit patients. A physician member admits and assumes

responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

2. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the portion of the H&P related to his/her specialty. Otherwise a physician member must conduct or directly supervise the history and physical examination upon admission (except the portion related to dentistry or podiatry).

B. MEDICAL APPRAISAL

All patients admitted for care at the Hospital for a dentist, non-MD oral surgeon, psychologist, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based on medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved.

5.7 MODIFICATION OF CLINICAL PRIVILEGES

On its own or pursuant to a request from the practitioner, the Medical Executive Committee may recommend a change in the clinical privileges. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to focused professional practice evaluation in accordance with procedures outlined on Section 3.4.D.

5.8 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignment fails to timely furnish the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article Seven (7).

ARTICLE 6

FOCUSED PROFESSIONAL PRACTICE EVALUATION

6.1 BASIS FOR REVIEW

Focused professional practice evaluation is the process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competency performing the requested privilege.

The focused professional practice evaluation shall be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process is a time-limited period during which the organization evaluates and determines the practitioner's professional performance. The process, criteria, method for monitoring, duration, and circumstances under which monitoring by an internal/external resource is outlined within the Medical Staff Policies and Procedures.

The procedures provided in this Article shall be invoked whenever it appears that the activities or professional conduct of any member of the Medical Staff:

- A. Jeopardizes or may jeopardize the safety or best interests of a patient, quality of care, treatment, or services, visitor, or employee;
- B. Presents a question regarding the competence, character, judgment, ethics, stability of personality, including the ability to work cooperatively with others in the provision of safe patient care, treatment, and services, adequate physical and mental health, moral character, or qualification of the member; or
- C. Violates these Medical Staff Bylaws, Rules and Regulations, or the Hospital policies, including Code of Conduct, or constitutes conduct that is, or is reasonably probable of being, disruptive to the Hospital operations.

6.2 INITIATION

A request for an investigation of the conduct of a member of the Medical Staff raising a question under Section 6.1 above must be in writing or determined in the performance monitoring processes, submitted to the President of the Medical Staff, and supported by reference to specific activities or conduct alleged. The President of the Medical Staff will apprise the Medical Executive Committee of the request for investigation. After discussion of the request for an investigation, the Medical Executive Committee may determine that an investigation commences or that no further investigation is warranted. In either event the affected member of the Medical Staff will be notified in writing that a request for investigation has been made and that an investigation will or will not commence. If the Medical Executive Committee was the source of the request for an investigation, it shall make appropriate record of the reasons. Early in any investigatory process, the Medical Staff member will be afforded the opportunity to meet informally with the committee, officer, or President of the Medical Staff conducting the investigation. If, in the Medical Executive Committee's view, more than sixty (60) days is needed for investigation, the Medical Executive Committee shall advise the affected Medical Staff member and specify an appropriate time for completion of the investigation.

6.3 INVESTIGATION/DATA COLLECTION

On recommendation of the President of the Medical Staff, the Medical Executive Committee may, itself, conduct any investigation it deems necessary or may assign this task to an appropriately charged officer, committee, or President of the Medical Staff. The investigative process shall not be deemed to be a hearing as that term is used in Article Seven (7). If the responsibility for investigation is delegated by the Medical Executive Committee, the responsible investigator(s) shall report to the Medical Executive Committee as soon as practical and in such form or manner as the Medical Executive Committee shall require.

6.4 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall act as soon as is practical after the conclusion of any investigation. Action taken by the Medical Executive Committee following the conclusion of any investigation may include, but is not limited to, the following actions:

- A. No corrective action;
- B. Proposed corrective action;
 - 1. Letter of admonition, reprimand or warning;
 - 2. Terms of probation including monitoring requirements or specific individual requirements of consultation;
 - 3. Reduction or revocation of clinical privileges;
 - 4. Suspension of clinical privileges until completion of specific conditions or requirements;
 - 5. Limitation of prerogatives related to the practitioner's delivery of safe patient care, treatment, and services;
 - 6. Suspension of Medical Staff membership for a specific period of time or without limit of time;
 - 7. Revocation of Medical Staff membership; or
 - 8. Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall prevent the Medical Executive Committee from implementing a summary suspension or restriction of privileges at any time, in the exercise of its discretion pursuant to Section 6.6 below. If the action is favorable to the practitioner, or constitutes an admonition, reprimand, or warning to the practitioner, or results in termination of the practitioner, it shall become effective as the final decisions of the Governing Body. If the Medical Executive Committee fails to investigate or initiate corrective action and the Governing Body determines that its failure to do so is contrary to the weight of the evidence then available, the Governing Body may, after consulting with the Medical Executive Committee, direct the Medical Executive Committee to investigate or initiate corrective action. The Medical Executive Committee shall inform the Governing Body of its action in response to such a directive. If the Medical Executive Committee fails to act after a directive from the Governing Body, the Governing Body may, in accordance with these Bylaws, after written notice to the Medical Executive Committee, take action directly against a Medical Staff member. The Governing Body shall inform the Medical Executive Committee in writing of what it has done.

6.5 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee or the Governing Body pursuant to Section 6.4 which constitutes grounds for a hearing as set forth in Section 7.2 shall entitle the Medical Staff member to the rights specified in Article Seven (7). In such cases, the President of the Medical Staff shall give the Medical Staff member written notice of the recommendation, the reasons for the proposed action, and of his/her right to request a hearing pursuant to the requirements in Section 7.3.A. A copy of the Bylaws detailing the hearing rights of the Staff Member will also be provided to the affected Staff Member.

6.6 SUMMARY SUSPENSION

A. CRITERIA FOR INITIATION

The President of the Medical Staff, the Vice President of the Medical Staff when acting for the President of the Medical Staff, Medical Executive Committee, or the CEO is empowered to restrict or suspend summarily without benefit of hearing or personal appearance any or all privileges of a member of the Medical Staff if there is a cause to believe that the Medical Staff member's conduct requires that immediate action be taken to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual. If the persons or body designated above fail, under the foregoing circumstances, to restrict or suspend a Medical Staff member's membership, or all or any portion of his/her clinical privileges, the Governing Body, or its designee, may, when necessary to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual, after reasonable attempts to contact the Medical Executive Committee, summarily restrict or suspend the Medical Staff member's membership or all or any portion of his/her clinical privileges. A restriction or suspension shall be effective immediately upon imposition, provided, however, that a restriction or suspension imposed by the Governing Body, or its designee, must be ratified by the Medical Executive Committee within two (2) working days of its imposition, excluding weekends and holidays, or it shall terminate automatically. The person or body responsible for imposing a restriction or suspension shall promptly give oral and written notice thereof to the Medical Staff member, President of the Medical Staff, CEO, as well as the Governing Body and Medical Executive Committee at their next meeting. The notice of the restriction or suspension given to the Medical Executive Committee shall constitute a request for corrective action and the procedures set forth in Section 7.1 shall be followed and documented in the Medical Staff member's credentialing and privileging file. In the event of any such restriction or suspension, the patients of practitioner shall be assigned to another Medical Staff member by the President of the Medical Staff. The wishes of the patient shall be considered, when feasible, in choosing the substitute Staff member.

B. MEDICAL EXECUTIVE COMMITTEE ACTION

After imposition of a restriction or suspension the affected member of the Medical Staff may request an interview with an ad hoc panel authorized to represent the Medical Executive Committee. The panel will be selected by the President of the Medical Staff in consultation with the President of the Medical Staff and will not include the person, in the case of a restriction or suspension imposed by an individual, who imposed the restriction or suspension. Any such interview shall not be deemed a "hearing" as that term is used in Article Seven (7). The interview shall be convened as soon as reasonably possible under all of the circumstances. The ad hoc panel may thereafter modify, continue without limit of time, or terminate the terms of the restriction or suspension. The panel shall give the Medical Staff member written notice of its recommendation and the reasons therefore with a copy to the President of the Medical Staff and the Medical Executive Committee.

C. PROCEDURAL RIGHTS

Unless the ad hoc panel of the Medical Executive Committee terminates the restriction or suspension, it shall remain in effect during the pendency of and the completion of the review process and of the hearing if a hearing is requested pursuant to Section 7.2 and pending any appeal to the Governing Body unless the restriction or suspension is terminated by the Judicial Review Committee (see Section 7.3.B). The Medical Staff member shall not be entitled to the procedural rights afforded by Article Seven (7) until such time as action has been taken under Sections 6.1 through 6.5, and then only if the action constitutes grounds for a hearing as set forth in Section 7.2.

6.7 AUTOMATIC SUSPENSION

The following shall result in automatic suspension or revocation of Medical Staff membership and/or clinical privileges and shall not, unless otherwise expressly provided or required by law, entitle the affected Medical Staff member to the rights provided for in Article Seven (7) of these Bylaws, or to any other procedural rights.

A. LICENSE

Whenever a Medical Staff member's license authorizing him/her to practice in this State is revoked, stayed, restricted, suspended, or the medical staff member is placed on probation by the State, the action and its terms shall automatically apply to his/her the Hospital, Medical Staff membership and/or privileges as appropriate. Whenever a Medical Staff member's license expires, he/she shall be automatically suspended from practice until there is evidence of a licensure renewal. Medical Staff members so affected shall not be entitled to the procedural rights afforded by Article Seven (7) regarding such automatic actions.

B. MEDICARE, MEDICAID SANCTIONS

Whenever a Medical Staff member has been involuntarily excluded from participation in the Medicare, Medicaid and other federally funded healthcare programs, he/she shall be automatically suspended from practice until the member has provided evidence that the exclusion has been removed.

