Carroll County Memorial Hospital

Medical Staff Bylaws
Rules & Regulations

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BYLAWS OF THE MEDICAL STAFF OF
CARROLL COUNTY MEMORIAL HOSPITAL

PREAMBLE

WHEREAS, Carroll County Memorial Hospital is a not-for-profit corporation, organized under the laws of the State of Missouri for the purpose of providing health care, inpatient and outpatient medical services, and promoting the wellbeing of the citizens of Carroll County, Missouri and the surrounding area; and

WHEREAS, the Governing Board of Directors of the Hospital has charged the Medical Staff of the Hospital with the responsibility for providing, promoting, monitoring and improving patient care in the Hospital; and to that end, the Medical Staff is continually striving to achieve quality patient care for patients of the Hospital and accepts and agrees to discharge its responsibilities subject to the ultimate authority of the Governing Board of Directors;

NOW, THEREFORE, the Medical Staff, as hereinafter organized and comprised, practicing in the Hospital shall conduct their activities in conformity with these Bylaws to carry out the functions delegated to the Medical Staff by the Governing Board of Directors.

DEFINITIONS

As used in these Bylaws, unless the context clearly indicates otherwise, terms are defined as follows:

1. **Administrative Delinquency.** A missing Practitioner or Allied Health Professional signature and/or date of signature, or other missing or incomplete information in medical record documentation where such date or signature is required by law, regulations, conditions of participation, payer contract, and/or the policies, procedures, or Governing Documents of the Hospital but does not adversely affect the health or welfare of a patient.
2. **CEO.** The individual appointed by the Governing Board of Directors to act in its behalf in the overall management of the Hospital. This individual may, consistent with the Hospital Bylaws, appoint a representative or designee to perform certain administrative duties identified in Bylaws.
3. **Allied Health Professional.** An individual, other than an individual who meets the further definition of "Practitioner" as defined herein, who provides direct patient care services or assist Practitioners in the Hospital as authorized under these Bylaws and consistent with the individual's scope of practice under applicable law. Allied Health Professionals are not eligible for Medical Staff membership.

4. **Applicant.** A Physician, Dentist, or Podiatrist who requests to join the Medical Staff or to obtain Privileges at Hospital.
5. **Application.** A request for initial appointment or reappointment to the Medical Staff as described in Article V of these Medical Staff Bylaws.
6. **Governing Board of Directors, Governing Board.** The Governing Board of Directors of Carroll County Memorial Hospital, organized pursuant to Title 19 Section 30-20.080 of the Missouri Code of State Regulations.
7. **Certified Mail.** Delivery by the United States Postal Service or by a commercial carrier and that delivery is verified by a receipt.
8. **Clinical Privileges, Privileges.** Permission granted to an individual, pursuant to Article VI of these Bylaws, authorizing performance of specific diagnostic, therapeutic, medical, dental, or surgical services within the Hospital.
9. **Clinical Service, Service.** A category of patient care designated in Article XI of these Bylaws.
10. **Corrective Action.** The disciplinary measures set forth in Article VII.
11. **Dentist.** An individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and who has a Valid Unrestricted License to practice dentistry in the State of Missouri.
12. **Executive Council.** The Hospital committee comprised of the Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer, Chief Revenue Officer, Chief People Officer, and Chief Medical Officer.
13. **Governing Documents.** The Hospital's Medical Staff Bylaws, the Medical Staff Rules and Regulations, the Hospital's Corporate Compliance Plan, and the Hospital's Risk Management Plan.
14. **Hospital.** Carroll County Memorial Hospital and its Governing Board of Directors, Executive Officers, Medical Staff, or departments, as the context may require.
15. **Medical Staff.** The organized body of Practitioners who have been granted membership and have been granted Privileges to attend patients and/or to provide diagnostic, therapeutic, medical, dental, or surgical Services in the Hospital.
16. **Medical Staff Committee.** The Committee of the Active Medical Staff as set forth in Article XI Section 11.3 of these Bylaws.
17. **Member.** An individual granted membership to the Medical Staff of Carroll County Memorial Hospital pursuant to these Bylaws.

18. **Physician.** An individual with a Valid Unrestricted License to practice medicine and surgery (M.D.), or osteopathic medicine and surgery (D.O.) through the Missouri Governing Board of Healing Arts, within the State of Missouri, or in another state when the context clearly requires.

19. **Physician Advisor.** An Active Member appointed pursuant to Article XIII Section 13.3 of these Bylaws to oversee certain administrative aspects of his or her respective Clinical Service.

20. **Podiatrist.** An individual with a Valid Unrestricted License to practice podiatry (D.P.M.) through the Missouri Governing Board of Podiatric Medicine.

21. **Practitioner.** An individual with a Valid Unrestricted License by the appropriate regulatory agency of the State of Missouri authorizing professional practice of a Physician and surgeon (M.D.), osteopathic Physician and surgeon (D.O.), Podiatrist (D.P.M.), or Dentist (D.D.S.).

22. **Prerogative.** The rights, by virtue of Medical Staff category or otherwise, granted to a Medical Staff Member, Practitioner or Allied Health Professional, and subject to the ultimate authority of the Governing Board and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

23. **Special Notice.** Written notice sent via Certified Mail, return receipt requested or by hand-delivery evidence by a receipt signed by the individual to whom it is directed.

24. **Valid Unrestricted License.** An unexpired license to engage in professional activities within the State of Missouri that is not limited on order of the licensing Governing Board in a manner which reduces the privilege to the exercise of all authority generally associated with a license.

ARTICLE I – NAME

These Bylaws address the Medical Staff of Carroll County Memorial Hospital.

ARTICLE II – MEDICAL STAFF PURPOSES AND RESPONSIBILITIES

2.1 Purposes. The purposes of this organized, self-governing Medical Staff are to:

A. Be accountable to the Governing Board for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff;

B. Promote patient care at the Hospital that is consistent with generally recognized standards of care;

C. Be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership may be fulfilled;

D. Provide an appropriate and efficient forum for Member input to the Governing Board and CEO on Hospital and medical issues; and

E. Coordinate care, treatment, and services with other providers and Hospital personnel.

2.2 Responsibilities. The Medical Staff's responsibilities shall include to:

A. Participate in the performance improvement/quality assurance, quality review, and utilization management of the Hospital and conducting activities required by the Hospital to assess, maintain, and improve the quality and efficiency of medical care in the Hospital, including without limitation:

1. Evaluating Practitioner and institutional performance through use of a valid system of measurement as developed by the Hospital, and based upon clinically sound criteria;

2. Monitoring critical patient care practices on an ongoing basis;

3. Establishing criteria and evaluating Practitioner credentials for appointment and reappointment to the Medical Staff, and for identifying the Clinical Privileges that are assigned to individual Practitioners and Allied Health Professionals in the Hospital;

4. Initiating and pursuing Corrective Action, with respect to Practitioners, when warranted;

5. Identifying and advancing the appropriate use of Hospital resources available for meeting patients' medical, social, and emotional needs, in accordance with sound resource utilization practices;

B. Make recommendations to the Governing Board regarding Medical Staff appointment and reappointment, including category and Clinical Service assignments, Clinical Privileges, and Corrective Action or disciplinary action, as appropriate;

C. Assist in the development, delivery, and evaluation of continuing medical education and training programs;

D. Develop and maintain Medical Staff Bylaws, Rules and Regulations, and policies that promote sound professional practices, organizational principles, and compliance with federal and state law requirements;

E. Enforce compliance with such Medical Staff Bylaws, Rules and Regulations, policies, and laws;

F. Participate in the Hospital's long-range planning activities;

G. Assist in identifying community health needs;

H. Participate in developing and implementing appropriate institutional policies and programs to meet those needs;

I. Fulfill the obligations and appropriately use the authority granted in these Medical Staff Bylaws in a timely manner through use of Medical Staff officers, committees and individuals and to account to the Governing Board;

J. Ensure that at least one Physician Member shall be on duty or available within a reasonable period of time for emergency service at all times;

K. Ensure timely completion of medical records by a Practitioner in accordance with state law and Hospital policy, including but not limited to documentation of:

    1. A medical history and physical examination completed no more than thirty (30) days before or twenty-four (24) hours after admission, but prior to any surgery requiring anesthesia services. If the history and physical examination is documented prior to admission, an updated history and physical examination are recorded within twenty-four (24) hours of admission, but prior to any surgery or procedure requiring anesthesia;

    2. Discharge summaries and all other required records within thirty (30) days of discharge or dismissal;

L. Perform any Medical Staff, committee, and/or Hospital functions for which they are responsible;

M. Abide by generally recognized standards of ethics and professional conduct relevant to their profession and specialty;

N. Satisfy continuing education requirements established by the Medical Staff;

O. Maintain as confidential all information and documents related to patients' conditions or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care, or actions or conduct of health care providers;

P. Service on-call and interpretation rosters by assisting the CEO, who has the final authority, concerning what on-call and interpretation rosters will be utilized by the Hospital, the criteria for serving on-call or interpretation rosters, and the schedule for service on all call and interpretation rosters. The Governing Board may require the Members to serve on the on-call rosters as a condition of Medical Staff membership if determined that such action is necessary to meet the needs of the Hospital and the community it serves. The Governing Board may also permit Members to be exempt from the on-call roster. Any Practitioner providing services on an on-call roster may be removed at any time by the CEO, after consulting with the President of the Medical Staff ("President") or Chair of the Governing Board of Trustees ("Governing Board Chair"), if it is determined that it is in the best interests of the Hospital, the Medical Staff, or patient care to do so. Requiring service on, or removal from, an on-call roster shall not be considered to be a reduction or change in Privileges nor an Adverse Action concerning the Practitioner's Privileges or Medical Staff membership. No Practitioner shall be entitled to a hearing or any appeal procedures as a result of the failure of the Practitioner to be appointed to or the removal of the Practitioner from any roster for on-call services or interpretation of tests or special procedures.

Q. A Member's failure to fulfill any of the aforementioned responsibilities or other obligations as described in these Bylaws may be grounds for denial of reappointment to the Medical Staff, reduction in Medical Staff category, restriction or revocation of Privileges, or other Corrective Action in a final action of the Governing Board or grounds for a hearing under Article VIII.

ARTICLE III – MEMBERSHIP

3.1 Nature of Membership.

A. No individual, including a person with a contract of employment with the Hospital, may admit or provide any health care services to patients in the Hospital unless that individual is a Member or has been granted Clinical Privileges in accordance with the procedures set forth in these Medical Staff Bylaws.

B. Medical Staff appointment shall confer only the Clinical Privileges and Prerogatives granted by the Governing Board in accordance with these Bylaws.

C. No Applicant shall be denied membership on the basis of sex, race, creed, color, national origin, age, or a handicap unrelated to the ability to fulfill patient care and required Medical Staff obligations.

D. No Practitioner shall be entitled to Medical Staff membership or to exercise particular Clinical Privileges at the Hospital merely because he or she:

1. Holds a license or obtained a professional degree recognized by the State of Missouri;
2. Belongs to any particular professional organization;
3. Holds a particular certification or fellowship, completed a program of residency training, or is a member of a specialty Governing Board, society, or body;
4. Has previously had Medical Staff membership or Privileges in this Hospital;
5. Is a current or former Member or holds or has held Privileges in any other hospital or other health care facility.

E. No Applicant shall be denied membership to the Medical Staff based solely upon the applicant's professional degree or the school or health care facility in which the applicant received medical, dental, podiatry, post-graduate training, or certification if the schooling or post-graduate training for a Physician was accredited by the American Medical Association or the American Osteopathic Association; for a Dentist was accredited by the American Dental Association and Commission on Dental Accreditation; or for a Podiatrist, was accredited by the American Podiatric Medical Association.

3.2 Qualifications for Membership.

A. Every Practitioner who applies for or holds Medical Staff appointment must, at the time of Application and initial appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Governing Board all of the following qualifications for membership and any other qualifications and

requirements as set forth in these Medical Staff Bylaws, the Medical Staff Rules and Regulations, Hospital Bylaws, policies and rules and other requirements or policies established by the Governing Board.

1. Holds a Valid Unrestricted License issued by the State of Missouri to practice as a Physician, Dentist, or Podiatrist and, if applicable, current, valid Drug Enforcement Agency ("DEA") and Bureau of Narcotics and Dangerous Drugs ("BNDD") registration.
2. Provides documentation of graduation from a Governing Board-approved medical, osteopathic, podiatric, or dental school recognized for licensure in this State, or if a psychologist, from a duly accredited college or university awarding a degree recognized for licensure as a psychologist in this State. Each Physician who has graduated from a medical school outside of the United States shall present proof of certification by the Educational Commission for Foreign Medical Graduates.
3. For Physicians, provides documentation of satisfactory completion of an approved internship or residency. Fellowship in an institution approved for residency training shall be regarded as residency training or internship.
4. Provides documentation evidencing an ongoing ability to provide patient care services consistent with acceptable standards of practice and available resources including current experience, clinical results, and utilization practice patterns.
5. Demonstrates ability to work with and relate to people, including other Members, Hospital employees and administration, the Governing Board, patients and visitors, and the community in general, in a cooperative, professional manner that maintains and promotes an environment of quality and efficient patient care.
6. Maintains personal behavior reasonably expected by the Governing Board and by community standards.
7. Is, has been, or can reasonably be expected upon appointment of membership to be, in compliance with the obligations of Medical Staff appointment as set forth in Article II Section 2.2 and equitable participation in the performance of Medical Staff obligations.
8. Adherence to generally recognized standards of medical and professional ethics applicable to his or her profession, licensure, and specialty.
9. Demonstrates freedom from, or adequate control over, any physical or mental condition that would significantly affect the Practitioner's ability to practice

with reasonable skill and/or safety. Physical or mental condition, as used in this paragraph, includes but is not limited to, use of any type of substance or chemical that affects cognitive, motor, or communication ability in any manner that interferes with, or that has a reasonable probability of interfering with the qualifications for membership such that patient care is, or is likely to be, adversely affected.

10. The ability to read and understand the English language, to communicate effectively and intelligibly in both written and verbal English language and to prepare medical record entries and other required documentation in a legible and professional manner.

11. Provides documentation of professional liability insurance of such kind, in such amount, and underwritten by such insurers, as required or approved from time to time by the Governing Board after consultation with the Medical Staff Committee.

12. Has never been convicted of a felony or misdemeanor related to the Practitioner's suitability to practice the Practitioner's profession.

13. Has not been excluded from or sanctioned by the Medicare or Medicaid programs or any other state or federal government program, and is not on the U.S. Department of Health and Human Services Office of Inspector General list of excluded individuals.

14. Shall purchase and maintain professional liability insurance covering the Practitioner with limits of at least $3,000.000.00 in the aggregate and $1,000.000.00 per occurrence.

B. In the case of new Applications for Medical Staff appointment and Clinical Privileges, and with respect to Applications for changes in Clinical Privileges, the requested appointment/Privileges/affiliation must be compatible with any policies, plans, or objectives formulated by the Governing Board concerning:

1. The Hospital's patient care needs, including current needs and projected needs;

2. The Hospital's ability to provide the facilities, personnel, and financial resources that will be necessary if the Application is approved; and

3. The Hospital's decision to contract exclusively for the provision of certain services with a Practitioner, or a group of Practitioners, other than the Applicant.

3.3 Duration of Appointment.

A. Initial appointment shall be for a period of not more than one year. Reappointment shall be for a period of not more than two years. Provided, however, that the duration of any such initial appointment or reappointment shall be subject to the provisions of Article VI.

B. Membership and Clinical Privileges of any Member shall terminate upon:

1. Expiration or other termination of any contractual or employment relationship with the Hospital; or

2. Expiration or other termination of the relationship of the Member with the entity that has a contractual relationship with the Hospital;

3. The effective date of the closure of a Service or effect date of an exclusive arrangement, as applicable to any Practitioner who previously held Privileges to provide such Services but who is not a party to the exclusive arrangement, irrespective of any remaining time on the current initial appointment or reappointment term.

C. In the event of termination of Membership status and/or Clinical Privileges pursuant to Section 3.3.B of this Article above, no right to a hearing or appellate review, including those provided in Article VIII, shall apply.

3.4 Procedures for Appointment and Reappointment. Procedures for evaluating Applications for initial appointment and for conducting periodic reappraisals for reappointment to the Medical Staff are outlined in Article V of these Bylaws.

3.5 Contract Practitioners. A Practitioner who is, or who will be, providing specified professional services pursuant to a contract with the Hospital is subject to all membership qualifications, appointment, reappointment, Clinical Privilege evaluations, and obligations of Medical Staff membership just as any other Applicant or Member.

3.6 Leave of Absence.

A. Upon a showing of good cause, Members may be granted leaves of absence by the Medical Staff Committee, subject to approval by the Governing Board, for a definitely stated period of time not to exceed six (6) months.