C. DRUG ENFORCEMENT ADMINISTRATION CERTIFICATION

Whenever a Medical Staff member's DEA certificate is revoked, suspended, stayed, restricted, or subject to probation, the action and its terms shall automatically apply to his/her right to prescribe, dispense, or administer medications covered by the certificate. Whenever a Medical Staff member's DEA certificate expires, the member's right to prescribe, dispense, or administer medications covered by the certificate shall be automatically suspended until there is evidence of a certificate renewal. There shall be no right to the hearing procedures afforded by Article Seven (7) based upon such automatic action.

D. MEDICAL EXECUTIVE COMMITTEE DELIBERATION ON MATTERS INVOLVING LICENSE AND DRUG ENFORCEMENT ADMINISTRATION

As soon as practical after action is taken as described in Section 6.7.A, or in Section 6.7.C, the Medical Executive Committee shall review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action as may be appropriate

based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Sections 6.2 and 6.3 as appropriate.

E. MEDICAL RECORDS

For failure to comply with the Medical Record Regulations and policies established by the Medical Staff Rules and Regulations or the Hospital Policies, a Medical Staff member's privileges to admit patients and to schedule admissions or provide consultations (except with respect to his/her patients already admitted to the Hospital) shall be automatically suspended upon the expiration of seven (7) days after he/she is given written notice and shall remain so suspended until all delinquent medical records are completed. A failure to complete the medical records within four (4) months after the date a suspension became effective pursuant to this Section shall be deemed a voluntary resignation from the Medical Staff.

F. PROFESSIONAL LIABILITY

For failure to maintain the amount of professional liability insurance, or its equivalent, if any, required under Section 16.3.A, a practitioner's membership and clinical privileges shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Executive Committee that he/she has secured professional liability coverage in the amount required under Section 16.3.A. A failure to provide such evidence within six (6) months after the effective automatic suspension date, shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership. Medical Staff members on leave of absence are not subject to automatic suspension for failure to provide evidence of professional liability insurance.

G. PROCEDURAL RIGHTS MEDICAL RECORDS

Medical Staff members whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provision of Section 6.7.E (failure to comply with medical records) shall not be entitled to the procedural rights set forth in Article Seven (7), unless otherwise expressly provided.

H. CONVICTION OF A FELONY

If any member of the Medical Staff shall be finally convicted of a felony, his/her Medical Staff membership and privileges shall be immediately and automatically terminated.

I. NOTICE OF AUTOMATIC SUSPENSION/TERMINATION; TRANSFER OF PATIENTS

Whenever a Medical Staff member's privileges are automatically suspended/terminated in whole or in part, notice of such suspension/termination shall be given by the Medical Staff Office to the Medical Staff member, President of the Medical Staff, as well as the Governing Body and the Medical Executive Committee at their next meetings. Giving of such notice shall not, however, be required in order for the automatic suspension/termination to become effective. In the event of any such suspension/termination, the Medical Staff member's patients shall be assigned to another Medical Staff member by the President of

the Medical Staff. The wishes of the patients shall be considered, when feasible, in choosing a substitute Staff member.

ARTICLE 7 **HEARING AND APPELLATE REVIEWS**

7.1 PREAMBLE AND APPELLATE REVIEWS

A. INTRA-ORGANIZATIONAL REMEDIES

The procedures provided for in this Article Seven (7) are strictly quasi-judicial in nature and shall not be utilized to hold notice and comment type hearings or to make legislative determinations or determinations as to the substantive validity of Bylaws, Rules and Regulations. Only the Governing Body may entertain challenges to the substantive validity of these Bylaws, and Rules and Regulations. When a substantive validity question is the sole issue, a petitioner shall be permitted a direct appeal and appearance before the Governing Body. Such appearance shall not be considered a “hearing” under this Article and shall be conducted in accordance with guidelines established by the Governing Body. A final determination by the Governing Body after such appeal shall be a condition precedent to the petitioner’s right to seek judicial review in a court of law.

B. EXHAUSTION OF REMEDIES

If an adverse ruling is made with respect to a Medical Staff Member’s membership, Staff status, or clinical privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital, or participants in the decision process; and the exclusive procedure for obtaining judicial review shall be by Petition for Writ of Mandamus.

C. DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

1. “Notice” refers to a written communication delivered personally to the required addresses or sent by the United States Postal Services, pursuant to Section 16.2, addressed to the required addresses at his/her or its address as it appears in the records of the Medical Staff Office.
2. “Petitioner” refers to the Medical Staff member or applicant who has requested a hearing or appearance pursuant to Section 7.3 or 7.1.A; and
3. “Date of Receipt” of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received seventy-two (72) hours after being deposited, postage prepaid, in the United States mail.

7.2 GROUNDS FOR HEARING

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing unless otherwise specified in these Bylaws:

- A. Denial of Medical Staff membership.
- B. Denial of requested advancement in Medical Staff membership status.
- C. Denial of Medical Staff reappointment.
- D. Demotion to lower Medical Staff category or membership status.
- E. Restriction or suspension of Medical Staff membership during the pendency of corrective action and hearing and appeals procedures.
- F. Expulsion from Medical Staff membership.
- G. Denial of requested privileges.
- H. Reduction in privileges.
- I. Restriction or suspension of medical staff membership and/or privileges during the pendency of corrective action and hearing and appeals procedure.
- J. Termination of privileges.
- K. Requirement of consultation or focused professional practice evaluation when the reviewing physician has the authority to supervise, direct, or transfer are from the physician being monitored.
- L. Any other action which required filing a report pursuant to state law, and with the National Practitioner Data Bank. Recommendations for any of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

7.3 REQUESTS FOR HEARING

A. NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which the Medical Executive Committee or authorized officer has, under these Bylaws, recommended or taken any of the actions constituting grounds for hearing as set forth in Section 7.2., the Medical Executive Committee or officer shall give the affected Medical Staff member notice of the decision and his/her right to request a hearing pursuant to Section 7.3.B, below.

B. REQUEST OF HEARING

The petitioner shall have thirty (30) days following the date of receipt of notice to request a hearing by a Judicial Review Committee. The request shall be sent to the President of the Medical Staff. If the petitioner does not request a hearing within thirty (30) days, he/she shall be deemed to have waived his/her right to a hearing and accepted the decision. It shall thereupon become the final action of the Medical Executive Committee and shall be subject to review and decision on that basis by the Governing Body.

C. TIME AND PLACE FOR HEARING

The President of the Medical Staff shall confirm a date for a hearing. Notice shall be given to the petitioner of the time, place, and date of the hearing. The date of commencement of the hearing shall not be less than thirty (30) days from the date of receipt of the request; provided that a hearing for a practitioner under suspension shall commence as soon as arrangement may reasonably be made.

D. NOTICE OF CHARGES

The President of the Medical Staff shall advise the petitioner in writing of the acts or omissions with which the petitioner is charged including, if applicable, a list of the medical records or charts being questioned. The President of the Medical Staff and the petitioner shall provide each other with a list of witnesses expected at that time to testify at the hearing. The President of the Medical Staff and the petitioner shall notify each other of additions to the list. Witness lists must be exchanged at least ten (10) days prior to commencement of the hearing.

E. JUDICIAL REVIEW COMMITTEE

The President of the Medical Staff shall select, in consultation with the CEO, a Judicial Review Committee consisting of at least three (3) Medical Staff members, including one member who is a physician from the same specialty as the petitioner, with alternates as appropriate. The members selected to serve on the Judicial Review Committee shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level and shall not be engaged in direct economic competition with the petitioner.

F. FAILURE TO APPEAR

Failure of the petitioner to appear without good cause and proceed at a hearing shall be deemed to constitute voluntary acceptance of the actions involved and waiver to any hearing rights, and it shall thereupon become the final recommendation of the Medical Board. Such final recommendation shall be subject on that basis alone to review and decision by the Governing Body.

G. POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person and shall be permitted by the hearing officer, or the President of the Medical Staff before appointment of hearing officer, on a showing of good cause.

7.4 HEARING PROCEDURE

A. PRE-HEARING PROCEDURE

It shall be the duty of the petitioner and the Medical Executive Committee to raise any procedural objections before the hearing so that decisions concerning such matters may expeditiously be made. Any such objections, when so raised, shall be preserved for consideration at any appellate review hearing which may subsequently be requested.

B. THE HEARING OFFICER

The President of the Medical Staff shall appoint an unbiased hearing officer to preside at the hearing. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing and, preferably, have experience in Medical Staff matters. The hearing officer shall have the authority to (1) rule on questions of procedure; (2) rule on the admission and exclusion of evidence; (3) participate in the deliberations of the Judicial Review Committee but shall not vote; (4) draft the findings and recommendations of the Judicial Review Committee as

requested by the Committee; and (5) advise the Judicial Review Committee generally on the discharge of its functions.

C. RECORD AND CONDUCT OF THE HEARING

The Judicial Review Committee shall maintain a record of the hearing by a certified shorthand reporter. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of the transcript if any shall be borne by the party requesting it. The hearing need not be conducted by technical rules of law relating to examination of witnesses or production of evidence except that irrelevant or unduly repetitious evidence shall be excluded.

D. RIGHTS OF THE PARTIES

At a hearing, both sides shall have the right to representation by counsel or other person. If either the petitioner or the Medical Executive Committee elects not to be represented by counsel, this fact will be noted in the record by the hearing officer. Both sides may ask the Judicial Review Committee member's questions relating to determining and to challenge for bias, call and examine witnesses, introduce exhibits, cross-examine witnesses, and otherwise rebut any evidence. The petitioner may be called by the Medical Executive Committee and examined as if under cross-examination.

E. REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competence. Accordingly, neither the petitioner, the Medical Executive Committee, nor the Governing Body shall be represented by legal counsel. If legal representation is permitted at the hearing, neither party shall be represented by legal counsel if the other party is not so represented. The foregoing shall not be deemed to deprive any part of its right to the assistance of legal council for the purpose of preparing the hearing. If there is no counsel, the petitioner shall be entitled to be accompanied by and represented at such hearings only by a physician, dentist, podiatrist, or clinical psychologist licensed to practice in the State who is not also an attorney-at-law, and who is preferably a member in good standing of the Medical Staff. The Body whose decision prompted the hearing shall appoint a representative from the Medical Staff or from the Governing Body (whichever Body's decision prompted the hearing), who shall present its recommendation, action or decision, and the materials in support thereof, and examine witnesses.

F. MISCELLANEOUS RULES

Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on, in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her position and the Judicial Review Committee may request such a statement be filed following the conclusion of the presentation or oral testimony. The Judicial Review Committee may interrogate the witnesses or call additional witnesses as its discretion.

G. BURDEN OF GOING FORWARD AND BURDEN OF PROOF

The Medical Executive Committee must initially come forward with evidence in support of such decision. Subject to the foregoing, the petitioner shall bear the ultimate burden of persuading the Judicial Review Committee, by the substantial weight of evidence provided at the hearing that the decision of the Medical Executive Committee lacked foundation in fact or was otherwise arbitrary, capricious, or unreasonable.

H. ADJOURNMENT AND CONCLUSION

The hearing may be adjourned and reconvened at the convenience of the participants without special notice. Upon receipt of all oral and written evidence and argument, the hearing shall be closed. The Judicial Review Committee shall thereupon conduct its deliberations and render a decision based on the record produced at the hearing including oral testimony, written statements, and all exhibits entered into evidence.

I. DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within forty-five (45) days after the close of the hearing (provided that in the event the petitioner is currently under summary suspension, this time shall be thirty (30) days), the Judicial Review Committee shall render a written decision which shall contain findings of fact sufficient in detail to indicate the basis for the Judicial Review Committee's decision on each matter contained in the notice of charges. The decision shall be delivered to the Medical Executive Committee, the President of the Medical Staff, the CEO, the Governing Body and, by delivery of registered or certified mail, to the petitioner. The decision of the Judicial Review Committee shall be considered final, subject only to the right of appeal as provided in Section 7.5.

7.5 APPEALS TO THE GOVERNING BODY

A. TIME FOR APPEAL

Within fourteen (14) days after the date of notice of the Judicial Review Committee decision, either the petitioner, or the Body whose decision prompted the hearing, may appeal to the Governing Body. No petitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation. All requests for appeal shall be delivered to the President of the Medical Staff in writing either in person, or by certified mail, return receipt requested, and shall include a statement for the reasons for the appeal. If the appellate review is not requested within the fourteen (14) day period, both sides shall be deemed to have accepted the Judicial Review Committee decision, and it shall become the final recommendation of the Medical Executive Committee. Such final recommendation shall be subject on that basis to final review and decision by the Governing Body.

B. REASONS FOR APPEAL

The reasons for an appeal from the Judicial Review Committee decision shall be: (1) lack of compliance with the procedures required by these Bylaws at the hearing so as to deny the petitioner a fair hearing; (2) the lack of substantive

rationality of a Medical Staff Bylaw, Rule or Regulation relied upon by the Judicial Review Committee in reaching its decision; and/or (3) action taken arbitrarily, unreasonably, or capriciously.

C. TIME, PLACE, AND NOTICE

The Governing Body shall, within thirty (30) days after the receipt of the request for appeal, set a date for the conduct of an appellate review before the Governing Body. The Governing Body shall give both parties notice of the time, place and date of the appellate review. The date of the appellate review shall not be less than fifteen (15) days nor more than ninety (90) days from the date of receipt of the request for appeal, provided, however, that when a request for appellate review is from a petitioner who is under summary suspension then in effect, the appellate review shall be held as soon as arrangements may be made, not to exceed sixty (60) days from the date of receipt of the request for appeal. The time for appellate review may be extended for good cause by the Governing Body, or appeal board (if any).

D. APPEAL BOARD

Whenever an appellate review is requested, the Governing Body may sit as the appeal board or each of them may appoint an appeal board which shall be composed of at least three (3) members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter.

E. APPEAL PROCEDURE

The proceedings on appeal shall be based upon the Judicial Review Committee record. The appeal board may accept additional evidence, subject to a showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence. The appeal board may accept such evidence directly, subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing, or may remand the matter to the Judicial Review Committee for taking of such further evidence. Each party shall have the right to present a written statement in support of his/her position on appeal and, in its sole discretion, the appeal board may allow each part or representative to appear personally and make oral argument. At the conclusion of oral argument, if allowed, the appeal board shall conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. If an appeal board is appointed, the appeal board shall present to the Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee or any other Body or person for further review and decision. If no appeal board is appointed, the procedures outlined in this Subsection shall apply to a hearing before the Governing Body.

F. DECISION BY GOVERNING BODY

Within forty-five (45) days after the conclusion of the appellate review proceedings before the Governing Body, the Governing Body shall render a final

decision in writing. The Governing Body may affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter for further review and recommendation by the Judicial Review Committee or any other Body or person. Any such further review by the Judicial Review Committee or other Body or person shall be conducted within a time frame set by the Governing Body and shall not exceed sixty (60) days unless the parties agree to the contrary. The recommendation based on further review, if any, by the Judicial Review Committee or other Body or person shall be submitted to the Governing Body for a final decision. Notice of the final decision of the Governing Body shall be provided to the petitioner, Medical Executive Committee and the CEO.

ARTICLE 8

ALLIED HEALTH PRACTITIONERS

8.1 QUALIFICATIONS

The Allied Health Practitioners (AHPs) category is defined in Section 2.3 of these Bylaws. AHPs are not eligible for Medical Staff membership. AHPs are eligible to apply to provide complex clinical services while working collaboratively with a Member of the Medical Staff of the Hospital only if they:

- A. Hold a license, certificate, or other legal credential required by State law that authorizes the AHP to provide certain professional health services in a category of AHPs that the Governing Body has identified as eligible to apply to provide complex clinical services upon the recommendation of the Medical Executive Committee;
- B. Document their experience, background, qualifications, appropriate education and training, demonstrated ability, current clinical competence, judgment, and physician and mental health with sufficient adequacy to demonstrate that any patient treated by them would receive care of the generally recognized professional level of quality and;
- C. Efficiency established by the Medical Executive Committee and approved by the Governing Body;
- D. Are determined by the Medical Executive Committee and the Governing Body, on the basis of documented references, to adhere to the lawful ethics of their respective professions, to work cooperatively with Medical Staff members, nurses, Hospital Administrative Staff, and others so as to not adversely affect safe patient care, treatment, and services or Hospital operations, and to be willing to commit to and regularly assist the Medical Staff and the Governing Body in fulfilling their obligations related to safe patient care, treatment, and services within the areas of their professional licensure, credentials and competence; and
- E. Each Allied Health Practitioner member granted complex clinical services in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by, and with an insurance carrier acceptable to, the Medical Executive Committee and the Governing Body.

8.2 DELINEATION OF CATEGORIES OF AHPs ELIGIBLE FOR STANDARDIZED PROCEDURES OR PROTOCOLS

The categories of AHP's, based on occupation or profession, eligible to apply for practice privileges in the Hospital, and the corresponding complex clinical services, prerogatives, terms and conditions for each AHP category, shall be designated by the Governing Body based on the recommendations from the Medical Executive Committee. The Governing Body shall review the designation of categories of AHPs eligible to apply for complex clinical services on the recommendation of the Medical Executive Committee.

8.3 PROCEDURE FOR GRANTING STANDARDIZED PROCEDURES OR PROTOCOLS

An AHP must apply for membership and complex clinical services as outlined in the applicable Allied Health Practitioners policies. Applications for initial membership and granting of complex clinical services shall be submitted and processed in a manner parallel to that provided in Article Three (3) and Four (4) for applicants to the Medical Staff unless otherwise specified in the Rules and Regulations. The Governing Body approval must be obtained as to the granting of complex clinical services to each AHP after review and recommendation by the Medical Executive Committee. An AHP who wishes to apply to a category which is not identified as being approved by the Governing Body must submit a written request to Medical Staff Services asking that the Governing Body consider identifying an additional category of AHPs as eligible to apply for complex clinical services at the Hospital. All requests must be approved by the Medical Executive Committee and Governing Body. Each AHP shall be subject to the supervision or direction of an Appointed Medical Staff member in the appropriate specialty.

8.4 HEARING RIGHTS OF AHPs

Nothing in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the rights for members of the Medical Staff specified in Article Seven (7). Procedure rights and corrective action are outlined in applicable Allied Health Practitioners' policies.

8.5 PREROGATIVES

The prerogatives that may be extended to an AHP shall be defined in the Rules and Regulations and hospital policy and may include:

- A. Provision of specified safe patient care, treatment, and services under the supervision or direction of an Appointed Medical Staff member and consistent with the complex clinical services granted to the AHP and within the scope of the AHP's licensure or certification;
- B. Requirements regarding specific criteria by the supervising medical staff member.
- C. Service on the Medical Staff, and Hospital Committees; and

- D. Attendance at meetings of the Hospital Department to which the AHP is assigned, as permitted by the Rules and Regulations, and attendance at education programs relevant to the AHP's field of practice.

8.6 RESPONSIBILITIES

Each AHP shall:

- A. Meet the responsibilities required by the Rules and Regulations, and those responsibilities specified in these Bylaws and hospital policy as are deemed by the Medical Executive Committee to be applicable to the limited scope of practice on the AHP.
- B. Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services;
- C. Participate, as appropriate, in patient care audits and other quality review, evaluation and monitoring responsibilities required of AHPs, and in discharging such other functions as may be required by the Medical Staff from time to time;
- D. Notify the President of the Medical Staff in writing immediately upon receiving notice of any adverse action by a state licensing agency, another hospital or health care facility, HMO, professional society or law enforcement agency including conviction of a misdemeanor or felony; and the filing or service of any professional liability suit or arbitration proceeding against the AHP; and
- E. Abide by the Bylaws, Rules and Regulations of the Medical Staff and other policies of the Medical Staff and Hospital adopted by the Medical Executive Committee and Governing Body.

ARTICLE 9

CLINICAL ORGANIZATION OF THE MEDICAL STAFF

9.1 RESPONSIBILITIES OF PRESIDENT OF THE MEDICAL STAFF

The President of the Medical Staff will serve as the Chief Officer of the Medical Staff. The President of the Medical Staff will be a member of the Appointed Medical Staff. The responsibilities of the President of the Medical Staff or his/her designee shall include, but are not limited to:

- A. Enforcing the Medical Staff Bylaws, Rules and Regulations, implementing sanctions when indicated, and ensuring compliance with procedural safeguards where corrective action has been warranted;
- B. Developing and implementing methods for Medical Staff Performance Improvement activities within the Hospital, including quality assurance, credentialing and privileging, and utilization management;
- C. Calling and arranging for all meetings of the Medical Staff in conjunction with the CEO;
- D. Calling, chairing, and arranging for all meetings of the Medical Executive Committee in conjunction with the CEO;
- E. Serving as an ex-officio member of all other Medical Staff Committees, without vote unless so designated by the Bylaws of the Medical Staff;

- F. Working collaboratively with Hospital Administration and the Governing Body in all matters of mutual concern with the Hospital;
- G. Appointing members and designating Chairs of all Medical Staff Committees, in conjunction with the CEO, unless otherwise provided for by these Bylaws;
- H. Representing the Medical Staff to the Governing Body outside licensing and accreditation agencies, and the public;
- I. Being a spokesperson for the Medical Staff in external professional and public relations;
- J. Performing such other functions as may be assigned to the President of the Medical Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee.
- K. Serving on liaison committees with the Governing Body, as well as outside licensing or accreditation agencies.

9.2 CLINICAL SERVICES

The Medical Staff of the hospital shall not be organized into clinical services, but rather shall, due to its size and the limited nature of the Hospital, constitute one clinical service.

9.3 MEDICAL DIRECTORS

A. SELECTION

Medical Directors will be Board Certified, or have affirmatively established comparable competence through the credentialing process.

B. RESPONSIBILITIES:

Each Medical Director shall:

1. Determine and manage the clinically related and administrative activities within his/her program.
2. Where Program Rules and Regulations are desired, shall be accountable for the development and implementation of those Rules and Regulations, ensuring that they support the overall Performance Improvement Plan of the Hospital, directly pertaining to professional medical care within their Program. Shall submit such Program Rules and Regulations to the Medical Executive Committee.
3. Develop and implement programs for orientation of new members, credentials review and privileges, delineation for initial appointment and reappointment, continuing medical education, utilization review, concurrent evaluation of practice, and retrospective evaluation of practice;
4. Continuously assess and improve the quality of care, treatment and services, and maintain quality improvement programs as appropriate.
5. Transmit to the appropriate authorities as required in these Bylaws, the Programs' recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action;
6. Recommend the criteria for clinical privileges that are relevant to the care provided in the Program;

7. Assess and recommend to the relevant Hospital authority space issues, resource needs, and off-site sources for needed safe patient care, treatment, and services not provided by the Program or the organization;
8. Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services;
9. Determine the qualifications and competence of personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
10. Maintain continuing surveillance of the professional performance of all members with clinical privileges within the Program with appropriate documentation thereof;
11. Assist in developing and enforcing hospital policies and procedures that guide and support the provision of care, treatment and services; the Medical Staff Bylaws, Rules and Regulations; and the requirements and Rules and Regulations (if any) of the Program;
12. Integrate the Program into the primary functions of the organization;
13. Coordinate and integrate interdepartmental and intradepartmental services;
14. Implement within the Program actions take by the Medical Executive Committee;
15. Perform such other duties commensurate with his/her office as may from time to time be assigned by the President of the Medical Staff, the Medical Executive Committee or the Governing Body;
16. Report to the Medical Staff on all professional and administrative activities within their Program; and
17. Establish such committees, task forces, or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

9.4 MEDICAL STAFF ONGOING PROFESSIONAL PRACTICE EVALUATION

Ongoing professional practice evaluation will be performed in order to allow the organization to identify professional practice trends that impact our quality of care and patient safety. The criteria used in the ongoing professional practice evaluation may include, but is not limited to, the review of clinical procedures performed and their outcomes, pattern of blood and pharmaceutical usage, utilization of tests and procedures, length of stay patterns, morbidity and mortality data, use of consultants, and other relevant criteria as determined by the MEC. Information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussions with other individuals involved in the care of each patient including consulting physicians, nursing, and administrative personnel. Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. These activities adhered to any policies and procedures intended to preserve confidentiality or legal privilege of information established by applicable law. Uncertainty regarding the practitioner's professional performance may require further evaluation through the focused professional practice evaluation. All members of the

Medical Staff will participate in quality assurance and quality improvement activities of the Medical Staff.

ARTICLE 10

ELECTED OFFICERS OF MEDICAL STAFF

10.1 TITLES OF OFFICERS

There shall be a President and Vice President of the Medical Staff. The President and Vice President must be members of the appointed Medical Staff at the time of nomination and election and must remain in good standing during their terms of office.

10.2 TERM OF ELECTED OFFICE

The President and Vice President of the Medical Staff shall each serve two (2) year terms, commencing on the first quarter of the year upon completion of elections.

10.3 NOMINATIONS

- A. The Nominating Committee, which is an ad hoc committee of the Medical Executive Committee, will solicit names of eligible nominees from the Medical Staff. The Nominating Committee will then review the list of nominees, determine whether they are eligible to hold a Medical Staff Office and are willing to do so, and then submit a list of nominees to the Medical Executive Committee.
- B. The Medical Executive Committee, after receiving nominations from the Nominating Committee, shall submit to the eligible voting members of the Medical Staff a list of qualified nominees for the office of President and Vice President of the Medical Staff.

10.4 ELECTION

The President and Vice President of the Medical Staff shall be elected by a plurality vote of the eligible voting members of the Medical Staff voting in an election. All elections shall be held in accordance with the applicable Medical Staff policy.

10.5 RESPONSIBILITIES OF ELECTED MEDICAL STAFF OFFICERS

A. PRESIDENT OF THE MEDICAL STAFF

In addition to his/her clinical duties set forth in Section 9.1 the President shall serve as the representative of the Medical Staff. As such, the President shall:

- 1. Communicate and represent the opinions, needs, and grievances of the Medical Staff to the Medical Executive Committee, the CEO and the Governing Body;
- 2. Preside at, and be responsible together with the CEO for, the agenda of all regular and special meetings of the Medical Staff;
- 3. Serve as a voting member and Chair of the Medical Executive Committee;
- 4. Participate in any Hospital deliberations affecting the discharge of Medical Staff responsibilities; and

B. VICE PRESIDENT OF THE MEDICAL STAFF

1. Communicate and represent the opinions, needs, and grievances of the Medical Staff to the Medical Executive Committee, the CEO and the Governing Body;
2. Serve as a voting member of the Medical Executive Committee.

10.6 REMOVAL OF THE PRESIDENT OR VICE PRESIDENT

- A. The President or Vice President may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude.
- B. The President or Vice President of the Medical Staff may be removed from the office when:
 1. A petition setting forth the deficiencies in performance of duties as President or Vice President and calling for a vote on removal signed by at least ten percent (10%) of the eligible voting members of the Medical Staff is presented to the President of the Medical Staff and;
 2. Two-thirds (2/3) of the eligible voting members of the Medical Staff responding to the official request for a vote, vote for the officer's removal.

10.7 VACANCIES IN OFFICE

- A. If the President of the Medical Staff is temporarily unable to fulfill the responsibilities of the office, the Vice President shall assume these responsibilities until the President is able to resume those duties.
- B. If, for any reason, the President of the Medical Staff is unable to complete the elected term of office, the Vice President of the Medical Staff shall assume the office of President of the Medical Staff.
- C. A new Medical Staff election shall be held for Vice President in accordance with Sections 10.3 and 10.4.
- D. If, for any reason, the Vice President of the Medical Staff is unable to complete the elected term of office, a new Medical Staff election shall be held in accordance with Sections 10.3 and 10.4.
- E. The elections shall be conducted in accordance with applicable policies, if any.

ARTICLE 11
MEDICAL EXECUTIVE COMMITTEE

11.1 RESPONSIBILITIES

The Medical Executive Committee is a committee of the Medical Staff which serves as the Staff's Executive Committee and is, save for the adoption or amendment of bylaws, empowered to act for the Medical Staff in the intervals between Medical Staff meetings. Modification or removal of this responsibility may be approved by the Medical Staff, subject to the approval of the Governing Body.