B. Absence for longer than six (6) months shall constitute voluntary resignation of Medical Staff membership and Clinical Privileges unless, upon good cause shown, an exception is granted by the Medical Staff Committee with approval of the Governing Board. Good cause may include:

1. Medical leave if it will not affect his or her ability to return to practice;

2. Military leave;

3. Educational leave; and

4. Personal or family leave not affecting his or her ability to return to practice (e.g., sabbatical to provide volunteer charity care, parental leave, or to provide care for an ailing family member within the home, etc.).

C. Members must request a leave of absence for any absence greater than thirty (30) days. Request for a leave of absence shall be made to the Chief of Staff and shall state the beginning and ending dates of the requested leave. Leaves of absence are generally matters of courtesy, not right. In the event that it is determined that an individual has not demonstrated good cause for a leave, this may result in automatic relinquishment of Staff appointment and Privileges at the Governing Board's discretion, and the determination will be final, with no recourse to a hearing and appeal. Such Practitioner or AHP will be required to reapply for Privileges and/or membership following any unexcused leave of absence.

D. During the leave of absence, the Member is not entitled to Clinical Privileges at the Hospital, and has no membership rights and responsibilities.

E. Prior to a leave of absence being granted, the Member shall have made arrangements for the care of patients during the leave of absence which are acceptable to the Medical Staff Committee and Governing Board. If a Member is responsible for supervising other healthcare providers, the Member must make appropriate arrangements for the transfer of supervision responsibilities acceptable to the Medical Staff Committee and the Governing Board prior to taking a leave of absence.

F. If the leave of absence is for other than medical reasons, the Member may be reinstated at the conclusion of the leave of absence upon filing, with the Chief of Staff, a written request for reinstatement and a statement summarizing the educational, licensure, or other activities undertaken during the leave of absence. The Member shall also submit such other information as requested by the Medical Staff Committee.

G. If the leave of absence is for medical reasons, then the Member must submit, to the Medical Staff Committee, a written request for reinstatement as well as a report or statement from his or her Physician indicating such Member is physically and/or mentally capable of resuming a Hospital practice, with or without reasonable accommodation and, if with reasonable accommodation, the nature of the accommodation(s) needed. The Member shall also provide such other information as may be requested by the Medical Staff Committee.

H. In acting upon the request for reinstatement, the Medical Staff Committee may approve reinstatement either to the same or a different Medical Staff category, and may limit or modify Clinical Privileges to be extended to the Member upon reinstatement, subject to approval by the Governing Board.

3.7 Illness and Impairments.

A. The Hospital shall educate all Members, Allied Health Professionals, and Hospital personnel to assist in their ability to recognize illness and other impairments in their peers.

B. All Members, Allied Health Professionals, and Hospital personnel shall report to the Governing Board, Medical Staff, or in accordance with the Hospital's risk management program, any instance in which a Practitioner or Allied Health Professional is rendering unsafe treatment in any form or manner.

C. The Hospital shall evaluate the credibility of such complaints, allegations, or concerns.

D. If deemed appropriate, the Governing Board and Medical Staff shall facilitate confidential self-referrals or referrals from other Medical Staff or Hospital personnel to a licensed independent Practitioner, if needed.

1. Referrals can be to an appropriate Member or to an outside source for evaluation, diagnosis, or treatment of the condition or concern.

2. Referrals will be held in confidence, except when state or federal laws or other ethical obligations require disclosure or when the health and safety of a patient is threatened.

E. The Hospital shall monitor the affected individual and the safety of patients until the rehabilitation or disciplinary process is complete. Such monitoring will continue for a time period afterwards as required and shall not be considered an Adverse Recommendation or Action, and shall not create a right to a hearing or appellate review under these Bylaws.

3.8 Obligations

A. Each member of the Medical Staff and each Practitioner granted temporary Privileges under these Bylaws must:

1. Provide the Practitioner's patients with generally recognized professional services consistent with the recognized standards of practice in the same or similar communities and the resources locally available;

2. Comply with these Bylaws; the Medical Staff Rules and Regulations; the Hospital Bylaws, policies and rules; the Hospital's Corporate Compliance

Plan; and all other standards, policies and rules of the Staff, the Hospital, and state and federal law;

3. Perform any Staff, committee and Hospital functions for which the Practitioner is responsible;
4. Complete medical records and other records in such manner and within the time period required by Hospital for all patients the Practitioner admits or in any way provides care for in the Hospital;
5. Abide by generally recognized standards of professional ethics; and
6. Satisfy the continuing education requirements of the Medical Staff.

B. Practitioner's failure to satisfy any of the aforementioned qualifications or obligations may be grounds for denial of reappointment to the Staff, reduction in Staff category, restriction or revocation of Clinical Privileges, or other disciplinary action as determined in a final action of the Governing Board pursuant to Article VIII of these Bylaws.

ARTICLE IV – MEDICAL STAFF CATEGORIES

4.1 Categories. The Medical Staff shall be divided into the following categories: Active, Consulting, Hospitalist, Courtesy, Emergency Room, and Locum Tenens.

4.2 Active Medical Staff.

A. Qualifications. In addition to the qualifications for Medical Staff membership in Article III above, an Active Member must:

1. Reside or have a business office within sufficiently close proximity to the Hospital's Clinical Service area(s) as determined by the Governing Board;

2. Admit patients, who meet professional standards for medical necessity, to the Hospital or perform a sufficient number, as determined by the Medical Staff Committee and the Governing Board, of procedures at the Hospital during each appointment/reappointment period or otherwise be regularly involved in the care of patients within the professional training and skill and Clinical Privileges of the Active Member.

B. Prerogatives. An Active Member may:

1. Admit patients without limitation, except as limited by the scope of his or her Clinical Privileges granted pursuant to Article VII or otherwise as provided in the Medical Staff Rules and Regulations;

2. Consistent with the Active Member's Clinical Privileges, and subject to any scope of practice limitations, supervise CRNAs for patients with physical status indicators 1 – 4 under general, regional, sedation, or monitored anesthesia;

3. Attend regular and professional meetings of the Medical Staff and any Medical Staff committees of which the Active Staff Member is a member;

4. Vote on all matters presented at all meetings of the Medical Staff and at all committee meetings of which he or she is a Member and present at, except as provided by resolution of the Medical Staff Committee and approved by the Governing Board;

5. Hold office in the Medical Staff, sit on, or act as chairperson of any committee, unless otherwise determined by resolution of the Medical Staff and as approved by the Governing Board;

6. Be appointed to the Governing Board of Directors pursuant to the Hospital's Bylaws;

7. Exercise the Clinical Privileges granted to him or her;

8. Take rotation call in the emergency room unless exempted by the Governing Board and the Medical Staff Committee.

C. Obligations. In addition to the basic obligations set forth in Article II, an Active Member must:

1. Contribute to the administration of the Medical Staff, including serving as a Medical Staff officer and on Hospital and Medical Staff committees as appointed or elected;

2. Participate in the performance improvement/quality assurance and utilization review activities required of the Medical Staff;

3. Fulfill the recognized function of Medical Staff membership by engaging in the Medical Staff's teaching and continuing education programs, consulting with other Members consistent with the Member's scope of practice and delineated Privileges, supervising Practitioners during the provisional period, and fulfilling such other functions as may reasonably be required of Members;

4. Attend regular and professional meetings of the Medical Staff and of any Medical Staff committees of which he or she is a Member;

5. Cooperate with the Hospital Governing Board and CEO to ensure on-call responsibilities of the Hospital are met on a 24/7 basis, including, but not limited to, on-call rosters and rosters for interpretation of tests necessary to meet the needs of the Hospital and its patients and any criteria for service on such rosters. No Member shall be entitled to a hearing or other rights of review based on denial of a request for exemption from on-call service.

4.3 Consulting Medical Staff.

A. Qualifications. In addition to the qualifications for Medical Staff membership in Article II, a Consulting Staff Member must:

1. Possess specialized skills needed at the Hospital for a specific project, or on an occasional basis, in consultation when requested by a Member; and

2. Demonstrate active participation in the active medical staff at another hospital requiring performance improvement/quality assurance activities similar to those at this Hospital or agree to fulfill the responsibilities of Active Staff membership specified in Article II concerning participation in performance improvement/quality assurance and utilization review activities at this Hospital and participation in clinical programs and attendance at committee meetings.

B. Prerogatives. A Consulting Staff Member may:

1. Perform Clinical Services delineated in the Clinical Privileges granted to him or her;

2. Examine patients and write consultation reports and orders for treatment or testing upon request of a Medical Staff Member;

3. Consistent with the Consulting Member's Clinical Privileges, and subject to any scope of practice limitations, supervise CRNAs for patients with physical status indicators 1 – 4 under general, regional, sedation, or monitored anesthesia;

4. Not admit patients to the Hospital, hold office on the Medical Staff, or participate in any vote during meetings of the Medical Staff;

5. Not be obligated to attend, but is permitted to attend, Medical Staff meetings;

6. Serve on committees or serve as chairperson in official circumstances, and may be required to attend committee or Clinical Service meetings, as assigned. In such Clinical Service or committee meetings, such Member may vote on all matters considered.

C. Obligations. A Consulting Staff Member shall meet the requirements as provided in Article II and Article IV.

4.4 Hospitalist.

D. Qualifications. In addition to the qualifications for Medical Staff membership in Article II, Section 2.2 above, a Hospitalist Staff Member must:

1. Possess specialized skills needed at the Hospital for a specific project, or on an occasional basis, in consultation when requested by a Member;

2. Admit patients, who meet professional standards for medical necessity, to the Hospital or perform a sufficient number, as determined by the Medical Staff Committee and the Governing Board, of procedures at the Hospital during each appointment/reappointment period or otherwise be regularly involved in the care of patients within the professional training and skill and Clinical Privileges of Hospitalist Staff Member.

E. Prerogatives. A Hospitalist Staff Member may:

1. Admit patients without limitation, except as limited by the scope of his or her Clinical Privileges granted pursuant to Article VII or otherwise as provided in the Medical Staff Rules and Regulations;

2. Perform Clinical Services delineated in the Clinical Privileges granted to him or her;

3. Not be obligated to attend, but is permitted to attend, Medical Staff meetings;

4. Serve on committees or serve as chairperson in official circumstances, and may be required to attend committee or Clinical Service meetings, as assigned. In such Clinical Service or committee meetings, such Member may vote on all matters considered.

F. Obligations. A Hospitalist Staff Member shall meet the requirements as provided in Article II and Article IV.

4.5 Courtesy Medical Staff.

A. Qualifications. A Courtesy Medical Staff Member shall be a Practitioner who is not active in the Hospital and who is honored by emeritus positions. This may be either a Practitioner who retired from active Hospital service or of outstanding reputation.

B. Prerogatives. A Courtesy member may:

1. Serve on committees of the Medical Staff;

2. Attend Medical Staff meetings;

3. Not hold office on the Medical Staff, or participate in any vote during meetings of the Medical Staff;

4. Not admit patients to the Hospital.

C. Obligation. Courtesy Members shall have no assigned duties or responsibilities.

4.6 Emergency Room Medical Staff.

A. Qualifications. The Hospital may, from time to time, enter into contracts with Physicians, Practitioners, or their group practices for the provision of services in the emergency department of the Hospital. Such providers shall be Emergency Room Medical Staff. An Emergency Room Medical Staff Member must satisfy the qualifications for Medical Staff membership in Article II.

B. Prerogatives. An Emergency Room Medical Staff Member may:

1. Perform Clinical Services delineated in the Clinical Privileges granted to him or her;

2. Not admit patients to the Hospital independent of the necessity to admit a patient while performing services in the emergency room;

3. Not hold office in the Medical Staff or vote at meetings of the Medical Staff or committees;

4. Not be obligated to attend, but is permitted to attend, Medical Staff meetings.

C. Obligations. An Emergency Room Member must fulfill the obligations of Medical Staff as set forth in Article II.

4.7 Locum Tenens Medical Staff.

A. Qualifications. A Locum Tenens Member shall be a Physician hired by the Hospital or a Member to provide coverage for defined periods of time and who has been granted Temporary Privileges, in accordance with Article VII. A Locum Tenens Member shall meet general qualifications for membership as set forth in Article II.

B. Prerogatives. A Locum Tenens Member:

1. May only supervise CRNAs for patients with physical status indicators 1 – 4 under general, regional, sedation, or monitored anesthesia if expressly provided in the individual's Clinical Privileges, subject to any limitations set forth therein;

2. Is encouraged to attend regular and special Medical Staff meetings and may be asked to serve on committees, but is not required to do so;

3. May not hold office in the Medical Staff or vote at Medical Staff or its committees' meetings;

4. May be granted Privileges for periods not to exceed sixty (60) days at a time.

C. Obligations. A Locum Tenens Member must continue to meet the general qualifications for membership set forth in Article II and Article IV and any other obligations required by the Governing Board or Medical Staff for the duration of the Locum Tenens' membership.

4.8 Provisional Period.

A. Scope and Duration. Medical Staff appointments and grants of initial or increased Clinical Privileges to any Members may be provisional for a period of up to one (1) year ("Provisional Period"). With respect to Applicants who are granted Temporary Privileges during the pendency of their Application for Medical Staff membership and Privileges subject to Article VII, the Provisional Period shall not run during the period of Temporary Privileges, but shall begin at such time as their Application is approved. During the Provisional Period, a provisional appointee's performance will be reviewed and evaluated by the Chief of Staff, or his or her designee. The designee may be any Active Staff Member. The Chief of Staff or his or her designee shall certify successful completion of the Provisional Period.

B. No Effect on Membership or Exercise of Privileges. During the Provisional Period, a Practitioner must meet all qualifications, can exercise all of the Prerogatives, and

must fulfill all of the Obligations of his or her requested Staff category; and the Practitioner can utilize all of the provisional Clinical Privileges granted to him or her.

C. Procedure for Extending the Provisional Period. If an initial provisional member is unable to obtain patient contacts, or because the Practitioner's caseload at the Hospital was inadequate to demonstrate ability to exercise the Privilege in question, the Practitioner may submit to the Credentialing Committee a statement to this effect, describing his or her caseload and signed by the Chief of Staff. Upon receipt of such statement, the Provisional Period for exercising the Privilege or Privileges involved shall be extended for a period not to exceed one (1) additional year unless the Medical Staff or the Governing Board of Directors, after receiving the report of the Credentialing Committee, determines such extension is inappropriate.

D. Procedural Rights. Whenever any Provisional Period expires without favorable conclusion for the Practitioner, or whenever an initial or additional extension is denied, the CEO will provide the Practitioner with Special Notice of the Adverse Recommendation and of his or her entitlement to the procedural rights provided in Article IX of these Bylaws.

ARTICLE V – ALLIED HEALTH PROFESSIONAL

5.1 Allied Health Professional Staff. An Allied Health Professional functions in a professional support role to a Practitioner, exercises judgment within the area of his or her professional competence and, is qualified by licensure, certification, or other approval to render care under the supervision of a Member who has been accorded Privileges to provide such care in the Hospital. Each patient's general medical condition and care shall be the ultimate responsibility of a qualified Physician Member. The following, without limitation, may be deemed Allied Health Professionals: audiologists, bacteriologists, chemists, chiropractors, clinical pharmacologists, dental auxiliary, nuclear medicine technicians, nurse anesthetists, nurse practitioners, optometrists, orthopedic and other surgical technicians, physicians assistants, physicists, physiologists, social workers, scrub technicians, speech pathologists, qualified therapists (occupational, physical, speech, respiratory), and registered dieticians or other qualified nutrition professionals.

A. Qualifications. To be eligible for Clinical Privileges within the Hospital, an Allied Health Professional must:

1. Be within a category of Allied Health Professionals approved for Clinical Privileges by the Governing Board;
2. Meet the personal qualifications specific in Article II;
3. Be authorized by the laws of Missouri to engage in an allied health profession, including having a Valid Unrestricted License issued by the appropriate regulatory authority, when required;
4. Provide evidence of adequate education, training, and experience with respect to the Clinical Services provided and as determined by the Governing Board;
5. Provide proof of malpractice insurance in an amount required by the Governing Board;
6. Meet all other requirements imposed by the Governing Board.

B. Prerogatives. An Allied Health Professional:

1. Is not a Member of the Medical Staff and shall have only such limited duties, responsibilities, and Prerogatives as may be specifically set forth herein;
2. May require Physician collaborators to perform any services in the Hospital;
3. Is not eligible to vote or hold office in the Medical Staff, but may be invited to attend Medical Staff meetings and may serve on committees of the Medical Staff when appointed;

4. May provide specifically designated patient care services under the supervision or direction of a Member;

5. May write orders consistent with their qualifications, licensure or certification, and only to the extent specified in the Medical Staff Rules and Regulations, Hospital policy, or position description for that category of Allied Health Professional;

6. May exercise such other Prerogatives as the Medical Staff may grant, with the approval of the Governing Board;

7. Cannot independently admit or discharge patients;

8. Is not eligible for procedural due process rights as provided to Medical Staff Members in these Bylaws, unless otherwise determined by the Governing Board.