- A. In addition to such other responsibilities as are set forth in these Bylaws, the Medical Executive Committee shall:

1. Receive and act upon reports and recommendations from the Medical Staff Committees and ad hoc committees.
2. Receive and act upon all quality and utilization management monitoring reports including infection control; medical records; and case management.
3. Subject to the authority of the Medical Staff, determine all professional medical policies of the Hospital.
4. With the President of the Medical Staff, set objectives for establishing, maintaining, and enforcing professional standards within the Hospital, for the continuing improvement of the quality of the care rendered in the Hospital, and assisting in developing programs to achieve these objectives.
5. Recommend to the Governing Body all matters relating to Medical Staff structure, mechanisms used to review credentials and to delineate clinical privileges for appointments and reappointments, recommend individuals for Medical Staff membership and clinical privileges, and recommend mechanisms for termination and corrective action when appropriate.
6. Request evaluations of practitioners privileged through the Medical Staff credentialing process in instances where there is doubt about an applicant's ability to perform the privileges requested.
7. Recommend to the Governing Body matters regarding the structure of the Medical Staff; and to advise on sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.
8. Be responsible for creating the appropriate Medical Staff Committee structure to carry out the necessary duties.
9. Be accountable to the Governing Body for the quality of medical care, and for the organization of performance improvement activities of the Medical Staff including the mechanism used to conduct, evaluate, and revise such activities, and reporting of outcomes of Medical Staff performance improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards.
10. Take reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted.
11. Assist in obtaining and maintenance of accreditation.
12. Inform the Medical Staff regarding the status of accreditation and licensure of the Hospital.
13. Develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster.
14. Determine annual dues, if any, for each category of Medical Staff membership.
15. Determine a processing fee, if any, to be charged to any applicant for Medical Staff membership.

16. Recommend the mechanism for corrective action and fair hearing procedures.
17. Establish a mechanism for dispute resolution between Medical Staff members involving the care of the patient.
18. Recommend to the Governing Body minimum requirements for malpractice insurance coverage for members of the Medical Staff.
19. In that the Medical Staff is small and the Hospital provides limited services, it shall perform directly the duties usually performed by Credentials, Safety, Ethics, Pharmacy, Health Information, Infection Control, Utilization Review and QA/QI committees.

B. REPORT OF MEDICAL EXECUTIVE COMMITTEE

The Medical Staff will be apprised of the activities and decisions of the Medical Executive Committee at the regular Medical Staff meetings. In the event a majority of the appointed Medical Staff members, present at a meeting at which there is a quorum, object to a specific determination, and call for a vote, the Medical Executive Committee's action shall thereafter be submitted to the entire voting membership of the Medical Staff for a vote of ratification or repeal.

11.2 RULES AND REGULATIONS

Subject to the approval of the Governing Body, the Medical Executive Committee shall adopt such Rules and Regulations of the Medical Staff, directly pertaining to professional medical care, as it considers appropriate and in furtherance of its responsibilities.

11.3 COMPOSITION

A. VOTING MEMBERSHIP

The voting membership of the Medical Executive Committee shall consist of the President of the Medical Staff, who shall serve as the Medical Executive Committee's Chairperson, the Vice President of the Medical Staff and the elected members. The CEO, CFO and Nurse Executive shall be ex-officio, non-voting members of the Medical Executive Committee. All physician members of the Medical Executive Committee must be appointed members of the Medical Staff in good standing, and be Board Certified (or equivalent).

B. ELECTED MEMBERSHIP

The procedure for electing at a minimum of two (2) and a maximum of five (5) members-at-large from the Medical Staff to serve on the Medical Executive Committee shall be as follows:

1. Nominations

- a. The Nominating Committee will solicit names of eligible nominees from the Medical Staff. The Nominating Committee will then review the list of nominees, determine whether they are eligible to serve on the Medical Executive Committee and are willing to do so, and then submit a list of nominees to the Medical Executive Committee.
- b. The Medical Executive Committee, after receiving recommendations from the Nominating Committee, shall submit to the Medical Staff a

list of qualified nominees for the elected positions on the Medical Executive Committee.

2. Election

The elected members-at-large shall be those individuals receiving the highest number of votes of the eligible voting members of the Medical Staff voting in the election. All elections shall be held in accordance with applicable policies.

3. The elected members-at-large shall each serve two (2) year terms. They may be re-elected.

C. MEMBERS NOT ELECTED

1. The Medical Director will serve as a voting member of the Medical Executive Committee regardless of other position elected by the Medical Staff.
2. Should the Medical Director be elected to President, Vice President, or a member-at-large position, he/she will only have a single vote.
3. The Medical Director must be an appointed member of the Medical Staff in good standing, and be Board Certified (or equivalent).
4. The Medical Director will serve as the member that provides communication between the Medical Staff and Governing Body.

D. REMOVE FROM OFFICE

1. A member-at-large of the Medical Executive Committee may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude.
2. Elected members-at-large of the Medical Executive Committee may be removed from office when:
 - a. A petition calling for a vote on removal signed by at least seventy-five percent (75%) of the eligible voting members of the Medical Staff is presented to the President of the Medical Staff; and
 - b. Two-thirds (2/3) of the eligible voting members of the Medical Staff responding to the official request for a vote, vote for an elected member's removal.

E. VACANCIES IN OFFICE

If an elected member-at-large of the Medical Executive Committee is unable to complete the elected term of office, the President of the Medical Staff and the Medical Director shall jointly appoint a replacement to fill out the unexpired term.

F. QUORUM

Fifty percent (50%) of the voting membership (but no less than three [3]) of the Board shall be considered a quorum.

G. MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action may be taken by a majority of the voting members present at a meeting at which a quorum is present; and a meeting at which a quorum is initially present may take action

notwithstanding the withdrawal of members, if any action is approved by at least a majority of the required quorum for such a meeting.

H. MEETINGS

Meetings of the Medical Executive Committee shall be held quarterly or more often whenever required by the President of the Medical Staff or state law.

ARTICLE 12
COMMITTEES OF THE MEDICAL STAFF

12.1 APPOINTMENT TO MEDICAL STAFF COMMITTEES

- A. Appointment and/or reappointment of members to Committees of the Medical Staff and designation of Chairpersons of each such committee shall be made by the President of the Medical Staff, in consultation with the CEO. Committee members may be removed by a two-thirds (2/3) vote of the Medical Executive Committee. The President of the Medical Staff shall be a non-voting ex-officio member of all committees, unless otherwise indicated.
- B. Unless otherwise stated, Committees shall include a broad representation of the Medical Staff; however, committees shall consist of an appropriate number of individuals to be of an effective, yet manageable, size. Medical Staff members have a duty to actively participate in Staff Committees under Section 3.3.
- C. Each Committee may, with the approval of the President of the Medical Staff in consultation with the CEO, form subcommittees, task forces, or ad hoc committees as appropriate to carry out the charge of the Committee. All such groups shall be considered committees of this Medical Staff.
- D. Membership on Medical Staff Committees shall be for a period of three (3) years and may be renewable.

12.2 DUTIES GENERALLY

- A. All Committees appointed under this Article shall report and make recommendations to the Medical Executive Committee as outlined under each individual committee in Section 12.5.
- B. Each Committee shall keep a record of the minutes of each of its meetings, including an attendance roster. A copy of the minutes, approved by the membership and signed by the Committee Chairman, shall be submitted to the President of the Medical Staff and will be kept on file.
- C. **FREQUENCY OF MEETINGS:**
Unless otherwise stated, meetings of all Committees shall be held at least semiannually, but more often whenever required by the President of the Medical Staff.

12.3 SPECIAL COMMITTEES

Special committees (sometimes called ad hoc committees) shall be established by the President of the Medical Staff in consultation with the CEO, as needed, and members shall retain their appointments until discharged by the President of the Medical Staff.

12.4 QUORUM

Thirty percent (30%) of the voting membership (but no less than three [3]) of the Committee shall be considered a quorum.

12.5 MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting at a committee meeting at which a quorum is present shall be the action of the group. A committee meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such a meeting, or such greater number as may be specifically required in these Bylaws.

12.6 MEDICAL STAFF STANDING COMMITTEES

The Medical Executive Committee may establish standing committees. In the absence of Standing Committees, the Medical Executive Committee shall perform directly those functions typically assigned to a committee. Upon establishment of a Standing Committee, the Medical Executive Committee shall define the purpose, duties, composition, meeting frequency, and reporting frequency of the Committee.

ARTICLE 13 **MEETINGS**

13.1 MEETINGS OF THE MEDICAL STAFF

A. REGULAR MEETINGS

Regular meetings of the Medical Staff shall be held at least annually as recommended by the President of the Medical Staff. Members of the Medical Staff shall be encouraged, but not required, to attend these meetings.

B. SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Medical Executive Committee or President of the Medical Staff. The President of the Medical Staff must call a special meeting of the Medical Staff whenever he/she is presented with a written request for such a meeting, signed by at least five (5) members of the Medical Staff. No business shall be transacted at any special meeting except that stated in the meeting notice.

C. NOTICE

Notice of the date, time, and place of the Medical Staff meetings shall be sent to each member at the member's last known business address, or electronically, at least two (2) weeks prior to the scheduled date of the meeting.

D. QUORUM

The presence of ten percent (10%) of the voting members of the Medical Staff at any regular or special meeting shall constitute a quorum.

E. VOTING

Only members of the Medical staff with voting privileges as outlined in Article Three (3) shall be eligible to vote at meetings of the Medical Staff.

13.2 MINUTES

Minutes shall be kept of all meetings of the Medical Staff and the Medical Executive Committee, and shall be filed with the President of the Medical Staff.