C. Obligations. Each Allied Health Professional shall:

A. Assume responsibility, to the extent applicable under his/her scope of practice, for the care and supervision of each patient in the Hospital for whom he or she is providing Clinical Services;

B. Meet the basic responsibilities contained in Article II, designed for Medical Staff Members;

C. Participate as requested in performance improvement/quality assurance program activities and in discharging related performance improvement/quality assurance duties as may be required from time to time;

D. Attend clinical and educational meetings of the Hospital and/or Medical Staff as requested, as well as meetings of committees of which he or she is a Member;

E. Refrain from any actions that are or may be reasonably interpreted as being beyond, or an attempt to exceed, the Allied Health Professional's scope of practice under state law and as authorized by the Hospital.

D. Procedural Rights. An Allied Health Professional is not eligible for the procedural due process right as provided for Medical Staff Members as listed in Article IX of these Bylaws unless otherwise determined by the Governing Board.

ARTICLE VI – APPLICATION, APPOINTMENT & REAPPOINTMENT

6.1 General. No individual shall exercise Clinical Privileges in the Hospital unless he/she applies for and is granted Medical Staff appointment as set forth in these Bylaws. Appointment to the Medical Staff shall confer only those specific Clinical Privileges as have been granted in accordance with these Bylaws.

6.2 Pre- Application. A prospective applicant desiring to apply for appointment to the Medical Staff shall obtain a pre-application form from the Medical Staff Office. The specific contents of the pre-application form shall be as determined by the Governing Board.

1. The pre-application form shall require;
    a. Proof of a valid unrestricted Missouri License,
    b. Information regarding education, residency or other training (as applicable),
    c. Privileges for which the individual intends to apply;
    d. Submission on the prescribed form, in writing to the medical staff office, signed by the prospective applicant.
2. With the pre-application, the prospective applicant will be offered an opportunity to review these Medical Staff Bylaws and the Medical Staff Rules and Regulations as necessary for completion of the pre-application form.
3. Completing a pre-application form is, and at all times shall be, the sole responsibility of the prospective applicant.
4. The prospective applicant shall be notified of omissions or gaps on the pre-application and shall be required to provide the requested information in detail prior to the further processing of the pre-application.
5. The Medical Staff Office will review completed and signed pre-application forms to determine whether the prospective applicant shall be issued an Application for Medical Staff Appointment.

A. No Application for appointment shall be provided to a prospective applicant, nor shall an Application be accepted from a prospective applicant, if the Credentialing Committee or CEO, based on information from a pre-application or any other source, that:

1. Hospital does not have the ability to provide adequate facilities or services for the prospective applicant or the patients to be treated by the prospective applicant;

2. Prospective applicant has interests or activities that are inconsistent with the needs, mission, operations, and plans of the Hospital and the communities it serves, including any Medical Staff development plan;

3. Hospital has contracted with an individual or group to provide the Clinical Services sought by the prospective applicant on an exclusive basis, and the prospective applicant will not be associated with the individual or group contracted with;

4. Prospective applicant does not meet the requirements relating to education, training, and licensure;

5. Prospective applicant has provided materially false or misleading information on any pre-application form, or in connection with any pre-application review process;

6. Prospective applicant otherwise fails to meet any other basic qualifications for Medical Staff membership.

B. A prospective applicant shall be provided written notice of the decision not to provide an Application for appointment to the Hospital's Medical Staff.

C. The prospective applicant shall be advised of the information relied on as grounds for not providing an application, and shall have a reasonable opportunity to submit information or evidence that the information relied upon is not accurate.

D. No individual shall be entitled to a hearing, or any other procedural rights, as a result of a refusal to provide the prospective applicant an Application form for appointment to the Hospital's Medical Staff.

6.3 Application. A prospective applicant shall be deemed an Applicant upon submitting a written, signed Application for Medical Staff appointment to the CEO, or his/her designee, on the Application form approved by the Governing Board.

6.4 Application Contents. Every Application for initial appointment to the Medical Staff must include at least the following:

A. Statement that the Applicant has been offered and/or received and read the Medical Staff Bylaws, Rules and Regulations, the Hospital Corporate Compliance Plan, and the Hospital Risk Management Plan; the Applicant agrees to be bound by the terms thereof if granted membership and/or Clinical Privileges; and the Applicant agrees to be bound by the terms thereof in all matters relating to consideration of the Application, without regard to whether membership or Clinical Privileges are granted.

B. Identification of post-secondary school training, including the name of the institutions and dates attended, any degrees granted, course of study or program completed, and for all post-graduate training, names of persons responsible for reviewing the Applicant's performance.

C. Copies of all currently valid professional licenses or certifications, DEA and/or BNDD registration applicable to the Applicant’s profession, with identification of the date of issuance and license number.

D. Records verifying any specialty or sub-specialty board certification, with identification of the date granted or projected date for recertification, or eligibility to sit for such board’s examination.

E. Statement as to whether the Applicant's health status is such that the Applicant is able to perform all the procedures for which he or she has requested Privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients. If the Applicant required reasonable accommodation, the Application should include a separate sheet to describe the accommodation(s) which will enable the Applicant to perform the clinical activities for which he or she has requested Privileges

F. Documentation verifying current professional liability coverage, including the policy number, name of past and present insurance carriers during the past five (5) years, and identification of malpractice claims history and experience.

G. Nature and specifics of any prior actions to deny, revoke, decline to renew or otherwise challenge or accept voluntary relinquishment (by resignation or expiration) of any professional license or certificate to practice in Missouri or in any other state or country; any controlled substances registration; membership or fellowship in local, state, or national organizations; specialty or sub-specialty Governing Board certification or eligibility; faculty membership at any medical or other professional school; Medical Staff membership, prerogatives or clinical privileges at any other health care institution including any Hospital, clinic, skilled nursing facility, or managed care organization in this or any other state; or professional liability insurance. Nothing in this paragraph shall require an Applicant disclose voluntary expiration of elective professional society memberships (i.e. Missouri State Medical Association).

H. Identification of the physical location and the address of the Applicant's office(s); names and addresses of other Practitioners with whom the Applicant is or has been associated and the dates of the associations; names and locations of all health care institutions or organizations (including third-party payors) with which the Applicant had or has any association, employment, privileges, or practice and the

dates of each affiliation and status held; general scope of clinical privileges or duties and documentation of conformity with applicable Hospital and Medical Staff Bylaws, and rules and regulations at such other institutions where the Applicant had privileges.

I. Medical Staff category and Clinical Privileges requested.

J. Status, and if applicable, resolution of any past or current criminal charges against the Applicant.

K. Names of at least three (3) medical or health care professionals in the Applicant's same profession, or a member of the local county or regional medical society (for use as professional references) who have known the Applicant and who, through observation, have personal knowledge of the Applicant's clinical ability; ethical character; the effect of his or her health status, if any, on the Privileges sought; ability to work cooperatively with others; and who are willing to provide specific written comments on these matters upon request from the Medical Staff or Hospital.

L. List and description of any potential conflict(s) of interest with the Hospital or its related entities (including any ownership or contractual interest the Applicant or his/her immediate family members might have with the Hospital or with entities that do business with the Hospital).

M. Such other information as the Governing Board may require, subject to existing legal requirements.

N. Applicant's signature.

6.5 Effect of Signing and Submitting Application. By signing and submitting an Application for appointment to the Medical Staff, the Applicant (at the time of Application and, if his or her Application is approved, continuously throughout the time he or she remains a Member of the Staff or holds any Privileges):

A. Acknowledges and attests that the Application is correct and complete, and acknowledges that any significant misstatement or omission is grounds for denial of appointment or for immediate and automatic dismissal from the Medical Staff.

B. Agrees to appear for personal interviews, if required, in support of his or her Application.

C. Consents to the release and review by Hospital Representatives of all documents (including requesting and reviewing information from the National Practitioner Data Bank and any other data bank, the Hospital is permitted or required by law to access) that may be necessary to evaluate his or her professional qualifications and ability to carry out the Clinical Privileges he or she requests, as well as his or her

professional ethical qualifications for Staff membership, and consents to Hospital Representatives consulting with prior associates or others who may have information bearing on his or her professional or ethical qualifications and competence.

D. Understands and agrees that if Medical Staff membership or requested Clinical Privileges are denied based on the Applicant's professional competence or conduct, the Applicant will be subject to reporting to the National Practitioner Data Bank.

E. Releases from any liability, all Hospital representatives for their acts performed in good faith and without malice in connection with reviewing, evaluating, or acting on the Application and the Applicant's credentials.

F. Releases from any liability, all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the Applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications necessary for appointment as discussed herein.

G. Agrees to practice in an ethical manner and to provide continuous care to patients.

H. Agrees to notify the Chief of Staff and the CEO, or their designee(s), immediately if any information contained in the Application changes. The foregoing obligation shall be a continuing obligation of the Applicant so long as he or she is a Member and/or has Clinical Privileges at the Hospital.

I. Agrees to be bound by the terms of and to comply in all respects with these Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, policies and procedures, Hospital's Corporate Compliance Plan, and Risk Management Plan.

6.6 Burden of Providing Information. The Applicant is responsible for producing information adequate to properly evaluate the Applicant's experience; background; training; demonstrated competence; utilization patterns; work habits including the ability to work cooperatively with others; to resolve any questions or conflicts and to clarify information as requested by appropriate Medical Staff, Governing Board, or Hospital authorities; and, upon request of the Credentialing Committee, CEO, Governing Board, or their designee(s), physical and mental health status.

6.7 Processing Application.

A. The Application shall be submitted to the office of the CEO (or his/her designee), who shall present the Application to the Credentialing Committee on or before the date of the next Medical Staff meeting.

B. The Applicant shall be notified of any missing information, release, authorization, or verifications, and it shall be the responsibility of the Applicant to have any missing information sent to the person or committee requesting the information.

C. The CEO (or his/her designee) will forward the Application to the Credentialing Committee for information collection and verification as set forth in Subsection K.

D. Additional information or documentation may be requested by Credentialing Committee, any department chair, or by the Medical Staff.

E. No Application shall be considered to be complete until it has been reviewed by the Credentialing Committee and it has been determined that no further documentation, release, authorization, or information is required to permit consideration of the Application.

F. No Application for appointment or reappointment shall be processed until all information, releases, authorizations, and documents required have been provided and the Application is considered complete.

G. Unless otherwise provided by these Bylaws, if the Applicant fails to submit information, release, authorization, or documentation within thirty (30) calendar days after being requested to do so, the Application shall be deemed to be incomplete and automatically withdrawn, unless the time is extended by the person or committee requesting the information.

H. Any Application deemed incomplete and automatically withdrawn will not be reviewed by the Credentialing Committee for a determination of professional competence or conduct.

I. Any Application deemed incomplete and automatically withdrawn will not afford the Applicant the right to a hearing or appellate review under these Bylaws.

J. The Chief of Staff may, but is not required to, conduct an interview with the Applicant before the Application is processed or reviewed by the Credentialing Committee.

K. Information Collection and Verification. The Credentialing Committee or its designee shall be responsible for collecting and verifying all qualification information received, and for promptly notifying the Applicant of any problems with obtaining required information.

   1. Upon notification of any problems or concerns with obtaining required information, the Applicant must obtain and furnish the required information.

   2. If the Applicant fails to furnish the requested information within thirty (30) calendar days of written request, the Application may be deemed incomplete

and automatically withdrawn without right to a hearing or appellate review. Any such determination an Application is incomplete and is automatically withdrawn is not a professional review action based on professional conduct or competence.

3. If the Application cannot be processed due to being incomplete, the Applicant shall be so informed by the CEO that the Applicant's Application is incomplete and deemed automatically withdrawn without review of the Applicant's professional competence or conduct, and without right to a hearing or appellate review.

4. The Credentialing Committee shall query the National Practitioner Data Bank and any other data bank as required by law or otherwise permitted.

5. The Credentialing Committee shall also check the OIG Cumulative Sanction Report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the Applicant has been convicted of a health care-related offense, debarred, excluded, or otherwise made ineligible for participation in Federal or state health care programs.

6.8 Credentialing

A. All individuals and groups required to act on an Application under Section 6.7 must do so in good faith and, except for good cause, complete their actions within the following time periods:

1.	Credentialing Committee Information Collection/Verification	60 days
2.	Credentialing Committee Review/Recommendation	Next Regular Meeting
3.	Medical Staff Committee Recommendation	Next Regular Meeting
4.	Governing Board Action	Next Regular Meeting

B. If action has not been taken on a completed Application within ninety (90) days of the Credentialing Committee's verification of credentials, the Applicant will be provided written notice of the reasons for the lack of action. The reasons shall relate to, but not be limited to, patient welfare, the objectives of the institution, the inability of the organization to provide the necessary equipment or trained staff, contractual agreements, or the conduct or competency of the applicant or medical staff member.

C. These time periods are considered guidelines and do not create any rights for an Applicant to have an Application processed within these precise periods; provided, however, that this provision shall not apply to the time periods contained in the

provisions of Article VIII. When Article VIII is activated by an Adverse Recommendation or action as provided herein, the time requirements set forth therein shall govern the continued processing of the Application.

D. The Credentialing Committee, at its next regularly scheduled meeting, shall review the Application, its supporting documentation, and any other relevant information available to the Credentialing Committee.

E. The Credentialing Committee shall vote on the Application and on the basis thereof, shall take action on Medical Staff appointment, category of Medical Staff membership and Prerogatives, and Clinical Service affiliation and scope of Clinical Privileges.

F. The Credentialing Committee may take any of the following actions:

1. *Deferral Action.* The Credentialing Committee may defer action for further consideration. A decision to defer any action on the Application must be revisited, except for good cause, within a reasonable time frame with subsequent recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Medical Staff membership and Prerogatives, Clinical Service affiliation, and scope of Clinical Privileges. The CEO shall promptly send the Applicant written notice of a decision to defer action on his or her Application.

2. *Favorable Recommendation.* If the Credentialing Committee makes a favorable recommendation regarding all aspects of the Application, the Credentialing Committee shall forward its recommendation, together with all supporting documentation, to the Medical Staff Committee.

3. *Adverse Recommendation.* If the Credentialing Committee makes a favorable recommendation regarding all aspects of the Application, the Credentialing Committee shall forward its recommendation, together with all supporting documentation, to the Medical Staff Committee.

L. The Medical Staff Committee may take any of the following actions:

1. *Favorable Recommendation.* If the Medical Staff Committee makes a favorable recommendation regarding all aspects of the Application, they shall forward its recommendation, together with all supporting documentation, to the Governing Board.

2. *Adverse Recommendation.* If the Medical Staff Committee makes an Adverse Recommendation regarding the Applicant, the CEO must immediately inform the Applicant in writing of the Adverse Recommendation, and he/she shall then be entitled to the procedural rights as provided in Article IX. No such Adverse

Recommendation shall be required to be forwarded to the Governing Board until after the Applicant has exercised, or has been deemed to have waived his or her right to a hearing as provided in Article IX of these Bylaws.

M. The Governing Board may take any of the following actions:

1. *Favorable Recommendation.* The Governing Board may adopt or reject any portion of the Medical Staff Committee's recommendation that was favorable to an Applicant, or refer the recommendation back to the Medical Staff Committee for additional consideration, but must state the reason(s) for the requested reconsideration and set a reasonable time limit within which a subsequent recommendation must be made. The Governing Board shall vote on the Application and on the basis thereof, shall take action on Medical Staff appointment, category of Medical Staff membership and Prerogatives, and scope of Clinical Privileges, and if appropriate, recommend the length of the Provisional Period. If the Governing Board's action is favorable, the action shall be effective as its final decision.

2. *Adverse Recommendation.* If the Governing Board's decision on receiving a favorable Medical Staff Committee recommendation is an adverse recommendation to the Applicant, the Governing Board shall so notify the Applicant in writing and the Applicant shall be entitled to the procedural rights provided in Article IX of these Bylaws.

3. *Without Benefit of Medical Staff Committee's Recommendation.* If the Medical Staff Committee fails to make a recommendation, the Governing Board may, after informing the Medical Staff Committee of its intent, and allowing a reasonable period of time for response by the Medical Staff Committee, make its own determination using the same criteria considered by the Medical Staff Committee. The Governing Board shall vote on the Application and on the basis thereof, then take action on Medical Staff appointment, category of Medical Staff membership and Prerogatives, and scope of Clinical Privileges, and if appropriate, recommend the length of the Provisional Period. If the Governing Board's decision is Adverse to the Applicant, the Governing Board shall promptly so inform the Applicant by Certified Mail, and he/she shall then be entitled to the procedural rights provided in Article IX of these Bylaws.

4. *Adverse Medical Staff Committee Recommendation.* If the Governing Board receives an Adverse Medical Staff Committee recommendation, the Governing Board shall so notify the Applicant in writing and the Applicant shall be entitled to the procedural rights provided in Article VII of these Bylaws.

N. Any report by an individual or committee, including the report of the Governing Board, must state the reasons for each recommendation or action taken, with specific reference to appropriate portions of the Application or other documentation. The reasons shall relate to, but not be limited to, standards of patient care, patient welfare, the objectives of the Hospital, or the professional competency or conduct of the Applicant. Any dissenting views at any point in the process must also be evidenced in writing, supported by reasons and references, and transmitted with the majority report.

6.9 Appointment

A. The Governing Board, or his/her designee shall notify the Applicant in writing of its final decision. An Adverse decision shall be sent by Certified Mail.

B. The Governing Board's decision and notice pursuant to the preceding subsection shall include: the Medical Staff category to which the Applicant is granted membership, the Clinical Privileges he/she may exercise, and if applicable the length of the Provisional Period, and any special conditions attached to the appointment.

C. With respect to Medical Staff appointments and reappointments, granting Medical Staff membership and Clinical Privileges shall be contingent upon review and ascertainment of adequate health status if requested.

D. Appointments may be for a period of less than two (2) years if the Governing Board determines it is necessary to establish or maintain an orderly system for renewal of appointments. In addition, the Governing Board may, after considering the recommendations of the Medical Staff, appoint an Applicant for less than two (2) years in order to provide for more frequent evaluations of the Applicant, if it is determined to be necessary to assure that the Applicant's professional competence and/or conduct are appropriate. Appointment for a period of less than two (2) years shall not entitle an Applicant to a hearing or other rights as set forth in Article IX.

E. If Membership and Clinical Privileges are granted, the Credentialing Committee or its designee shall collect and maintain all relevant information regarding the Member's professional and collegial activity, performance and conduct in the Hospital for inclusion in each Staff Member's credentials file. Such information shall include, but is not limited to:

    1. Findings of quality assessment and utilization review activities demonstrating patterns of patient care and utilization;

    2. Continuing education activities and participation in other internal training;

3. Clinical activity at the Hospital;
4. Previously successful or currently pending challenges to the Member's licensure, sanctions imposed or pending, and other problems related to the Member's practice or professional conduct;
5. Health status, including any reasonable evidence of current health status that may be requested by the Medical Staff Committee retained in a separate file as the confidential medical record;
6. Records of attendance at required Medical Staff and Hospital meetings;
7. Compliance with requirements related to the preparation of medical records;
8. Ability to work cooperatively with other Practitioners, Hospital personnel, and the Governing Board;
9. General character of relationships with patients and the Hospital;
10. Ability to comply with all applicable Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, policies and procedures, and the Hospital's Corporate Compliance and Risk Management Plans;
11. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital;
12. Ability to practice in an efficient manner taking into account the patients' medical needs, the facilities, services, and resources available and generally recognized utilization standards as identified by the Utilization Review Committee;
13. Any other relevant information that could affect the Member's status and Privileges at the Hospital, including any activities of the Member at other hospitals and the Member's clinical practice outside the Hospital.

F. An Applicant who has received a final Adverse decision, has voluntarily resigned or withdrawn an Application for appointment or reappointment, fails to apply for reappointment while under investigation, may not reapply for the denied Medical Staff category or Clinical Privileges for a period of at least one (1) year from that date unless the Governing Board expressly provides otherwise.

G. Any reapplication after the one (1) year period will be processed as an initial Application and the Applicant must submit such additional information as required by the Medical Staff or the Governing Board to show that any basis for the earlier Adverse Action has been resolved.

6.10 Reappointment

A. No later than ninety (90) days prior to the date of expiration of the Member's appointment, the CEO, or his or her designee, will notify the Member of the upcoming expiration date.

B. No later than sixty (60) days before the expiration date, the Member must furnish, to the CEO or their designee, the following reappointment materials in writing and on a form approved by the Governing Board:

   1. All information necessary to bring Member's file current regarding the information required, including all current licensure and Governing Board certification information, controlled substance registration, professional liability insurance coverage, the status of other institutional affiliations, pending or completed disciplinary actions, and health status changes;

   2. Any requests for changes to Clinical Privileges, with the basis for any requested changes;

   3. Any requests for Staff category or Clinical Service assignment changes, with the basis for the requested changes.

   4. Member shall provide attestation statement of continuing medical and/or professional training and education completed during the preceding period.

C. If a Member without good cause fails to provide this information in a timely manner, the Member will be deemed to have voluntarily resigned from the Staff, and shall have his or her membership and Clinical Privileges terminated automatically at the end of the current term unless the Member requests, in writing, an extension and the extension is granted by the Medical Staff.

D. The individual whose membership is so terminated is entitled to the procedural rights provided in Article IX for the sole purpose of determining the issue of good cause.

E. The CEO, or his/her designee, shall verify the information provided on the reappointment Application and notify the Member of any deficiencies, inadequacies, or verification problems.

F. The CEO or his/her designee will provide the Member's information to the Credentialing Committee.

G. The Credentialing Committee or its designee shall be responsible for collecting and verifying all qualification information received, and for promptly notifying the Applicant of any problems with obtaining required information.

H. The Credentialing Committee shall review the Member's file and any other relevant information available to it, and shall prepare a written recommendation to approve or disapprove the reappointment Application including any special limitations on reappointment or non-reappointment, Medical Staff category, and Clinical Privileges. If new or different Clinical Privileges or Medical Staff category are requested, the Credentialing Committee shall make recommendations on the length of the Provisional Period if applicable.

I. The Credentialing Committee shall submit its written recommendation to Medical Staff Committee.

J. The Medical Staff Committee will submit recommendation to the Governing Board for final approval.

K. The final determinations regarding reappointment applications shall follow the process set forth in Sections 6.7, N through Q. For purposes of reappointment, the terms "Applicant" and "appointment" as used in those sections shall be read, as "Member" and "reappointment," respectively.

L. Notice provided to a Member and the Member's provision of updated information shall follow the procedure included in Section 6.8.A of this Article. Thereafter, and except for good cause, any other party who is obligated to act under these Bylaws must forward reappointment reports and recommendations to the Credentialing Committee, and all such reports and recommendations must be returned to the Governing Board of Directors before the expiration of the Medical Staff membership of the Member.

M. The time periods addressed are guidelines for accomplishing the reapplication process.

N. If this process has not been completed by the end of the membership or appointment term due to Hospital's delay, the Member remains a current Member and keeps his or her Clinical Privileges until the time that the process is complete, unless Adverse Action is taken.

O. If the delay is due to the Member's failure to provide information included in Section 6.8.B of this Article, his or her Medical Staff membership ends on the expiration date as provided in said Section 6.8C unless explicitly extended as provided therein. Any extension of the process shall not create a right of automatic reappointment for the current term.

P. The Member may, either in connection with reappointment or at any other time, request modification of his or her Medical Staff category or Clinical Privileges by

submitting written notice to the CEO, or his/her designee. A modification request is processed in the same manner as an Application for reappointment.

Q. Reappointment terms will generally be for a period of not more than two (2) years. Reappointment terms may be for a period of less than two (2) years if the Governing Board determines it is necessary to establish or maintain an orderly system for renewal of appointments.

R. In addition, the Governing Board may, after considering the recommendations of the Credentialing Committee, reappoint a Member for less than two (2) years in order to provide for more frequent evaluations of the Member, if it is determined to be necessary to assure that the Member's care and/or conduct are appropriate.

S. Reappointment for a period of less than two (2) years shall not entitle a Member to a hearing or other rights as set forth in Article IX.

6.11 Application for Privileges as Allied Health Professional.

A. Application for Clinical Privileges. Every Allied Health Professional who seeks Clinical Privileges must make written application for such Privileges or for any changes in Privileges.

1. The Medical Staff Committee, with input from the Credentialing Committee and approval of the Governing Board, will develop written guidelines for types of Allied Health Professionals that include:

    a. Minimum training and experience requirements;

    b. Types of patients the Allied Health Professional category may see;

    c. A description of Services to be provided by the Allied Health Professional category, including any special equipment, procedures or protocol that may be required;

    d. The degree of assistance the Allied Health Professional category may require from a Medical Staff Member including the nature of any supervision requirements or other limitations for each Service;

    e. Whether the category of Allied Health Professional shall require sponsorship and, if so, procedures for the designation of a sponsor.

2. Applications shall be submitted to the CEO or his/her designee, who will provide Allied Health Professionals' applications for grant of Clinical Privileges to the Credentialing Committee.

3. Applications from Allied Health Professionals for Clinical Privileges shall include:

a. The name of the Medical Staff Member who will be the sponsor of the applicant unless and until a change in sponsor is granted;

b. Documents and information relevant to the applicant's profession set forth in Article VI of these Bylaws;

c. Documentation necessary to demonstrate satisfaction of any requirements or written guidelines established for the Allied Health Professional's category by the Medical Staff;

d. A written statement of the clinical duties and responsibilities for which the allied health professional is requesting Clinical Privileges;

e. An agreement to abide by the applicable provisions of these Bylaws, Medical Staff Rules and Regulations, the Hospital's Corporate Compliance Plan and the Hospital's Risk Management Plan.

4. Allied Health Professionals' applications for grant of Clinical Privileges shall be reviewed by the Credentialing Committee in accordance with procedures established by the Medical Staff and the Governing Board.

5. The Credentialing Committee will refer their recommendation concerning the Allied Health Professional applicant to the Medical Staff Committee. The Medical Staff will refer their recommendation to the Governing Board. The CEO may grant temporary Privileges to the Applicant pending final consideration and action by the Governing Board. The Governing Board will make the final determination as to whether the application is approved or denied, taking into consideration the recommendation of the Medical Staff Committee and the CEO.

B. Service Assignment. An Allied Health Professional shall be individually assigned, when appropriate, to the Clinical Service appropriate to his or her professional training and shall be subject to an initial probationary period, formal periodic reviews, and disciplinary procedures as determined for his or her category and as set forth in the Hospital's employee handbook.

C. Review of Credentials. An Allied Health Professional's credentials shall be reviewed on at least an annual basis the first two (2) years of the appointment and at least every two (2) years thereafter.

D. Procedural Rights. An Allied Health Professional is not eligible for the procedural due process rights as provided for Members in Article IX of these Bylaws.

ARTICLE VII –DELINEATION OF CLINICAL PRIVILEGES

7.1 Exercise of Privileges. Medical Staff appointment or reappointment alone shall not confer any Clinical Privileges, or right to practice at the Hospital. Clinical Privileges may only be exercised as granted by the Governing Board, except that Temporary Privileges may be granted in accordance with Section 7.11 of this Article.

7.2 Basis for Privilege Determinations.

A. Clinical Privileges recommended to the Governing Board shall be based upon information submitted by a Member, Allied Health Professional, or any Applicant in accordance with these Bylaws, and the criteria identified in Article III and Article IV. The following factors may also be used in determining Privileges:

1. Patient care needs in the area for the type of Privileges requested;
2. Geographic location of the Member or Allied Health Professional;
3. Coverage available in his or her absence;
4. Adequacy of professional liability insurance.

B. If necessary, review of patient records treated in other Hospitals or practice settings may be relied upon for Privilege determinations.

C. Privilege determinations for current Members or Allied Health Professionals seeking reappointment or a change in Privileges must include observed clinical performance and documented results of quality assessment and utilization review activities including, but not limited to, the appropriateness of admission and length of stay, necessity of procedures, and indication for ancillary services.

7.3 Responsibility in Defining Privileges.

A. The Credentialing Committee shall define and recommend the Clinical Privileges to be granted and exercised at the Hospital.

B. Recommendations may include the operative, invasive, and any special procedures or services, or conditions associated with Privileges, such as levels of severity or complexity, and the requisite training, experience, or other qualifications required to perform the procedures or otherwise exercise the Clinical Privileges.

C. The Credentialing Committee and the Medical Staff Committee recommendations shall be reviewed and are effective only upon approval by the Governing Board.

D. The delineation of Privileges must be reviewed at reappointment, and recommendations from the Credentialing Committee and the Medical Staff Committee are given to the Governing Board. The Governing Board must approve any revisions.

7.4 Consultation and Other Conditions.

A. Special requirements for consultation may be required of the Member as a condition to the performance of any or all Clinical Privileges in addition to the requirements set forth in the Medical Staff Rules and Regulations and/or policies of the Hospital or Service.

B. Each individual requesting Clinical Privileges agrees that in dealing with cases outside the scope of his or her training, or in an unusual area of practice, he or she will seek appropriate consultation with a practitioner who has expertise in such cases and, if necessary, refer such cases to the practitioner.

7.5 Requests.

A. An application for original delineation of Privileges and for continuation of Privileges shall be made at the time of appointment or reappointment to the Medical Staff or, for Allied Health Professionals, prior to the commencement of providing requested services for the Hospital.

B. Requests for modifications of Privileges between reappointment periods may be submitted at any time, except that such request may not be resubmitted within one year of the time a similar request has been denied, unless additional education and experience have subsequently been accomplished.

C. Requests for Temporary Privileges may be made at any time, and in accordance with these Bylaws.

7.6 Procedure.

A. Requests for Clinical Privileges shall be processed in accordance with the procedures outlined in Article VI of these Bylaws, as applicable.

B. Temporary Privileges requests shall be processed according to Section 7.11 of this Article.

7.7 Special Conditions for Dentists.

A. Clinical Privileges requests received from a Dentist shall be reviewed in accordance with the procedures contained in this Article.

B. A Dentist's request for Privileges to perform surgical procedures shall be reviewed by the Physician Advisor of the Surgical Services.

C. A Physician Member who is active and of good standing on the Medical Staff shall at all times be responsible for the care of a patient receiving services from the Hospital.

D. The Dentist and the Physician Member must agree on the performance of any surgical procedure if a significant medical abnormality is present.

E. The Dentist is responsible for the dental care of the patient, including the dental history, physical examination, and all appropriate elements of the patient's record.

7.8 Special Conditions for Podiatrists.

A. Clinical Privileges requests received from Podiatrists shall be reviewed in accordance with the procedures contained in this Article.

B. The Podiatrist is responsible for the podiatric care of the patient, including the podiatric history, physical examination, and all appropriate elements of the patient's record.

C. Surgical procedures by a Podiatrist are limited to those that may be performed within the lawful scope of podiatry and within standard of care for that setting.

7.9 Special Conditions for Allied Health Professional Staff.

A. Requests for Clinical Privileges by Allied Health Professionals shall be processed in the manner specified in Article VI, as applicable.

B. An Allied Health Professional may, subject to any licensure requirements, supervision requirements, Privileges granted, or other limitations, exercise independent judgment within the areas of his or her professional competence and participate directly in the medical management of patients under the supervision of a Physician who has been accorded Privileges to provide such care.

C. A Physician Member must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization, and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.

7.10 Emergency, Disaster Privileges. For purposes of this section, "Emergency" is defined as a situation where acute symptoms are present, of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs. A state of emergency/disaster may be declared if the Hospital's Emergency Response Plan is activated, and the Hospital is unable to handle the immediate and emergent patient care needs with its existing Medical Staff. In these situations, Disaster Privileges may be granted.

A. <u>Emergency Privileges.</u>

1. In case of an Emergency, as defined in this paragraph, any Member is authorized and shall be assisted to render medical treatment to attempt to save

the patient's life or to save the patient from serious harm, as allowed within the Member's scope of practice, and notwithstanding the Member's Staff category, or level of Clinical Privileges.

2. Emergency Privileges may be granted by the Chief of Staff or the CEO.

3. A Practitioner exercising Emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care.

4. The refusal to grant Emergency Privileges, or the termination or withdrawal of Emergency Privileges shall not entitle the Practitioner involved to a hearing or any other procedural rights or review unless the decision is required to be reported to the National Practitioner Data Bank.

B. Disaster Privileges.

1. When the Hospital's Emergency Response Plan is activated, and the Hospital is unable to handle immediate and emergent patient care needs with its existing Medical Staff, the CEO or Chief of Staff may grant Disaster Privileges to individuals deemed qualified and competent for the duration of the state of emergency.

2. Disaster Privileges will be granted on a case-by-case basis as the discretion of the CEO or Chief of Staff.

3. Unless exceptional circumstances exist requiring immediate Disaster Privileges, any individual seeking Disaster Privileges must provide identification and proof of licensure as follows:

   a. A current employer or hospital photo identification card clearly identifying professional designation;

   b. A current license, certification, or registration;

   c. Primary source verification of licensures, certification, or registration;

   d. Identification as a member of a Disaster Medical Assistance Team, Medical Reserve Corps, or Public Health Service Commissioned Corps;

   e. Identification demonstrative registration with the Emergency System for the Advance Registration of Volunteer Healthcare Professionals or with other recognized state or federal disaster assistance groups;

   f. Other identification demonstrating the individual has authority or licensure to render patient care, treatment, and services; or

g. Identification by a Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's competence and qualifications.