13.3 ATTENDANCE REQUIREMENTS

To foster quality professional interaction and awareness of items of general interest to the Medical Staff, as well as applicable standards and policies, each Staff member:

- A. Shall be required to attend meetings of each committee of which he/she is a member.
- B. Shall be encouraged, but not required, to attend meetings of the Medical Staff.

ARTICLE 14 **CONFIDENTIALITY AND IMMUNITIES**

14.1 CONFIDENTIALITY OF INFORMATION

A. CONFIDENTIALITY OF INFORMATION: GENERAL

Medical Staff and Medical Staff Committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, in authorized conduct of Medical Staff proceedings, pursuant to officially adopted policies of the Medical Staff, including the authorization of representatives of the Hospital and the Medical Staff to solicit and provide information bearing upon a physician's, dentist's, podiatrist's, clinical psychologist's, or Allied Health Professional's ability and qualifications; or by express approval of the Medical Executive Committee.

B. BREACH OF CONFIDENTIALITY

Effective professional practice evaluation, the consideration of the qualifications of Medical Staff members and applicants to perform specific procedures, and the evaluation and improvement of the quality of care rendered in the Hospital must be based on free and candid discussions. Any breach of confidentiality of the records, discussions, or deliberations of the Medical Staff or Committees is considered outside appropriate standards of conduct for this Medical Staff, disruptive to the operations of the Hospital, and detrimental to quality patient care, treatment, and services. Further, all patient care, treatment, and service records and related activities shall be kept confidential and not be disclosed inappropriately by any member of the Medical Staff. Any such breach of confidentiality shall be a basis for corrective action under Article Seven (7) of these Bylaws.

14.2 ACTIVITIES AND INFORMATION COVERED

The confidentiality described in this Article shall apply to all acts, communications, reports, or disclosures undertaken in connection with this or any other health care facility's or organization's activities.

14.3 IMMUNITY FROM LIABILITY FOR ACTIONS TAKEN AND INFORMATION PROVIDED

Each representative of the Medical Staff and/or the Hospital acting pursuant to these Bylaws shall be exempt, to the fullest extent permitted by law, from liability to an applicant or Medical Staff member for damages or other relief for any action taken, or statements or recommendations made within the scope of his/her duties, or for providing information concerning any person who is or has been an applicant to or member of the Staff, or who did or does, exercise clinical privileges or provide serves at the Hospital.

14.4 INDEMNITY AND DEFENSE

The Hospital shall indemnify and defend Medical Staff members for their good faith participation in professional practice performance evaluation activities within the scope of their duties pursuant to these Bylaws.

ARTICLE 15 **ORGANIZED HEALTH CARE ARRANGEMENTS**

The Hospital, together with all members of the Medical Staff, Allied Health Practitioners and non-physician health care providers that provide clinical services at the Hospital (collectively, for the purposes of this Article Fourteen (14) only, "Hospital Staff"), constitutes an Organized Health Care Arrangement ("OHCA") under the HIPAA Privacy Regulations. Accordingly, the Hospital and Medical Staff will issue a joint notice of privacy practices, as permitted under the HIPAA Privacy Regulations, and each member of the Hospital Staff will abide by the terms of this joint notice with respect to Protected Health Information he or she may receive in connection with his or her participation in professional activities of the OHCA. The Hospital and hospital staff may share Protected Health Information with each other, as necessary to carry out treatment, payment, or health care operations functions relating to the OHCA.

ARTICLE 16 **GENERAL PROVISIONS**

16.1 ACCEPTANCE OF PRINCIPLES

All members of any class or category, by application for membership in this Medical Staff, do hereby agree to be bound by the provisions of these bylaws, a copy of which shall be given in a timely fashion to each member on initial application, and a copy of each amendment thereto promptly after adoption. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or the Governing Body shall direct.

16.2 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall

be in writing and shall be delivered personally or by the United States Postal Services. In the case of notice to the Governing Body, Medical Staff, or officers of committees thereof, the notice shall be addressed as follows:

Elkhorn Valley Rehabilitation Hospital
5715 E. 2nd Street
Casper, Wyoming, 82609

In the case of a notice by the Hospital or Medical Executive Committee to an applicant, Medical Staff member, or other party, the notice shall be addressed to the business address as it appears in the records of Medical Staff Office at the Hospital. If personally delivered, such notice shall be effective upon delivery to the person or to such address, and if mailed as provided for above, such notice shall be effective three (3) days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner set forth.

16.3 PROFESSIONAL LIABILITY INSURANCE

A. PROFESSIONAL LIABILITY INSURANCE

Each member granted staff membership or privileges at the Hospital shall maintain in force professional liability insurance in a form of coverage and in not less than the minimum amounts, if any, as from time to time may be determined by the Governing Body on the recommendation of the Medical Executive Committee, or shall provide other proof of financial responsibility in such manner as the Governing Body may from time to time establish.

B. DISPOSITION AND/OR FINAL JUDGMENT

Each member of the Medical Staff shall report to the Medical Staff Office the filing or service of any professional liability suit against the member, the disposition (including settlement), and/or final judgment in professional liability cases in which they are involved within thirty (30) days of disposition and/or final judgment.

16.4 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff Offices, leadership positions, Medical Staff or Hospital Committees, or the Medical Executive Committee shall, at least ten (10) days prior to the date of appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff, as outlined in applicable policies. At the time they assume the office, leadership position, or committee membership, and on an annual basis thereafter, practitioners in these positions will be required to sign a Conflict of Interest and Confidentiality statement.

ARTICLE 17
AMENDMENT OF BYLAWS AND RULES AND REGULATIONS
OF THE MEDICAL STAFF

17.1 BYLAWS

The Bylaws shall be reviewed periodically and amended to reflect the Hospital's current practices with respect to the Medical Staff organization and functions. Suggested changes in the Bylaws of the Medical Staff shall be submitted to the President of the Medical Staff. The Medical Staff Bylaws will be reviewed by a special committee of the Medical Staff in accordance with the requirements of appropriate regulatory or licensing bodies. The Bylaws may be amended by the affirmative vote of the majority of the Medical Executive Committee members present at a meeting at which there is a quorum, or by majority affirmative vote taken by dissemination to all Medical Staff members where at least the number of responses constituting a quorum of the Staff is received. Amendments approved by the Medical Staff shall become effective when approved by the Governing Body, which approval shall not be withheld unreasonably. The Bylaws may not be unilaterally amended by the Medical Staff, Medical Staff Officers, Medical Executive Committee, or the Governing Body, or in a manner that is inconsistent with the Hospital Corporate Bylaws. In the event of any inconsistencies, the Corporate Bylaws shall govern. The Medical Executive Committee is authorized to act on behalf of the Medical Staff regarding amendments to the Bylaws which may be necessary to meet state or federal requirements, or are merely clerical in nature.

17.2 ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

- A. All Medical Staff Rules and Regulations that are in effect immediately preceding the adoption of these Bylaws and that are not inconsistent with these Bylaws shall be considered as Rules and Regulations adopted in accordance with these Bylaws and shall continue in effect until amended pursuant to these Bylaws.
- B. Medical Staff Rules and Regulations may be amended on by the affirmative vote of majority of the Medical Executive Committee members who are present at a meeting at which a quorum is present, subject to the approval of the Governing Body.
- C. The Rules and Regulations may not be unilaterally amended by the Medical Staff, Medical Staff Officers, Medical Executive Committee, or the Governing Body, or in a manner that is inconsistent with the Hospital Corporate Bylaws.
- D. An amendment by means of Section 17.2.B may be repealed by the Medical Staff in accordance with Section 17.1 provided a ballot is called for in accordance with that Section at or before the next regular meeting of the Medical Staff following the adoption of the amendment in question. Such a request for amendment must be initiated by a ten (10) member vote of the appointed Medical Staff.

17.3 ADOPTION AND AMENDMENT OF HOSPITAL POLICIES

- A. All Hospital policies that are in effect immediately preceding the adoption of these Bylaws and that are not inconsistent with these Bylaws shall be considered as

policies adopted in accordance with these Bylaws and shall continue in effect until amended pursuant to these Bylaws.

- B. Hospital policies may be amended on by the affirmative vote of majority of the Medical Executive Committee members who are present at a meeting at which a quorum is present, subject to the approval of the Governing Body.
- C. Hospital policies may not be unilaterally amended by the Medical Staff, Medical Staff Officers, Medical Executive Committee, or the Governing Body, or in a manner that is inconsistent with the Hospital Corporate Bylaws.

17.4 PROVISION OF TEXT

When significant changes are made to the Medical Staff Bylaws Rules and Regulations, or policies, the Medical Staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials.

ARTICLE 18 **ADOPTION**

These Bylaws, when adopted by the Medical Executive Committee shall replace all previous Bylaws of the Medical Staff and shall become effective within thirty (30) days of approval by the Governing Body, pending notification to all Medical Staff.

MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff is responsible to the Governing Body for the professional medical care performed at the Hospital and the quality of medical care rendered. In accordance with the Bylaws of the Medical Staff, the following Rules and Regulations pertaining to professional care are hereby adopted. Individual Clinical Programs may adopt Program specific Rules that govern both practice in the Service and the professional medical care to be rendered by members of the Service. These documents are complementary.

1. PATIENT TYPES AND ADMISSION OF PATIENTS

A. Description

The Hospital is an acute rehabilitation hospital that responds to the medical needs of those patients who present themselves for rehabilitative care. In addition, the Hospital manages outpatient services. The Hospital shall accept for care patients suffering from rehabilitation and related types of disease dependent upon facilities, personnel, and licensure.

B. Definitions

Patient encounters at the Hospital fall into two general categories:
Inpatient and Outpatient.

1). Inpatient: An inpatient is a person who has been admitted to the hospital for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted to a licensed inpatient bed with the expectation of remaining overnight, even if it later develops that the patient can be discharged before midnight.

2).Outpatient: A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services from the hospital.

C. Admission Criteria

Inpatients may be admitted to the Hospital by a qualified member of the Medical Staff who has been granted the privilege to admit patients to the Hospital in accordance with the State law and criteria for standards of medical care established by the Medical Staff. All patients shall be under the direct care or supervision of a member of the Medical Staff.

- 1). No patient shall be admitted to the Hospital without a recorded diagnosis.
- 2). It shall be the responsibility of the Medical Staff member to report all cases of reportable diseases in accordance with the regulations of the State.

Outpatients may be accepted for outpatient hospital registration when referred by a licensed practitioner as permitted by State law:

- 1). No patient shall be registered to the Hospital without a recorded diagnosis.
- 2). No patient shall be registered to the Hospital as an outpatient without a valid prescription.

D. Admission of Patients

Only those members authorized in accordance with the Bylaws of the Medical Staff may admit inpatients to the Hospital. The patient's Attending Physician shall execute, or cause to be executed, all physician responsibilities as to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures that governs admitting and discharging of patients from the Hospital.

At the time of admission, the admitting Medical Staff member shall provide relevant information to nursing management, security services and/or other appropriate personnel, to ensure a safe environment. This information will be shared with the intent to protect the patient from self-harm as well as protect other patients, staff and visitors from sources of danger.

2. MEDICAL RECORDS

A. Definitions:

A medical record shall consist of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Medical Records Department. The information contained therein, and any other patient specific information, shall be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access

Access to confidential materials by members of the Medical and other staffs of the Hospital, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in focused professional practice evaluation or ongoing professional practice evaluation, risk management, Medical Staff credentialing, educational pursuit, or some other

appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored.

C. Required Medical Record Documentation

Elements required in an inpatient medical record include identification data; appropriate comprehensive history and physical examination; consultations; post procedure note; progress note for each visit; discharge summary; autopsy report; and other pertinent information such as Patient Advance Directives.

Elements required in an outpatient medical record include identification data; valid prescription; and other pertinent information such as Patient Advance Directives. If a physician sees a patient in the outpatient setting, a progress note will be completed for each visit.

The Medical Staff are responsible for completing the medical record within thirty (30) days.

D. Documentation Rules

- 1). Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted and prohibited abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record shall be as stated in the Hospital's Policies and Procedures governing medical records.
- 2). Entries must be legible, authenticated with signature, date and time by the individual making the entry.
- 3). The attending physician shall be responsible for the timely preparation and completion of the patient Medical Record. Medical Record entries must be authenticated within a time frame as required by State and Federal regulations following the patient's discharge.
- 4). Symbols and abbreviations may not be used on the face sheet or in the final diagnosis, but may be used within the medical record when approved by the Medical Staff.
- 5). A medical practitioner progress note should be completed for each visit or consult documented within 24 hours of the visit.
- 6). All documentation must conform with the Centers for Medicare and Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management Services (regardless of payer).
Inpatient documentation must include:
 - a. Chief complaint and reason for admission
 - b. History of present illness
 - c. Review of systems and pain evaluation
 - d. Past family and social history
 - e. Physical examination

- f. Assessment and plan
- Outpatient/specialty clinic documentation for registration must include:
- a. Valid prescription for services
 - b. Certification and Re-certification of services
- 7). A focused medical assessment must be done prior to or at the time of any procedure that requires sedation including
 - a. Presenting diagnosis/condition
 - b. Description of symptoms
 - c. Significant past medical history
 - d. Current medications
 - e. Any drug allergies
 - f. Indications for the procedure
 - g. Focused physical exam as indicated
 - h. Proposed treatment or procedures
 - 8). Orders:
 - a. Orders for ancillary and diagnostic services must include the diagnosis and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service / treatment.
 - b. An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted and **not** permitted in, medication orders, both generally and for specific types of medications.
 - c. For treatment orders, provide explanation as appropriate.
 - 9). Documentation of phone consultations should be included in the legal medical record.
 - 10). All clinical e-mail correspondence with patients must be maintained with the legal, medical record. This should include the patient's initial question and the clinical response.
 - 11). Education and instructions provided to the patient and family should be documented in the record.

3. CONSENT AND DISCLOSURE

A. Informed Consent

No care or treatment shall be rendered to any patient in the Hospital, without a written consent signed by the patient. In those situations in which the patient's life is in jeopardy and consent cannot be obtained, the Physician proposing the care or treatment to the patient shall follow Hospital policies and procedures in either proceeding with the treatment or obtaining consent from the appropriate surrogate decision-maker. Except in an emergency, as above, proper informed consent is a prerequisite to any procedure or treatment for which it is appropriate, including transfusions and the use of blood products. The information provided

shall include the specific procedure or treatment, or both, the reasonably foreseeable risks, and reasonable alternatives for care and treatment.

B. Disclosure of Unanticipated Outcomes and Medical Errors

Definitions:

An Adverse Event is a negative result from a diagnostic test, defect, failure and/or error within the healthcare system, medical treatment or surgical intervention.

An Unanticipated Outcome is a result that differs significantly from what was anticipated to be the result of a treatment or procedure.

Disclosure

The attending physician responsible for the patient's care, or his/her designee as appointed by the President of the Medical Staff, shall serve as the primary communicator of an unanticipated outcome or adverse event to the patient and/or family/legal guardian person designated as the primary communicator with the patient/family. The attending physician or credentialed designee shall document in the progress notes of the patient's medical record what was communicated to the patient/family and any response or other discussion.

4. ASSESSMENT (TYPES AND SERVICE)

A. Definitions

- 1) A History and Physical (H&P) will be completed for all inpatients admitted to the hospital. The H&P will conform to the following requirements to ensure quality of care and comply with Joint Commission, CMS and State regulations:
 - a. An H&P that is greater than thirty (30) days old is invalid.
 - b. If a medical H&P exam has been done within thirty (30) days of inpatient admission, it must be updated with an interval note within 24 hours of admission, noting any changes in the patient's condition. If no changes have occurred, the absence of change must be documented.
 - c. If the medical H&P has been done within thirty (30) days of the inpatient admission, it may be completed by another licensed independent practitioner that does not have privileges at the hospital.
- 2) An interval H&P will be completed within 24 hours of admission for all cases in which the H&P contained in the medical record is older than 24 hours. The interval H&P will contain an update to the patient's current medical history that may have changed since the original H&P or to address any areas where more current data is available. The patient's medical record will also reflect an update to the physical examination. The interval H&P must contain either the changes in medical history or physical exam, or a statement indicating that no changes have occurred.
- 3) A rehabilitation physician must complete an assessment/consult within 24 hours of admission.
- 4) An H&P is not required for those patients seen in the outpatient setting. If an appointed physician performs a procedure on an outpatient, an H&P is required.

B. Complete H&P:

A complete H&P has the following components:

History, physical examination, assessment, and treatment plan as indicated:

- a. History includes:
 - (1) Presenting diagnosis/condition (chief complaint/reason for visit)
 - (2) Description of symptoms
 - (3) Significant past medical & surgical history
 - (4) Current medications
 - (5) Any drug allergies
 - (6) Psychosocial status
 - (7) Review of systems
 - (8) Significant family history
- b. Physical examination (should include as appropriate an examination of body areas/organ systems):
 - (1) Vital signs
 - (2) Cardiovascular system
 - (3) Respiratory systems
 - (4) Neurological system
 - (5) Gastrointestinal system
 - (6) Eye
 - (7) Ear, Nose and Throat (ENT)
 - (8) Genitourinary system
 - (9) Musculoskeletal
 - (10) Skin
 - (11) Psychiatric
 - (12) Hematologic/lymphatic/immunologic
- c. Assessment
- d. Functional Status
- e. Treatment Plan

5. PLANNING CARE, TREATMENT AND SERVICES

A. Orders

All orders for treatment must be in writing, dated and timed, and signed by the issuing Orders written by other than a member of the Medical Staff or duly licensed member of the house staff must be cosigned by the supervising physician prior to implementation.

B. Verbal/Telephone Orders

Verbal/telephone orders shall be issued by a member of the Medical Staff to licensed nursing personnel, and registered pharmacists. Verbal/telephone orders appropriate to their discipline may be given to any licensed physical therapist, occupational therapist, speech language pathologist, respiratory therapist, or

dietician. Verbal/telephone orders shall be issued only if the circumstances are such that an immediate order is required and it would be impractical for the prescriber issuing the order to do so in writing.

- 1). Verbal/telephone orders are appropriate in the following situations:
 - a. Emergency;
 - b. If person placing the order is physically unavailable;
 - c. If the physician/clinician is performing a procedure;
 - d. Prescribers shall remain on the telephone to allow the receiver of the order to write out the complete order and then for the receiver to read it back to the prescriber.
- 2). Verbal/telephone orders must be signed within a designated time frame as specified by state regulations and hospital policy by the prescribing practitioner or by attending or covering physician on an infrequent basis.

C. Responsible Providers

Patients must receive the name of the physician or other practitioner primarily responsible for their care, treatment, and services, and the name of the physician or other practitioner responsible for performing any procedures.

6. MEDICATIONS

An order for medication must comply with the Medical Staff approved medication policies and procedures which govern the content of, abbreviations and nomenclature permitted in, medication orders, both generally and for specific types of medications.