4. Primary source verification of licensure, certification, or registration of individuals with Disaster Privileges will begin as soon as practicable, including:
   a. Professional licensure;
   b. DEA registration (if applicable);
   c. National Practitioner Data Bank;
   d. Criminal background check.
5. Individuals granted Disaster Privileges are subject to oversight by the Medical Staff.
6. Disaster Privileges are effective only so long as the state of emergency continues.
7. Disaster Privileges shall terminate:
   a. Immediately upon notice to the individual with Disaster Privileges the state of emergency necessitating Disaster Privileges has concluded;
   b. When the Hospital's emergency response plan is inactivated; or
   c. At the request of the CEO or Chief of Staff, for any reason.

7.11 Temporary Privileges.

A. Temporary Privileges may only be granted to fulfill an important patient care need, including Locum Tenens coverage; or when an Applicant with a complete, clean Application is awaiting review and approval of the Medical Staff and the Governing Body.

B. Temporary Privileges may be granted as described in Subsection A of this section, and are available only to a licensed Applicant, when documentation submitted substantially supports that the requesting Applicant has the requisite qualifications, ability, and judgment to perform the Privileges requested and provides documentation that professional liability insurance requirements have been met.

C. A request for Temporary Privileges may be initiated by the CEO, Chief of Staff, Applicant, or Allied Health Professional applicant.

D. The CEO, or his/her designee, shall confirm the requestor's application is complete and verify licensure; relevant training and experience; current competence; ability to perform Privileges as requested; query the National Practitioner Data Bank;

confirm the individual has not been subject to involuntary termination of medical staff membership at another organization; confirm the individual has not been subject to involuntary limitation, reduction, or denial of Clinical Privileges; and confirm the individual meets all other applicable qualifications set forth in these Bylaws.

E. Once completed, the CEO, or his/her designee, shall provide the request for Temporary Privileges to the Chief of Staff, or his/her designee.

F. Requests for Temporary Privileges will be reviewed by the Chief of Staff, or his/her designee.

G. If the Chief of Staff, or his/her designee determines the criteria for granting Temporary Privileges have been satisfied as set forth herein, she/he may make a favorable recommendation to the CEO.

H. After reviewing a favorable recommendation of the Chief of Staff to grant Temporary Privileges, the CEO may grant Temporary Privileges for an initial period of no more than sixty (60) days, with subsequent renewals not to go beyond the pendency of the Application or other limitations set forth in these Bylaws.

I. Any renewal of Temporary Privileges can be made only upon the recommendation of the Chief of Staff and the concurrence of the CEO, or his/her designee, all of which must be in writing, and is contingent upon the receipt of information that continues to support the granting of the requestor's Application for membership and Privileges.

J. Temporary Privileges cannot be extended if the Application is still pending due to the Applicant's failure to respond in a satisfactory manner to a request for more information or clarification.

K. The Chief of Staff may require that an individual granted Temporary Privileges consult with the relevant Physician Advisor, and that such Physician Advisor report regarding the Practitioner’s activity in the Hospital during the Temporary Privileges period.

L. Upon receipt of the documentation specified in this section from an individual who is not an Applicant for Medical Staff membership, Temporary Privileges to provide Clinical Services to a specific patient or patients, or for a specified period, may be granted by the CEO, or his/her designee, with the concurrence of the Chief of Staff if all other criteria for Temporary Privileges have been met.

M. The CEO may at any time, upon the recommendation of the Chief of Staff, terminate Temporary Privileges. Such termination may be effective immediately, or such other time as established by the CEO or Chief of Staff.

N. The Chief of Staff shall assign a Member to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the Hospital or have chosen another Practitioner with appropriate Clinical Privileges in the Hospital.

O. The granting of Temporary Privileges is a courtesy by the Hospital. Neither the granting, denial, suspension, nor revocation of such Privileges entitle the Practitioner to any procedural rights for a hearing or appellate review created by these Bylaws.

P. By accepting the Temporary Privileges status, the Practitioner agrees to comply with the Medical Staff Bylaws, the Medical Staff Rules and Regulations, Hospital Compliance Program, Hospital Risk Management Program, and Hospital policies and procedures in matters relating to his or her activities in the Hospital.

Q. Temporary Privileges for Locum Tenens. Temporary Privileges may be granted to a Practitioner who applies for appointment as a Locum Tenens.

1. The Locum Tenens Temporary Privileges may be granted for a maximum period of sixty (60) days.
2. Locum Tenens Privileges may be granted only if the Hospital receives a complete Application.
3. Procedures for reviewing the completed Application of a Practitioner requesting Locum Tenens Privileges shall follow those procedures for granting other Temporary Privileges.
4. The CEO may at any time, upon the recommendation of the Chief of Staff, terminate Temporary Privileges of a Locum Tenens.
5. Such termination may be effective immediately, or such other time as established by the CEO or Chief of Staff.
6. The Chief of Staff shall assign a Member to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the Hospital or have chosen another Practitioner with appropriate Clinical Privileges in the Hospital.
7. The granting of Locum Tenens Privileges is a courtesy by the Hospital.
8. Neither the granting, denial, suspension, nor revocation of such Privileges shall entitle the Practitioner concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeal.

7.12 Telemedicine Privileges.

A. Prior to a Practitioner providing telemedicine services to patients of the Hospital, the Practitioner must be appropriately credentialed and granted Clinical Privileges to the Hospital.

B. Such Practitioners may be credentialed in accordance with Articles IV, VI and VII of these Bylaws or, at the Hospital's discretion, Hospital may rely upon credentialing information evidencing the Practitioner's current active medical staff membership at another hospital.

C. If the Hospital chooses to rely upon the credentialing information of another hospital in lieu of the requirements of this Article VII, Hospital will verify the other hospital at which the Practitioner is an active medical staff member is a Medicare participating hospital; what privileges the Practitioner has been granted at the other hospital; and the Practitioner holds a Valid Unrestricted License in the State of Missouri.

D. Practitioners may only be granted Privileges to provide telemedicine services to patients of the Hospital if the Hospital has a written agreement with the distant-site hospital or telemedicine entity in accordance with 42 C.F.R. Parts 482 and 485.

E. The Credentialing Committee shall also check the OIG Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the Applicant has been convicted of a health care-related offense, debarred, excluded or otherwise made ineligible for participation in Federal or state health care programs.

ARTICLE VIII – CORRECTIVE ACTION

8.1 Grounds for Corrective Action. Corrective Action against a Member, Practitioner, or Allied Health Professional may be initiated whenever the Member engages in or exhibits actions, statements, demeanor, or conduct, either within or outside the Hospital, that is, or is reasonably likely to be:

A. Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital;

B. Disruptive to Hospital operations;

C. Damaging to the Medical Staff's or the Hospital's reputation;

D. Below the applicable standard of care;

E. A known or suspected violation of applicable ethical standards or the Hospital's Governing Documents;

F. A known or suspected violation of any law or regulation relating to federal or state programs;

G. Grounds for disciplinary action by the Missouri Governing Board of Healing Arts or other agency applicable to the Practitioner or Allied Health Professional.

8.2 Procedure.

A. Requests for Corrective Action. A Member of the Medical Staff, any standing committee of the Medical Staff, CEO, or the Governing Board may make a request for an investigation ("Investigation Request") into potential Corrective Action of a Member, Practitioner, or Allied Health Professional.

1. All Investigation Requests shall be in writing, shall be made to the Medical Staff, and shall state the specific events, activities, or conduct which constitute the grounds for the Investigation Request.

2. The Medical Staff shall promptly notify the CEO and chair of the Governing Board in writing of receipt of an Investigation Request.

B. Discretionary Interview; Resolution Prior to Corrective Action.

1. Prior to or upon receipt of an Investigation Request, the Medical Staff or its designee may, at the Medical Staff option, conduct an informal interview with the Member, Practitioner, or Allied Health Professional subject to the Investigation Request.

2. If this option for informal interview is exercised, the individual who is subject to the Investigation Request will be informed of the general nature of the

allegations against him or her and will be permitted to discuss, explain, or refute them.

3. The interview provided in this section is not a procedural right of the Member, Practitioner, or Allied Health Professional and need not be conducted according to the procedural rules provided in Article IX of these Bylaws.

4. The party initiating the interview shall prepare a dated, written summary of the interview.

5. This written summary shall be forwarded to the Medical Staff and shall be retained in the Member, Practitioner, or Allied Health Professional's confidential peer review file.

C. Formal Investigation.

1. The Medical Staff Committee will conduct or cause to be conducted an investigation surrounding the facts alleged in the Investigation Request which may include, but are not limited to, the discretionary informal interview set forth in Article VIII Section 8.2.B, interviews with individual(s) or group(s) who submitted the Investigation Request, and/or other individuals who may have knowledge of information relevant to the events involved. The investigation process is not a "hearing" as that term is used in Article IX and shall not entitle the Member or Practitioner to the procedural rights provided in Article IX.

2. If an investigation is not conducted by the Medical Staff Committee, the party conducting the investigation will submit a written investigative report to the Medical Staff Committee as soon as practicable after receiving the assignment to investigate.

3. The Medical Staff Committee may, at any time in its discretion, and shall at the request of the Governing Board, terminate the investigative process and proceed with action as provided below.

D. Suspected Physical or Mental Disability.

1. If the party conducting the investigation has reason to believe the conduct of the individual who is the subject of the Investigative Request was the result of a physical or mental disability, the Medical Staff Committee may require the individual involved to submit to an impartial physical or mental evaluation within a specified time and pursuant to the guidelines set forth below.

2. Failure by the individual to comply, without good cause, shall result in immediate suspension of the individual's Medical Staff membership and all

Privileges until such time as the evaluation is completed, results are reported to the Medical Staff Committee, and the Governing Board takes final action.

3. The Hospital shall name the Physician who shall conduct the examination and shall pay for the examination. All reports and other information results from the mental or physical evaluation shall be maintained in a separate file as a confidential medical record.

E. Medical Staff Committee Action. As soon as practicable after the conclusion of the investigative process, if any, the Medical Staff Committee shall act. Its action may include recommending, without limitation, the following:

1. Rejection of the request for Corrective Action;
2. Verbal warning or a letter of reprimand;
3. Education and/or training;
4. Medical or psychiatric treatment or referral of the individual to an impaired provider program;
5. A probationary period with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision;
6. A requirement of prior or concurrent consultation or direct supervision;
7. A limitation of the right to admit patients;
8. Reduction, suspension or revocation of all or any part of the individual's Clinical Privileges;
9. Suspension or revocation of the individual's Medical Staff membership.

F. Adverse Recommendations Regarding Members. Any Adverse Recommendation of the Medical Staff Committee regarding a Member shall be submitted to the CEO who shall provide Special Notice stating the Adverse Recommendation to the individual and they shall entitle the affected Member to the procedural rights provided in Article IX.

G. Adverse Recommendations Regarding Non-Members.

1. Adverse Recommendations of the Medical Staff Committee regarding Practitioners who are not Members of the Medical Staff shall be forwarded to the CEO who may notify the affected individual, but such individual shall not be entitled to the procedural rights provided in Article IX unless the Adverse Recommendation must be reported to the National Practitioner Data Bank.

2. The CEO shall inform the Governing Board of the Medical Staff's Adverse Recommendation.

3. The Governing Board shall act on the recommendation, except the Practitioner shall not be entitled to a hearing or appellate review unless the Adverse Recommendation must be reported to the National Practitioner Data Bank.

H. Favorable Medical Staff Committee Recommendations.

1. If the Medical Staff Committee's recommendation is favorable to the Member, Practitioner, or Allied Health Professional, the Medical Staff Committee shall promptly forward its recommendation to the CEO who will provide the Medical Staff Committee's recommendation to the Governing Board.

2. The Governing Board may adopt or reject any portion of the Medical Staff Committee's recommendation that was favorable or refer the recommendation back to the Medical Staff Committee for additional consideration, but must state the reason(s) for the requested reconsideration and set a time within which a subsequent recommendation must be made.

I. Effect of Adverse Recommendation, Finality. No Adverse Recommendation is to take effect or to be forwarded to the Governing Board until after a Member has exercised or has been deemed to have waived his or her right to a hearing as provided in Article IX.

8.3 Temporary Suspension of Privileges.

A. At any time during the investigation, the Medical Staff Committee may, with approval of the CEO, suspend all or any part of the Privileges of the individual subject to the Investigation Request.

B. This suspension shall be deemed to be administrative in nature and shall remain in effect during the investigation and shall not indicate validity of the allegations made.

C. Any decision to impose such an administrative temporary suspension of Privileges shall not be subject to appeal.

D. If an administrative temporary suspension of Privileges is imposed, the investigation shall be completed within fourteen (14) days of the effective date of the suspension.

E. If the investigation is not completed within fourteen (14) days of the suspension, the reasons for the delay shall be transmitted to the chairman of the Governing Board who may consider whether to request the Governing Board vote to lift the suspension.

F. If the chairman of the Governing Board does not request such consideration from the Governing Board, the suspension shall remain in place and the investigation shall be completed as soon as practicable.

8.4 Summary Suspension.

A. Grounds for Summary Suspension. If a Member, Practitioner, or Allied Health Professional's conduct is of such a nature as to warrant action to protect the life, health, or safety of any patient or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee, or other person present in the Hospital or to preserve the continued operation of the Hospital. Additionally, summary suspension may be imposed on such individuals upon the occurrence of any of the following:

1. Being charged with a felony;
2. Being charged with the commission of a misdemeanor which may relate to the individual's qualifications for Medical Staff membership or ability to perform Clinical Privileges;
3. Engaging in or being charged with unlawful or unethical activity related to the practice of his or her profession;
4. Engaging in any dishonest, unprofessional, abusive, or inappropriate conduct which is or may be disruptive of Hospital operations or procedures;
5. Having any medical staff membership, clinical privileges, certification, licensure, or registration terminated, suspended, restricted, limited, reduced, or modified in any way;
6. Having resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or privileges;
7. Having voluntarily surrendered or agreed not to exercise any privileges while under investigation or to avoid an investigation;
8. Having made a material misstatement or omission on any pre-application or Application for appointment or reappointment, or at any time providing incorrect information or otherwise deceiving or attempting to deceive or mislead the Medical Staff and/or Hospital, its agents, Governing Board, and/or other representatives;
9. Having falsified or inappropriately destroyed or altered any medical record;
10. Refusing to submit to evaluation or testing relating to the individual's mental or physical status, including refusal to submit to any testing related to drug or alcohol use;

11. Abandoning a patient or wrongfully failing or refusing to provide care to a patient;

12. Failing to maintain appropriate malpractice insurance or a current, Valid Unrestricted License to practice his or her profession;

13. Engaging in clinical activities outside the scope of the individual's Privileges.

B. Who May Suspend. The Chief of Staff, Vice Chief of Staff, Secretary, the applicable Physician Advisor, or CEO, after consultation with at least one of the foregoing, shall have the authority to summarily suspend or restrict all or any portion of the Clinical Privileges of a Member, Practitioner, or Allied Health Professional if an appropriate basis for such suspension is deemed to have occurred.

C. Procedure for Summary Suspension. The individual imposing the summary suspension shall immediately inform the CEO of the suspension, who shall promptly notify the individual subject to the suspension. If such affected individual is a Member, notification shall be made by Special Notice.

1. Such summary suspension shall become effective immediately upon imposition and shall continue in effect until the grounds for suspension no longer exist as determined by the Medical Staff Committee, CEO, and the Governing Board, or until the matter is resolved by further proceedings.

2. The applicable Physician Advisor shall assign a suspended Member, Practitioner, or Allied Health Professional's patients then in the Hospital to another qualified individual, considering the wishes of the patient, when possible, in selecting a substitute.

3. As soon as possible, but in no event later than fourteen (14) days after a summary suspension is imposed, the Medical Staff Committee shall convene to review and consider the need to modify, continue, or terminate the summary suspension. This meeting is not a hearing as contemplated in Article IX, even if the affected individual attends the meeting, and no procedural rights or requirements shall apply to this meeting.

4. If the Medical Staff Committee recommends terminating the individual's summary suspension, the Medical Staff Committee shall so notify the Governing Board who shall act to confirm the Medical Staff's decision to terminate summary suspension, or refer the matter back to the Medical Staff for reconsideration.

5. The terms of the summary suspension, as sustained or as modified by the Medical Staff Committee, shall remain in effect pending a final decision thereon by the Governing Board.

8.5 Automatic Suspension.

A. It is the responsibility of each Member, Practitioner, and/or Allied Health Professional to immediately notify the CEO of any of the following circumstances which may warrant automatic suspension of Privileges and provide the CEO a copy of the written order or notice from the applicable licensing agency, insurer, court, or other individual or entity.

B. The Hospital may impose automatic suspension of Privileges upon knowledge of any of the following circumstances with respect to a Member, Practitioner, or Allied Health Professional, regardless of whether such individual has reported the matter to the CEO.

C. The CEO shall give Special Notice to the individual whose membership and/or Clinical Privileges are subject to automatic suspension.

D. Any patients then under the care of the individual subject to automatic suspension shall be assigned to other Members, with deference given to the patients' preferences.

E. The individual subject to automatic suspension shall have thirty (30) days from the date of the Special Notice to provide clear and convincing evidence the facts relied upon by the Hospital in imposing the automatic suspension are incorrect or have been cured.

F. Absent the provision of such clear and convincing evidence, the individual's applicable Privileges and/or Medical Staff membership shall automatically terminate effective the day following the last day of the automatic suspension.

G. Failure to immediately notify the Hospital as required in this section may result in forfeiture of Privileges for one (1) year after which time, if imposed, the individual shall be required to submit for reapplication of Privileges.

H. If the individual subject to the automatic suspension provides clear and convincing evidence disputing the facts relied upon in imposing the automatic suspension, the CEO may reinstate the individual's Clinical Privileges.

1. <u>Licensure.</u>

a. *Revocation.* When an individual's license to practice his or her profession in Missouri is revoked, suspended, or on probation, his or her Staff membership and Clinical Privileges shall be immediately and automatically revoked as of the date of license revocation, suspension, or probation and shall continue until such license returns to an active status in good standing.

b. *Restriction.* When an individual's license to practice his or her profession in Missouri is limited or restricted, those Clinical Privileges which he or she has been granted, that are within the scope of the limitation or restriction, are similarly automatically limited or restricted as of the date of license limitation or restriction and shall continue for the duration of the restriction or limitation.

2. Controlled Substances Regulation.

    1. *Revocation.* Whenever a Member or Practitioner's Drug Enforcement Administration (DEA), Bureau of Narcotics and Dangerous Drugs (BNDD), or other controlled substances number is revoked, he or she shall immediately notify the CEO and provide a copy of the applicable agency's decision or notification of such revocation. A Member or Practitioner whose license, permit, or registration for controlled substances is revoked shall immediately and automatically be divested of his or her Privileges and right to prescribe medications covered by such number. A suspension under this provision shall continue until the applicable license, permit, or registration is reinstated and the Member or Practitioner provides the CEO documentation the license, permit, or registration is active and in good standing.

    2. *Suspension or Restrictions.* When a Member or Practitioner's DEA, BNDD, or other controlled substances number is suspended, limited, or restricted in any manner, his or her right to prescribe medications covered by the number is similarly suspended or restricted during the term of the suspension or restriction.

3. Medical Records Completion.

    a. In conformance with these Bylaws and the Medical Staff Rules and Regulations, all medical records shall be complete within fourteen (14) days following discharge of the patient.

    b. On the fifteenth day following the date of discharge, incomplete records will be considered delinquent.

    c. On that day, the Hospital will notify the Member, Practitioner, or Allied Health Professional of such delinquent records and of the provisions of this section providing for suspension of Privileges due to medical record deficiencies.

    d. The Hospital will document its efforts to notify the individual and to arrange for completion of the delinquent records.

e. If medical records are not completed within thirty (30) days from the date of discharge, Privileges may be suspended.

f. If Privileges are suspended pursuant to this provision, written notice of such suspension of Privileges, including if applicable rights to admit or schedule patients and to provide services at the Hospital or Hospital owned clinic or other locations will be sent to the individual.

g. Such suspension will remain in effect from the date of the letter of suspension until all delinquent records are completed.

h. This automatic suspension will be considered administrative in nature during the first thirty (30) days of suspension if the delinquency is an Administrative Delinquency.

i. If a Member is suspended longer than thirty (30) days for delinquent medical records, a suspension may be reportable to the National Practitioner Data Bank unless such suspension is due entirely to Administrative Delinquencies.

j. If any of the delinquencies are related to non-Administrative Delinquency deficiencies, the suspension may be deemed reportable to the National Practitioner Data Bank.

k. If a suspension for medical record delinquency is caused, in whole or in part, by any medical record deficiency that is not an Administrative Delinquency, a failure to cure all non-Administrative Delinquencies within thirty (30) days after the date a suspension becomes effective pursuant to this Section will be deemed to be a voluntary resignation of the Member's Privileges and membership.

l. Medical record deficiencies related to individuals other than Members may warrant the imposition of disciplinary action based on any contract, policy, procedure, or handbook of the Hospital.

4. Professional Liability Insurance. Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, including lapse, denial, or non-renewal of coverage, or falling below the minimum required insurance amount as set forth in these Bylaws, shall result in immediate and automatic suspension of Medical Staff membership and Clinical Privileges until such time as a certificate of appropriate insurance coverage is furnished.

5. Exclusion from State or Federal Health Care Reimbursement Programs. Upon exclusion, debarment, or other prohibition or limitation from participation in

any state or federal health care reimbursement program, the Member, Practitioner, or Allied Health Professional's applicable Medical Staff membership and/or Clinical Privileges shall be immediately and automatically suspended until such time as the exclusion, debarment, prohibition, or limitation is lifted.

6. Conviction of a Crime. Upon conviction of a felony or a crime involving moral turpitude in any court of the United States either federal or state, the Member, Practitioner, or Allied Health Professional's applicable Medical Staff membership and/or Clinical Privileges shall be automatically revoked.

7. Failure to Maintain an Alternate. All Members must name an alternate with equivalent or greater Privileges at the Hospital to attend patients in the event of incapacity or unavailability for any reason. Failure to name an appropriate alternate will result in immediate suspension from the Medical Staff and/or Clinical Privileges until such time as an alternate is named. In the event an appropriate alternate is not designated or available, the Chief of Staff and CEO will be contacted immediately for intervention, follow-up, and resolution.

8. Procedural Rights and Additional Corrective Action. No Member, Practitioner, or Allied Health Professional shall be entitled to the procedural rights set forth in Article IX as a result of an automatic suspension under this section. Any of the persons entitled to initiate Corrective Actions under Section 8.2.A of this Article may, however, initiate such action on the basis of any of the occurrences specified in Section 8.2.A, and if as a result thereof, an Adverse Recommendation or decision is made which exceeds the scope of the sanctions automatically imposed under paragraphs A through F of this section, the individual shall be entitled to the same procedural rights to which he or she would be entitled under Article IX and other applicable provisions of these Bylaws, but only with respect to the additional sanctions recommended or imposed.

ARTICLE IX – HEARING & APPELLATE REVIEW PROCEDURES

9.1 Purpose. The purpose of this Article is to provide and set forth the mechanisms for an internal resolution of matters bearing on the professional competency and conduct of Members who have membership and Privileges at the Hospital. This Article sets forth the procedures to be followed in connection with all hearings to be provided to Members. For purposes of this Article, "Member" shall include current Medical Staff Members or Applicants for membership, and any reference to a Member's rights for a hearing or appellate review shall be subject to the Prerogatives and other rights or limitations set forth in Article IV for the applicable Medical Staff category or Practitioner type.

9.2 Right to Hearing.

A. Adverse Actions Recommendations Defined. Except as otherwise specifically provided in these Bylaws, Members shall be entitled to a hearing on matters related to the Member's professional competency and conduct; provided, however, that only the following recommendations or actions shall constitute an Adverse Recommendation or Action entitling a Member to a hearing:

1. Denial of initial appointment to the Hospital's Medical Staff, but only if such denial is based on professional conduct or competency;
2. Denial of reappointment to the Hospital's Medical Staff;
3. Suspension or revocation of Medical Staff membership;
4. Denial of requested Medical Staff category when such denial is based on professional competency or conduct and not for other administrative reasons such as failure to meet the applicable qualifications or other criteria;
5. Reduction, suspension, revocation, denial, curtailment, limitation, restriction or other modification of Privileges, unrelated to Administrative Delinquencies or administrative suspensions, and other than a reduction, suspension, revocation, denial, limitation, or restriction of Temporary Privileges;
6. Suspension or precautionary suspension of Privileges for more than thirty (30) days;
7. Imposition of a mandatory concurring consultation requirement.

B. Adverse Action, When. A recommendation or action listed in Section 9.2.A of this Article shall be deemed Adverse only when it has been:

1. Recommended by the Medical Staff;

2. Taken by the Governing Board, contrary to a favorable recommendation of the Medical Staff Committee; or

3. Taken by the Governing Board on its own initiative, without benefit of a prior recommendation by the Medical Staff Committee.

C. Actions, Recommendations That Do Not Give Right To Hearing. The following recommendations or actions shall not be deemed Adverse Actions and shall take effect without rights to a hearing or appeal unless otherwise specifically provided.

1. An oral or written reprimand or warning, letter of admonition, letter of guidance, or extension of the Provisional Period;

2. Imposition of any general consultation requirement, or any requirement that the Member must be supervised while performing certain procedures;

3. Imposition of a probationary period;

4. Denial of requested Privileges because the Member failed to satisfy the basic qualifications or criteria of training, education, or experience established for the granting of Privileges or for Medical Staff appointment;

5. Denial, termination, reduction, restriction, or limitation of Temporary, Locum Tenens, or Emergency Privileges;

6. Reduction, suspension, revocation, denial, limitation, restriction, relinquishment or termination of Privileges and membership as provided in Article VII above;

7. Ineligibility for Medical Staff appointment or reappointment and/or the Clinical Privileges requested because a Clinical Service has been closed, or there exists an exclusive contract limiting the performance of the Service with which the Member is associated to one or more Practitioners;

8. Termination or revocation of Medical Staff appointment, or Clinical Privileges, either in whole or in part because the Hospital has decided to close a Clinical Service or grant an exclusive contract limiting the performance of Privileges within the Service in which the Member practices to one or more Practitioners; and one or more hearings were conducted by the Governing Board, a committee thereof, or *ad hoc* committee, formed for the purpose of evaluating the proposed closing or exclusive contracting.

9. Termination of the Member's employment or other contract unless the employment contract or Clinical Services contract provides otherwise;

10. Ineligibility for Medical Staff appointment or requested Clinical Privileges because of lack of facilities, equipment, or because Hospital has elected not to

perform, or does not provide the Clinical Service that the Members intends to provide, or the procedure for which Clinical Privileges are sought;

11. Reduction, suspension, revocation, denial, limitation, or restriction of Clinical Privileges, Staff appointment, or denial of Staff appointment because of the failure of the Member to comply with requirements of the Hospital's Governing Documents pertaining to any required dues, or any other requirement not based on professional competence or conduct;
12. Reduction, suspension, revocation, denial, limitation, or restriction of Medical Staff appointment or Clinical Privileges related to a Temporary Suspension;
13. Voluntary resignation, withdrawal, suspension, or relinquishment of an Application for appointment, reappointment, or specific Privileges when professional competence or conduct is not under investigation or at issue;
14. Voluntary resignation, withdrawal, suspension, or relinquishment of Privileges or Medical Staff membership which is not in return for the Member refraining from conducting an investigation of professional competence or conduct;
12. Imposition of a requirement for retraining, additional training or continuing education;
15. Imposition of specified or intensified review, including concurrent or retrospective review;
16. Suspension of Privileges, either in whole or in part, or Medical Staff membership for less than thirty (30) days;
17. Actions of any professional peer review entity in the assignment of standard of care determinations; or
18. Routine peer review and routine Corrective Action or peer counseling, whether conducted by or through the Medical Staff, the Hospital's Risk Management Committee, or another Hospital Committee.

9.3 Initiation of Fair Hearing.

A. Notice of Adverse Recommendation or Action. In all cases in which the body or committee, under these Bylaws has the authority to, and pursuant to this authority, has taken any action constituting grounds for a hearing as set forth in Section 9.2 of this Article, the Member shall promptly be given Special Notice in writing in accordance with the provisions below. Notice shall include a copy of Article IX of these Bylaws regarding Hearing and Appellate Review Procedures and shall state the Adverse Recommendation made. Such Member shall have thirty (30) days following the date of the receipt of such notice within which to request a fair hearing

by the Hearing Committee. Such request by the Member for a fair hearing must be sent to the CEO by Certified Mail and received by the CEO no more than thirty (30) days following the date the individual received such notice. In the event the Member does not request a fair hearing within the timeframe, and in the manner set forth in this section, the Member shall be deemed to have waived the opportunity for a fair hearing and to have accepted the action described in the notice of Adverse Recommendation or Action and it shall thereupon become effective immediately.

B. Time and Place for Fair Hearing. Upon receipt of a request for a fair hearing, the CEO shall deliver such request to the Medical Staff Committee. The Medical Staff Committee shall, within thirty (30) days after receipt, schedule and arrange for such a hearing. The Medical Staff Committee shall give notice to the Member of the time, place, and date of the hearing ("Notice of Fair Hearing"). Except as provided in this section, the date of commencement of the hearing shall be not less than fifteen (15) days, nor more than sixty (60) days from the date of receipt of the request by the CEO for a fair hearing; provided, however, that when the request is received from a Member who is under suspension which is then in effect, the fair hearing shall be scheduled to commence as soon as the arrangements may reasonably be made, but not to exceed fourteen (14) days from the date of receipt of the request for a fair hearing by the CEO.

C. Notice of Charges. As a part of, or together with the Notice of Fair Hearing, the Medical Staff Committee shall state in writing, and in concise language, the alleged acts or omissions of the Member, a list of patient records in question, or other reasons for the Adverse Recommendation against Member.

D. List of Witnesses. Either the Medical Staff Committee or the Member (each individually a "Party") may request a list of witnesses from the other Party prior to the hearing. Such request must be received by the other Party within ten (10) days of the date of the Notice of Fair Hearing. The Party receiving a written request for a list of witnesses must furnish to the other, in writing, the names and addresses of witnesses, so far as is then reasonably known, who will give testimony or evidence in support of that party at the fair hearing. If either the Medical Staff Committee or Applicant or Member (each, a "Party"), by written notice, requests a list of witnesses, then each Party within ten (10) days of such request, and at least three (3) days prior to the scheduled hearing date, shall furnish to the other a list, in writing, of the names and addresses of the individual, so far as is then reasonably known, who will give testimony or evidence in support of that party at the fair hearing. In the case of a Member who is under suspension which is then in effect, a Party must provide written notice requesting a list of witnesses from the other

Party within seven (7) days of receipt of the request, and at least three (3) days prior to the date of the scheduled hearing.

E. Appointment of Hearing Committee/Presiding Officer.

1. *Hearing Committee.* When a fair hearing is requested, the Chief of Staff shall appoint an ad hoc committee ("Hearing Committee") which shall be composed of not less than three (3) individuals with active medical staff membership and privileges with at least one hospital, but are not required to have membership on the Hospital's Medical Staff. An individual shall not be disqualified from serving on the Hearing Committee merely because they participated in the investigation off the acts or omissions at issue. Knowledge of the matter involved shall not preclude a Member of the Active Medical Staff from serving as a Member of the Hearing Committee. A Member of the Hearing Committee shall not be in direct economic competition with the accused Applicant or Member.

2. *Presiding Officer.* The Chief of Staff shall designate the Presiding Officer for the fair hearing. The Presiding Officer is not a member of the Hearing Committee. The Presiding Officer shall maintain decorum and assure participants have a reasonable opportunity to be heard and to present relevant oral and documentary evidence. The Presiding Officer shall be entitled to determine the order of procedure during the Hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the procedure for the fair hearing. The Presiding Officer is authorized to meet with the participants in advance of the hearing to establish an efficient process for the hearing.

3. *Witness List.* The list of witnesses expected to be called may be amended to add witnesses not contemplated at the time an earlier list of witnesses was provided to the other party upon request. An amended list of witnesses shall include a brief summary of the nature of the anticipated testimony of each witness. An updated list shall be furnished to the Applicant or Member at least three (3) working days prior to the hearing. The Applicant or Member shall also furnish a list of witnesses to the Hearing Committee at least three (3) working days prior to the hearing.

F. Forfeiture of Hearing. Failure of the individual requesting the hearing, who would otherwise be entitled to a hearing under these Bylaws, to appear and proceed at such a hearing, without good cause as determined by the Presiding Officer, shall be deemed to constitute voluntary acceptance of the recommendation or actions

involved, a forfeiture of any right to a hearing and to any appellate review to which they may have otherwise been entitled. Such recommendation or action shall then be submitted to the Governing Board to become final and effective.

G. Personal Presence. The Member who is granted a hearing, as provided by these Bylaws, is entitled to appear in person unless personal appearance has been waived, or the Member has failed, without good cause, to appear after appropriate notice.