A. Complete medication orders shall include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescriber. There is a documented diagnosis, condition or indication for each medication ordered.

B. Medications brought by or with the patient to the hospital shall not be administered to the patient unless all of the following conditions are met:

- 1) The drugs have been specifically ordered by the patient's licensed physician or AHP and the order entered in the patient's medical record. The order must include the drug name, dosage, frequency, and route.
- 2) The drugs have been positively identified and examined for lack of deterioration by the pharmacist or physician and have been re-labeled, if necessary, by the pharmacist to provide adequate identification for those responsible for administering the drug.

C. Inpatient drugs used shall be only those listed in the hospital Drug Formulary with the exception of:

- (1) those obtained by the Non-Formulary Drug Procedure;
- (2) those employed for purposes of direct therapeutic benefit to a particular patient in an emergency, when approved by the President of the Medical Staff or designee. Investigational drugs shall be used in accordance with applicable State and Federal laws and regulations as well as applicable policies.

D. Medication ordering and administration must comply with all applicable policies such as using patient specific information, monitoring the effects of the medications, not using unapproved abbreviations, etc.

E. The ordering practitioner is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

7. PROVIDING CARE, TREATMENT AND SERVICES

A. Daily Care of Patients

A hospitalized patient must be seen by the attending physician, or appropriate covering physician, and/or allied health practitioner daily at least five (5) times per week. A rehabilitation physician must see the patient a minimum of three (3) times per week. A progress note shall be written on each patient for each visit in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status at the time of observation. This note will be completed or dictated on the day of the visit or will be indicated as a late entry in the medical record.

B. Consultations

It is the responsibility of the Medical Staff through the Medical Director to see that members obtain consultations when appropriate. A consultation for a medical staff member with rehabilitation privileges is required upon admission if the admitting physician is not privileged as such. A consultation is obligatory in the event that the patient requires a scope of care that is outside the expertise and/or clinical privileges of the attending practitioner, when the diagnosis is unknown or unclear after ordinary diagnostic procedures have been performed, in unusual complex situations when the skills of another specialist is required, or if there is some uncertainty as to the appropriate course of treatment for a given patient. Consultations shall show evidence in the Medical Record of the consultant's review of the patient's record, his/her pertinent findings on the examination of the patient, and the consultant's opinion and recommendations. In case of emergencies, a nurse is authorized to seek appropriate medical consultation if the responsible attending physician is not immediately available and the patient's condition is expected to decline.

8. COORDINATING CARE AND TREATMENT

A. Discharge

1). Patients shall be discharged only under the direction of the responsible physician. This discharge order may be written by the physician's supervised allied health practitioner. It is the responsibility of the attending physician to plan discharge in a timely and coordinated fashion. The responsible practitioner shall be obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For patients that have been in the hospital for a period more than 48 hours, a discharge summary is required. For patients with a stay less than 48 hours, a discharge note is sufficient. All inpatient deaths shall have a discharge summary regardless of length of stay. The discharge summary must be completed by the discharging

practitioner within thirty (30) days of discharge.

2) Should a patient leave the hospital against medical advice, this shall be documented in the patient's medical record and the patient should be requested to sign the appropriate release form.

3) Discharge Summary

a. The content of the discharge summary should be consistent with the rest of the record and include:

- (1) Admitting date and reason for hospitalization.
- (2) Discharge date.
- (3) Final diagnoses.
- (4) Succinct summary of significant findings, treatment provided and patient outcome.
- (5) Documentation of all procedures performed during current hospitalization and complications (if any).
- (6) Condition of patient upon discharge and to where the patient is discharged.
- (7) Discharge medication, follow-up plan, and specific instructions given to the patient and / or family, particularly in relation to activity, diet, medication, and rehabilitation potential.

B. Patient Death

Should a patient expire, the Medical Staff will follow hospital policy regarding "Death of a Patient".

9. RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS

A. Autopsy

The Medical Staff will follow hospital policy regarding the autopsy process.

B. Suicidal Patient

For the protection of patients, the Medical Staff, Nursing Staff, and the hospital, the following standards are to be met in the care of the patient who is determined to be potentially suicidal:

- 1) Psychiatric consultation shall be obtained as soon as possible after a patient has threatened suicide or made a suicide attempt.
- 2) Prior to the consultation, the physician in charge of the care should evaluate the type of immediate care the patient requires and write the appropriate orders (for transfer).
- 3) Any patient that is suspected of being suicidal should be considered for transfer to a psychiatric unit in another facility.
- 4) Should a transfer not be immediately possible, the physician should consider ordering one to one observations until such time that a transfer is possible.

C. Restraints

A restraint can only be used if needed to improve the patient's well-being or to protect the safety of other patients or others and less restrictive interventions have been determine to be ineffective. A Licensed Independent Practitioner may order restraints. Seclusion may not be ordered. The order for restraint must

comply with the medical staff approved Hospital policy on restraints. Hospital policy shall specify the time within which an order must be obtained after each use of restraint and the maximum time for the use of either intervention. PRN orders are not allowed.

D. Organ and Tissue Donation

Members of the Medical Staff are expected to follow the Hospital Protocol for identifying Potential Organ and Tissue Donors. The Protocol provides that any deceased patient's next of kin or other legally-authorized individual shall, at or near the time of notification of death, be asked whether the deceased was an organ donor or if the family is a donor family.

E. Disaster/Emergency Situations

The responsibilities of the person granted privileges are limited to his/her legal authority to act within their license and specialty to provide care during a disaster period. Instruction regarding this limitation will be provided by the CEO or designee. A list will be maintained by the nursing manager as to the person being granted disaster privileges, a copy of their drivers license or available a copy of their license to practice issued by a state, federal or regulatory agency, current picture ID, identification through a written document signed by the CEO or designee that emergency privileges have been granted. At least one member of either the Hospital staff and/or Medical Staff must verify the knowledge that the Practitioner being granted privileges is in fact familiar to them and is eligible to practice in the professional status presented. The practitioner being granted privileges will report to the Medical Director or a member of the Medical Executive Committee for direction, orientation to assigned areas and supervision.

10. TRANSFER OF PATIENT

If the attending physician transfers the care of a patient permanently to another Hospital Medical Staff member, the outgoing physician shall clearly document the transfer of responsibility in the medical record to the new attending physician.

11. CONFLICT OF CARE RESOLUTION

All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about the patient's condition that they believe are not being adequately addressed or they have concerns about decisions being made in the care of the patient. The chain of command involves administrative and clinical lines of authority. The lines of authority are established to ensure effective conflict resolution in patient care situations. The concerned member of the team should express their concerns to their immediate supervisor. If they still feel the issue is not adequately resolved they should ask to speak to the supervisor's manager and up the chain of command. In all cases, the final authority in the chain of command on patient care decisions shall rest with the President of the Medical Staff or the President of the Medical Staff designee.

12. CONFIDENTIALITY

A. All members of the Medical Staff, Allied Health Practitioner associated with that staff, and their respective employees and agents, shall maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by the Hospital or by business associates of the facility, in accordance with any and all privacy and security policies and procedures adopted by the Hospital to comply with current Federal, State and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations.

Protected Health Information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with the Hospital health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the medical staff member to any health care provider within the facility who has responsibility for that patient's care.

B. The use of electronic signature (computer key) is acceptable only under the following conditions:

- 1). The practitioner whose signature the electronic signature represents is the only one who has possession of the electronic User ID and password combination, and is the only one who uses it
- 2) Medical Staff Services retains a signed statement to the effect that the practitioner is the only one who has the computer key password, and is the only one who will use it.

C. All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and confidential to the same extent as other Hospital medical records. Passwords used by a member of the Medical Staff to access Hospital computers shall be used only by such member, who shall not disclose the password to any other individual (except to authorize security staff of the computer system). The use of a member's passwords is equivalent to the electronic signature of the member. The member shall not permit any practitioner, resident, or other person to use his/her passwords to access Hospital computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Governing Body regarding security measures, be a violation of State and Federal law and may result in denial of payment under Medicare and Medicaid.

**Elkhorn Valley Rehabilitation Hospital
Governing Body RESOLUTIONS**

**SUBJECT:
Bylaws, Rules and Regulations of the Medical Staff**

RESOLUTION:

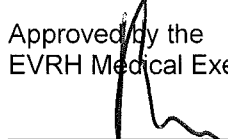
WHEREAS, the Bylaws, Rules and Regulations of the Medical Staff of EVRH have been presented to this Board for approval; and

WHEREAS, these Bylaws, Rules and Regulations have received the affirmative vote of the majority of the Medical Executive Committee members and received the affirmative vote, conducted by mail ballot, of a majority of the eligible voting members of the Medical Staff of EVRH responding.

NOW THEREFORE, BE IT RESOLVED, that the Governing Body of EVRH approves the amended Bylaws, Rules and Regulations of the Medical Staff of EVRH;

FURTHER RESOLVED, that by reason of such approval, the Governing Body does not relinquish or delegate its authority to adopt other conditions or criteria relating to Staff membership or privileges. The Board's authority and responsibility in this regard are lodged in it by reason of the laws of the State of Delaware, the Certificate of Incorporation, the Corporate Bylaws and the acts of the Board of Directors of Elkhorn Valley Rehabilitation Hospital, Inc.


Approved by the
EVRH Medical Executive Committee



Signature of Chair/Date

8/15/2011


Approved by the
EVRH Medical Staff:



Signature of President of Medical Staff/Date

8/15/11

Approved by the
Governing Body:



Signature of Secretary/Date

8/15/11