H. Representation. The individual requesting the hearing may be accompanied by, and represented at, the hearing only by another Practitioner of the same profession who is licensed to practice in the State of Missouri, or by an attorney participating at the Member's expense. The body whose decision prompted the hearing shall appoint a representative from the Medical Staff to present its recommendation in support thereof and to examine witnesses. If the Member participates with an attorney, the Medical Staff may also appear through an attorney.

9.4 Hearing Procedure.

A. Rights of the Parties. At the fair hearing, both parties have the following rights, subject to reasonable limitations established by the Presiding Officer:

1. Be accompanied by an attorney or other individual of the party's choice;
2. Call, question, examine, and cross-examine witnesses;
3. Introduce relevant evidence and exhibits;
4. Impeach any witness;
5. Rebut any evidence;
6. Make a record of the hearing by use of a court reporter or an electronic recording unit at the party's expense;
7. Submit a written statement at the close of the hearing.

B. If the Member does not testify on his/her own behalf, the Member may be called and examined as if under cross-examination, and the refusal of the Member to provide truthful testimony may be deemed a failure to participate in the hearing and waiver of the right to a hearing.

C. Procedure and Evidence. The hearing need not be conducted according to rules of legal procedure relating to the examination of witnesses or presentation of evidence. Relevant evidence shall be admitted by the Presiding Officer if it is of the type of evidence upon which reasonable persons are customarily rely upon in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit

memoranda concerning any issues of law or fact, and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by them and entitled to notarize documents. The Hearing Committee may question any witnesses or direct that additional witnesses be called as it deems appropriate.

D. Basis of Decision. In reaching a decision, the Hearing Committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered according to the Bylaws in connection with applications for appointment or reappointment to the Medical Staff and for Privileges. The Hearing Committee or Presiding Officer may at any time take official notice of any generally accepted technical or scientific principles relating to the matter at hand and of any facts that may be judicially noticed by Missouri courts. The parties to the hearing shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the Presiding Officer or Hearing Committee.

E. Burden of Proof. For purposes of this paragraph and its subparagraphs, the terms Applicant and Member shall have the meanings set forth in the Definitions provisions of these Bylaws. At any hearing conducted under this fair hearing plan, the following rules governing the burden of proof shall apply:

1. When the hearing relates to denial, limitation, or other restriction of an Applicant's request for initial appointment or Privileges, the Applicant shall have the burden of producing evidence to demonstrate the Adverse Recommendation or Action lacks any substantial factual basis or that the basis or conclusions drawn therefrom are arbitrary, capricious, or unreasonable.

2. Otherwise, the body who proposed the Adverse Recommendation or Action and occasioned the hearing shall first come forward with evidence in support of its recommendation or action. Thereafter, the burden shall shift to the Member who requested the hearing to come forward with evidence in support of their challenge to the Adverse Action.

3. After the evidence has been submitted by both sides, the Hearing Committee may affirm the Adverse Recommendation or Action unless it finds that the Member who requested the hearing has proven by clear and convincing

evidence that the Adverse Recommendation or Action lacks any factual basis or that such basis or the conclusions drawn therefrom are arbitrary or capricious.

F. Record of Hearing. A record of the hearing of sufficient accuracy shall be kept so an informed decision can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Presiding Officer may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. If the Member who requested the hearing requests an alternative method, the Member shall bear the cost of using the alternative method. Regardless of which party chooses the method for making a recording of the hearing, the Hospital shall be the primary custodian of the hearing record. Upon request, the Member shall be entitled to obtain a copy of the record at his or her expense.

G. Postponements and Extensions. The Presiding Officer may grant requests for postponement of a hearing upon a showing of a good cause. The Presiding Officer may recess the hearing and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

H. Adjournment and Decision. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall deliberate outside the presence of the parties, except the Presiding Officer or legal counsel representing the Hearing Committee, if any, and at such time and in such location as is convenient to the Hearing Committee. Upon conclusion of the Hearing Committee's deliberations, the hearing shall be adjourned.

1. *Presence of Hearing Committee Members and Vote.* A majority of the Hearing Committee shall be present at all times during the hearing and deliberations. If a committee member is absent from any part of the proceedings, the Presiding Officer in the Presiding Officer's discretion may rule that such member be excluded from further participation in the proceedings or recommendations of the Hearing Committee.

2. *Report*- Within twenty (20) days after adjournment of the hearing, the Hearing Committee or Presiding Officer shall make a written report of their findings and recommendations with specific references to the hearing record and other documentation considered. The Hearing Committee or Presiding Officer shall forward the report, the hearing record, and all other documentation used during the hearing to the body whose Adverse recommendation or Action occasioned the hearing. The report shall include a statement of the basis for its recommendations.

3. *Action on Report* - Within twenty (20) days after receipt of the hearing report from the Hearing Committee, the Medical or Governing Board, as applicable, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter.

    a. Unfavorable Findings and Recommendations of the Medical Staff Committee, Governing Board. If the recommendations of the Medical Staff Committee or Governing Board, as applicable, are unfavorable to the Applicant or Member who requested the hearing, the CEO shall send Special Notice to the Applicant or Member, and shall advise them of their right to an appellate review, the time period and requirements for submitting a request for an appellate review, state that failure to request an appellate review within the specified time period shall constitute a waiver of the right to appellate review and all other rights to which they may have otherwise been entitled, and state that after receipt of a timely request for an appellate review, the Applicant or Member will be notified of the date, time, and place of the appeal.

    b. Favorable Findings and Recommendations of the Medical Staff Committee, Governing Board. If the Medical Staff Committee's recommendation is favorable to the Applicant or Member who requested the hearing, the Medical Staff Committee shall promptly forward it, together with all supporting documentation, to the Governing Board for final action. The Governing Board shall take action thereon by adopting the recommendation, or rejecting the Medical Staff Committee's recommendation in whole or in part by referring the matter back to the Medical Staff Committee for further consideration. Any such referral back to the Medical Staff from the Governing Board shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Governing Board must be made, and may include a directive a follow-up hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence on the matter, the Governing Board shall take final action. The CEO shall, on behalf of the Governing Board, promptly send Special Notice of the Governing Board's final action to the affected Applicant or Member informing the Applicant or Member of each action taken. A favorable determination shall become the final action of the Governing Board and the matter shall be considered closed.

9.5 Appellate Review.

A. Initiation and Prerequisites of Appellate Review.

1. *Grounds for Review.* The grounds for appeal from an Adverse Recommendation of the Hearing Committee shall be limited to the following:

   a. Substantial failure by the Hearing Committee to comply with this fair hearing plan or these Bylaws in general so as to deny a fair hearing; or

   b. The recommendations of the Hearing Committee were not supported by substantial evidence contained in the Hearing record, or were arbitrary or capricious.

2. *Timeframe for Request.* An Applicant or Member shall have ten (10) days after receiving Special Notice of his or her right to request an appellant review, to submit a written request for such review.

3. *Procedure for Submitting Request.* Such request shall be directed to the CEO, in person or by Certified Mail, and may include a request for a copy, at the Member's expense, of the Hearing Committee report and record of and all other material, favorable or unfavorable, if not previously provided, that was considered in making the Adverse Recommendation or Action. If the Member wishes an attorney to represent him or her at any appellate review, the request for appellate review shall so state.

B. Waiver by Failure to Request Appellate Review. A Member who fails to request an appellate review in accordance with Section 9.5.A of this Article waives any right to such review. Such waiver shall have the same force and effect as stated in this Article regarding waiver by failure to request a hearing.

C. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Governing Board. As soon as practicable, the Governing Board shall schedule and arrange for an appellate review which shall not be less than ten (10) days, nor more than thirty (30) days, after receipt by the CEO of the request of review; provided, however, that an appellate review for a Member who is under summary suspension shall be held as soon as the arrangements for it may be reasonably made, but not later than fifteen (15) days after the CEO's receipt of the request. At least ten (10) days prior to the date of the appellate review, the CEO shall send the Applicant or Member Special Notice setting forth the time, place, and date of the appellate review. The Appellate Review Body may extend the time for the appellate review for good cause, and if the request is made as soon as is reasonably practicable.

D. Appellate Review Body. The Governing Board shall determine whether the appellate review shall be conducted by the Governing Board as a whole, or by an appellate review committee composed of three (3) or more members of the Governing Board, appointed by the Chairperson of the Governing Board ("Appellate Review Body"). If a committee is appointed, one of its members shall be designated as chairperson by the Governing Board Chairperson.

E. Appellate Review Procedure.

1. *Nature of Proceedings.* The proceedings by the Appellate Review Body shall be in the nature of an appellate review, based upon the record of the hearing before the Hearing Committee, the Hearing Committee's report, and all subsequent results and actions thereof. The Appellate Review Body also shall consider any written statements submitted pursuant to Section 9.5.E.2 below and such other materials, as may be presented and accepted under Sections 9.5.F.2 or 3.

2. *Written Statements.* Each party shall have the right to present a written statement in support of their position on appeal. The Applicant or Member seeking appellate review shall, at least five (5) days prior to the scheduled date of the appellate review, submit to the Appellate Review Body, through the CEO, a written statement describing the findings of fact, conclusions, and procedural matters with which the Applicant or Member disagrees and the reasons for such disagreement. The body whose Adverse Recommendation occasioned the review may submit a written statement in support of the body's action and/or in reply to the Physician's statement at least two (2) days prior the date of the appellate review. The CEO shall immediately forward a copy of the statement to the affected Applicant or Member.

F. Conduct of the Appellate Review.

1. *Presiding Officer.* The chairperson of the Appellate Review Body shall preside over the appellate review, including determining the order of procedure, making all required rulings, and maintaining decorum during all proceedings.

2. *Oral Statements.* The Appellate Review Body may, at its discretion, allow the parties or their representatives to appear and make statements. Parties or their representatives appearing before the Appellate Review Body must answer questions posed to them by the Appellate Review Body.

3. *Consideration of New Matters or Evidence.* If a party wishes to introduce new matters or evidence not raised or presented during the original hearing, and not otherwise reflected in the record, the party may introduce such information at the appellate review, only if expressly permitted by the Appellate Review Body

in its sole discretion. Generally, such new matter or evidence would not be considered unless the offering party demonstrates the matter or evidence could not reasonably have been discovered in time for the initial hearing.

G. Presence of Members and Vote. A majority of the Appellate Review Body shall be present at all times during the review and deliberations. If a member of the Appellate Review Body is absent from any part of the review or deliberations, the chairperson of the Appellate Review Body, in his or her discretion, may rule that such member be excluded from further participation in the review, deliberations, or recommendation of the Appellate Review Body.

H. Recesses and Adjournments. The Appellate Review Body may recess the review proceeding and reconvene the same without additional notice if it deems such recess necessary for the convenience of the participants, or to obtain new or additional evidence or consultation. When oral statements (if allowed) are complete, the appellate review shall be closed. The Appellate Review Body shall then deliberate outside the presence of the parties, and at such time and in such location as is convenient to the Appellate Review Body. Upon conclusion of the Appellate Review Body's deliberations, the review shall be adjourned.

I. Presence of Hearing Committee Members and Vote. A majority of the Hearing Committee shall be present at all times during the hearing and deliberations. If a committee member is absent from any part of the proceedings, the Presiding Officer in the Presiding Officer's discretion may rule that such member be excluded from further participation in the proceedings or recommendations of the Hearing Committee.

J. Action Taken. The Appellate Review Body may recommend the Governing Board affirm, modify or reverse the Adverse Recommendation or, in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to the Appellate Review Body within ten (10) days and in accordance with the Appellate Review Body's instructions. Within five (5) days after receipt of such recommendation after referral from the Hearing Committee, the Appellate Review Body shall make its recommendation to the Governing Board.

K. Final Decision of the Governing Board. At the Governing Board's the next regular meeting after receipt of the Appellate Review Body's recommendation, the Governing Board shall render its final decision in the matter, in writing, and shall send notice thereof to the affected Applicant or Member and Chief of Staff. The Governing Board's final decision shall be immediately effective and the matter shall not be subject to any further referral or review.

L. Right to One Hearing Only. Except as otherwise provided in this Article, no Applicant or Member shall be entitled to more than one hearing on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the Medical Staff Committee or the Governing Board, or a combination of acts of such bodies.

M. Reporting. The CEO or his or her designee shall report any final action taken by the Governing Board pursuant to the Bylaws to the appropriate authorities as required by law and in accordance with applicable Hospital procedures regarding the same.

9.6 General Provisions.

A. Waiver. If at any time after receipt of notice of an Adverse Recommendation, action, or result, a Member fails to make a required request or appearance or otherwise fails to comply with this fair hearing plan, the Member shall be deemed to have consented to such Adverse Recommendation, action, or result and to have voluntarily waived all rights to which they might otherwise have been entitled with respect to the matter involved.

B. Exhaustion of Remedies. If an Adverse Recommendation, action, or result is made with respect to a Physician's Medical Staff membership, category, status, or Privileges at any time, regardless of whether they are a Member, they must exhaust the remedies afforded by the 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.

C. Professional Review. The appointment and reappointment process, the investigation and Corrective Action processes, the hearing and appellate review processes, and all other processes and all other Governing Documents in which the professional practice skills, qualifications, competency, clinical services, quality of medical care provided, efficiency of medical care provided, and/or professional conduct of a Member of the Medical Staff are reviewed, evaluated, and/or reported on and/or a recommendation is made or action taken are part of the professional/peer review process at Hospital. All of the immunities, protection, and privileges available under state and/or federal law are intended to apply to these processes.

D. Payment of Attorney Fees. If any practitioner or Allied Health Practitioner who is the subject of an Adverse Recommendation or action initiates a suit against any entity or person who is in any way involved in any peer review, credentialing, re-credentialing, Corrective Action, or other action, recommendation or decision, the individual filing the suit shall be required to pay all costs and expenses incurred by

each individual defendant in defending the suit, including reasonable attorneys' fees, unless the individual substantially prevails against the individual defendant.

ARTICLE X – OFFICERS

10.1 Officers of the Medical Staff. The officers of the Medical Staff shall consist of a Chief of Staff, a Vice-Chief of Staff, Chief Medical Information Officer, and may include a Secretary/Treasurer (each, an "Officer", collectively, the "Officers"). The Active Members shall elect Officers at the annual Medical Staff meeting, held in accordance with Article XII of these Bylaws.

10.2 Term of Office. The term of office is one (1) year, commencing on January 1, and each Officer shall continue to hold office until a successor is elected, or the officer resigns or is removed from office.

10.3 Qualifications of Officers. Each Officer shall:

A. Be an Active Member at the time of nomination and election, and remain in good standing throughout the Member's term of office. Any Officer failing to maintain such status shall immediately be removed from office;

B. Have been recognized for a high level of clinical competence in the Member's field and have demonstrated executive and administrative ability through active participation in Medical Staff activities and other experience;

C. Have demonstrated a high level of interest in and support for the Medical Staff and Hospital by the Member's tenure and the Member's level of clinical activity at the Hospital;

D. Willingly and faithfully exercise the duties and authority of the office held and cooperate and work with the other Officers, CEO, Governing Board, and their respective committees;

E. Be nominated by the Medical Staff and elected at the annual meeting of the Medical Staff.

10.4 Election of Officers.

A. Conduct of Election. The Medical Staff Committee shall be responsible for arranging for an election of Officers. At the discretion of the Medical Staff Committee, an ad hoc nominating committee may be appointed. Such committee, if appointed, shall consist of three (3) members, and shall include the immediate past and current Chief of Staff and at least one (1) other Active Member appointed by the Chief of Staff. The committee shall offer one (1) or more nominees for each office. The voting members of the Medical Staff shall be notified of the nominations in such manner as is determined by the Medical Staff Committee at least fifteen (15) days prior to elections.

B. Format of Ballots. The decision to use mail or electronic ballot shall be at the discretion of the Medical Staff Committee.

C. Vote Required to Elect Officer. Officers shall be elected, subject to Governing Board approval, by a plurality vote of the Active Members who are present at the Medical Staff's annual meeting each year or by mail or electronic ballot. If the elections are held by mail or electronic ballot, Officers shall be elected by a plurality vote of all Active Member ballots received within such time period as is established by the Medical Staff.

D. Governing Board Approval. A list of all Officers and their respective positions elected by the Active Members of the Hospital's Medical Staff as set forth herein shall be communicated to the Governing Board. The Governing Board shall take action to approve or reject the Officers' so elected. A rejection by the Governing Board shall be communicated to the Medical Staff who shall provide the name of the Member with the second greatest number of votes for the same office to the Governing Board for action to approve the Officer.

E. Effective Date of Office. Officers so elected and approved by the Governing Board shall take office on January 1 following said meeting.

10.5 Vacancies in Office.

A. Vacancy in Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief of Staff shall assume the duties and authority of the Chief of Staff for the remainder of the unexpired term. In the event the Vice-Chief of Staff is unable, for any reason, to serve out the remaining term of the Chief of Staff, the Medical Staff Committee shall fill the vacancy of the office of Chief of Staff for the remainder of the term with another Active Member of the Medical Staff, subject to approval of the Governing Board.

B. Other Officer Vacancies. Vacancies in office during the Medical Staff Year, except for the Chief of Staff, shall be filled by another Active Member of the Medical Staff as appointed by the Medical Staff Committee, subject to approval of the Governing Board.

10.6 Removal of Officers.

A. Grounds for Removal, Who May Remove. Either the Active Members of the Medical Staff or the Governing Board may act to remove any Officer for conduct detrimental to the interests of the Medical Staff and/or the Hospital, suffering from a physical or mental infirmity rendering the Officer incapable of fulfilling the duties of office, failure to perform necessary functions of the office held, or any action or conduct that would form the basis for Corrective Action under these Bylaws.

B. Initiation, Consideration of Action to Remove Officer. An action to remove an Officer may be initiated by the Governing Board, or petition or vote of 1/3 of the Active Members. Removal shall be considered at a special meeting called for that purpose. The Officer shall be afforded the opportunity to speak on his or her own behalf prior to the taking of any vote on removal.

C. Vote to Remove Officer. Removal of an Officer may be made by a two-thirds majority vote of the Active Members present at the special meeting, provided that notice of the meeting at which such action takes place shall have been given in writing to such Officer at least ten (10) days prior to the date of such meeting.

D. Effective Date of Removal. An affirmative vote sufficient to remove the Officer shall become effectively immediately and create a vacancy in the Officer's position to be filled pursuant to the terms of these Bylaws.

10.7 Duties of Officers.

A. Chief of Staff. The Chief of Staff shall:

1. Call, preside at, and oversee the preparation of the agenda for all meetings of the Medical Staff and be a member ex officio without vote of all committees;
2. Serve as chairperson for the Medical Staff Committee;
3. Be responsible for the organization and administration of the Medical Staff in accordance with the terms of the Bylaws and Rules and Regulations;
4. Devise and be responsible for the processes, supervision, control, and appraisal of medical care in the Hospital;
5. Act in cooperation and coordination with the CEO in all matters of mutual concern within the Hospital;
6. Aid in coordinating activities and concerns of the Hospital administration and of nursing and other patient care services with those of the Medical Staff;
7. Be responsible for the enforcement of the Governing Documents and implement sanctions when indicated;
8. Be responsible for compliance with appropriate procedures for Corrective Action as set forth in the Bylaws;
9. Appoint members to all standing, special, and disciplinary Medical Staff committees except the Medical Staff Committee;
10. Report the views, needs, policies, and grievances of the Medical Staff to the Governing Board and CEO;

11. Receive and interpret the policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
12. Be the spokesperson for the Medical Staff in its professional and public relations;
13. Be responsible for the educational activities of the Medical Staff;
14. Assist in monitoring the performance of those with Clinical Privileges for adherence to Hospital and Clinical Service policies and procedures including, but not limited to, requirements for alternate coverage and for obtaining consultation, for adherence to sound principles of clinical practice generally, for unexpected patient care management events and patient safety;
15. Oversee compliance with the process for credentials review and delineation of Privileges as defined in these Medical Staff Bylaws;
16. Direct the development, implementation, and day to day functioning and organization of the Medical Staff components of the quality review, risk management, and utilization management programs and ensure these programs are clinically and professional sound in accomplishing program objectives and are in compliance with regulatory and accrediting agency requirements and report to the Governing Board on the same;
17. Sit on the administrative executive council;
18. Attend meetings of the Governing Board as needed, or his/her designee;
19. Perform such other duties set forth in these Bylaws, the Hospital and Medical Staff rules, and rules of the Governing Board.

B. Vice Chief of Staff. The Vice Chief of Staff shall:

1. In the absence of the Chief of Staff, assume all the duties and have the authority of the Chief of Staff;
2. Automatically succeed the Chief of Staff when the latter is unable to serve for any reason;
3. Perform all such duties of supervision that shall be assigned by the Chief of Staff;

C. Chief Medical Information Officer. The Chief Medical Information Officer shall:

1. Serve as liaison between the facility's medical information technology vendor(s) and Hospital Medical Staff;

2. Serve as a liaison between the Hospital IT department and clinical staff;
3. Champion and provide leadership for the selection, implementation, advancement, and optimization of clinical information systems;
4. Support the use of clinical information systems in the delivery of high-quality patient care;
5. Assist in strategic planning and budgeting with respect to clinical information systems, at the request of Hospital Administration;
6. Build relationships with Medical Staff and Hospital clinical staff to gain support of information technology initiatives;
7. Report to the Medical Staff and/or Governing Board on issues related to the Hospital's electronic medical record and other medical information systems; and
8. Perform such other duties that shall be assigned by the Chief of Staff.

D. The Secretary/Treasurer. If no Secretary/Treasurer has been elected for the term, the duties below shall be performed by a designee of the Chief of Staff. If a Member is elected as a Secretary/Treasurer, the duties of that office shall include:
1. Calling Medical Staff meetings at the request of the Chief of Staff;
2. Providing notice to all Members of all meetings;
3. Keeping minutes of all Medical Staff meetings;
4. Responding to all correspondence and performing such other duties as ordinarily pertain to the office of Secretary;
5. Keeping accurate account of Medical Staff funds and business transactions, if any;
6. Performing such other duties as ordinarily pertain to the office of Treasurer.

ARTICLE XI – COMMITTEES

11.1 Organization of Committees.

A. Committees of the Medical Staff shall be standing, special, or ad hoc.

B. All committees and Physician Advisors, other than the Medical Staff, shall be appointed by the Chief of Staff.

C. All standing committees of the Medical Staff and their chairpersons must be appointed within thirty (30) days after the annual meeting of the Medical Staff.

D. The CEO or a designated representative shall be an ex-officio member without vote of all committees unless otherwise expressly provided.

E. The standing committees shall be: Medical Staff Committee, Credentialing Committee, Quality Improvement/Risk Management Committee, Utilization Review Committee, Infection Control Committee, and the Pharmacy and Therapeutics Committee.

F. Special committees may be appointed by the Chief of Staff at the request of the Members, the CEO, the Governing Board, or as necessary to meet licensing or accreditation standards. The activity of such committees shall be reported to the Medical Staff, CEO, and the Governing Board. The existence of such committees shall cease upon completion of the purposes for which they are organized.

G. The chairman of the committee shall schedule regular meetings, and may call special meetings at any time, or such may be called by the Chief of Staff or by one-third (1/3) of the committee's members.

11.2 Clinical Service Committees.

Unless otherwise established by these Bylaws, the following general rules apply:

A. Regular Meetings. Clinical Services shall hold meetings as called by the Physician Advisor for that Clinical Service. All committees shall meet as specified in these Bylaws and may establish their own schedules in accordance with these Bylaws. Regular meetings may be held as part of the Medical Staff meeting(s).

B. Special Meetings. A special committee meeting may be called by the Chief of Staff, the committee chairperson, or by one-third (1/3) of the members of the committee.

C. Notice. Written or oral notice stating the place, day, and hour of any committee meeting shall be given to each Member of a Clinical Service or committee member not less than twenty-four (24) hours before the time of the meeting. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.

D. Quorum. Fifty percent (50%) of the members of a committee with voting rights, but not less than two (2) such individuals, shall constitute a quorum at any meeting. Once a quorum for a meeting is reached, all actions and topics addressed at the meeting shall be deemed to be made under a quorum, even if members leave during the meeting and attendance at any point during the meeting falls below a quorum.

E. Manner of Action. The action of a majority of the members with voting rights, present at a meeting at which a quorum is reached, shall be the action of the committee of Clinical Service. Action may be taken without a meeting by unanimous consent, in writing, signed by each member entitled to vote thereon.

F. Ex-Officio Members. Individuals serving under these Bylaws as ex-officio members (that is, by virtue of their position) of a committee, shall have the rights, privileges, and obligations of regular members, except they shall not be counted in determining the existence of a quorum, nor may they vote.

G. Minutes and Records. Minutes of each regular and special meeting of a committee or Clinical Service shall be prepared and shall include a record of the attendance of members, actions, and the vote taken on each matter. The minutes shall then be approved and signed by the chairman of the committee.

H. Attendance Requirements. All Members of the Active Staff shall be required to attend all meetings of committees and Clinical Services of which they may be members. Absence from three (3) consecutive meetings or from more than four (4) meetings of any committee or Clinical Service for any twelve (12) month period without good cause, shall be considered as resignation from the Medical Staff. Good cause shall be determined by the chairperson. Any question as to the validity of good cause for an absence shall be referred to the Medical Staff Committee for consideration.

11.3 Medical Staff Committee.

A. Composition. The Medical Staff Committee shall be a standing committee and consist of the all Active Medical Staff. The CEO of the Hospital will serve as an ex-officio member.

B. Meetings and Records. The Medical Staff Committee shall meet at least monthly as necessary to transact its business.

C. Special Meeting. Special meetings of the Medical Staff Committee may be called by the Chief of Staff, CEO, or by a majority of the members of the Medical Staff Committee.

D. Vote. All members of the Medical Staff Committee shall have one (1) vote. A member may not vote by proxy.

E. Duties. The Medical Staff Committee shall:

1. Coordinate activities and general policies of the various clinical departments;
2. Receive and act upon committee reports and recommendations;
3. Implement the policies of the Medical Staff, including, but not limited to, enforcement of the Governing Documents;
4. Serve as liaison among the Medical Staff, CEO, and Governing Board;
5. Ensure the Medical Staff is kept apprised of the Hospital's accreditation/licensing program and informed of the Hospital's accreditation/licensing status;
6. Investigate the credentials of all Applicants for membership and to make recommendations to the Governing Board in conformance with the Bylaws;
7. Recommend Privileges for Members;
8. Review information regarding the performance and clinical competence of Members and AHPs, and make recommendations for reappointments and renewal or changes in Privileges at least every two (2) years;
9. Investigate any alleged breach of ethics that may be reported;
10. Request evaluations of Member Privileges through the Medical Staff processes in instances where there is doubt about the Applicant's ability to perform requested Privileges;
11. Make appropriate effort to ensure professional, ethical conduct, and competent clinical performance by all Members, including the initiation of and/or participation in Corrective Action or review procedures when warranted and implementation of any actions taken as a result thereof;
12. Oversee and direct medical education activities and programs for Members;
13. Participate in identifying community health needs, setting Hospital goals, and establishing plans and programs to meet those needs;
14. Report at general Medical Staff meetings regarding the proceedings of all meetings and decisions made regarding Medical Staff policy in the interim between Medical Staff meetings;
15. Make recommendations on Hospital management matters to the Governing Board through the CEO;
16. Make recommendations to the Governing Board regarding Medical Staff structure;

17. Act on behalf of the Medical Staff, if appropriate, and subject to ratification of the Medical Staff, with respect to matters which require action prior to the next scheduled or special meeting of the Medical Staff;

18. Organize the Medical Staff's performance improvement/quality assurance, quality review, and utilization management activities and establish a mechanism to conduct, evaluate, and revise such activities;

19. Maintain a record of its proceedings and activities.

11.4 Credentialing Committee.

A. Composition. The Credentialing Committee shall be a standing committee and consist of a representative of the Executive Council, Director of Quality, a member of medical records, and a member of the Medical Staff Committee. The CEO shall serve as an ex-officio member. Committee can add ad hoc members to facilitate decision making.

B. Meetings. The Credentialing Committee members will prepare the Credentialing files for submission to the Medical Staff Committee at its regular monthly meetings.

C. Special Meeting. Special meetings of the Credentialing Committee may be called by the CEO or by a majority of the members of the Credentialing Committee.

D. Vote. All members of the Credentialing Committee shall have one (1) vote. A member may not vote by proxy.

E. Duties. The Credentialing Committee shall:

1. Review, at least every two (2) years, all information available regarding the performance and clinical competence of Members and Allied Health Staff Members with Clinical Privileges, and as a result of such reviews, to make recommendations for reappointments, renewal, or changes in Clinical Privileges as established by these Bylaws;

2. Review the credentials of all applicants and to make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws;

3. The Credentialing Committee shall retain all relevant information regarding the Applicant's professional and collegial activity, performance and conduct in the Hospital for inclusion in each Member's credentials file. Such information shall include, but is not limited to, the following:

a. Findings of quality assessment and utilization review activities, demonstrating patterns of patient care and utilization;

b. Continuing education activities and participation in other internal training;

c. Clinical activity at the Hospital;

d. Previously successful or currently pending challenges to the Member's licensure, sanctions imposed or pending, and other problems related to the Member's practice or professional conduct;

e. Health status, including any reasonable evidence of current health status that may be requested by the Medical Staff;

f. Records of attendance at required Medical Staff and Hospital meetings;

g. Performance as a Staff Officer, Committee Member, or Chairperson;

h. Compliance with Hospital Rules related to the preparation and completion of medical records (including requirements regarding timeliness and accuracy);

i. Ability to work cooperatively with other Practitioners, Hospital personnel, and the Governing Board;

j. General character of relationship with patients, Hospital staff and Administration, and the Governing Board;

k. Ability to comply with all applicable Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, policies and procedures, and Hospital's Corporate Compliance Plan;

l. Voluntary or involuntary termination or limitation of Medical Staff membership, reduction or loss of Clinical Privileges at another Hospital;

m. Ability to practice in an efficient manner, taking into account the patients' medical needs, the facilities, Clinical Services, and resources available, and generally recognized utilization standards as identified by the Utilization Review Committee;

n. Any other relevant information that could affect the Member's status and Privileges at the Hospital, including any activities of Member at other Hospitals, and his or her clinical practice outside the Hospital.

11.5 Quality Improvement/ Risk Management Committee.

A. Composition. The Quality Improvement/ Risk Management Committee shall be a standing committee and consist of at least two (2) Members, the quality coordinator and risk coordinator. The medical records director and the CEO shall serve as ex-officio members. Other Hospital representatives may be invited to participate as indicated.

B. Meetings. The Quality Improvement/Risk Management Committee shall meet at least monthly and otherwise at the call of the Chief of Staff, CEO, or chairperson of the Governing Board.

C. Special Meeting. Special meetings of the Quality Improvement/Risk Management Committee may be called by a majority of the members of the Quality Improvement/Risk Management Committee.

D. Vote. All members of the Quality Improvement/Risk Management Committee shall have one (1) vote. A member may not vote by proxy.

E. Duties. The Quality Assurance/Risk Management Committee shall:

a. Investigate and determine applicable standards of care;

b. Oversee periodic review of medical records to ensure the records:

1. Accurately reflect documentation of medical events;

2. Reflect the diagnosis, results of diagnostic tests; therapies ordered, condition, in-hospital progress, and condition of the patient at discharge;

3. Are sufficiently complete;

4. Comply with all Hospital medical record documentation policies, including but not limited to, those proscribed by the Bylaws and the Rules and Regulations;

c. Forward results of medical record reviews and preparing recommendations to the Medical Staff on an annual basis or as requested by the Medical Staff;

d. Comply with risk management statutes and evaluating and improving the quality of health care services provided in the Hospital;

e. Implement a planned and systematic process for monitoring and evaluating the quality of the care and treatment of patients served and the performance of all individuals with Privileges;

f. Perform reviews of surgical procedures to assure surgery performed in the Hospital meets Hospital and other applicable standards of care;

g. Review overall quality of care throughout the Hospital, including selected deaths, unimproved cases, tissue, infections, complications, error in diagnosis, medical assessment and treatment of patients, use of medications, use of blood and blood components, operative and other procedures, appropriateness of clinical practice patterns, significant departures from established patterns of clinical practice, use of developed criteria for autopsies, sentinel event data, patient safety data, and results of treatment; and

h. Report findings, conclusions, recommendations, actions taken, and the results of actions and preparing recommendations to the Medical Staff, CEO, or other committees through its chairperson.

11.6 Utilization Review Committee.

A. Composition. The Utilization Review Committee shall consist of at least two (2) Physicians, the chief nursing officer, the case manager, the quality coordinator, and other personnel as necessary. The medical records director and the chief revenue officer or designee shall serve as advisory staff to the Utilization Review Committee.

B. Meetings. The Utilization Review Committee shall meet quarterly or as needed at the request of the Chief of Staff, chairperson of the Utilization Review Committee, or CEO.

C. Vote. All members of the Utilization Review Committee shall have one (1) vote. A member may not vote by proxy.

D. Duties. The Utilization Review Committee shall:

1. Assure the development, maintenance, and execution of an effective Utilization Review plan to assure that required extended duration reviews are continuously performed and documented;
2. Ensure the Hospital's Utilization Review plan meets any licensing or accreditation requirements;
3. Recommend the Utilization Review plan or amendments thereto to the Governing Board for approval;
4. Assure the efficient utilization of beds, services, and health facilities through concurrent and retrospective reviews of the necessity for admissions, and appropriate duration of stays.
5. Require that the Utilization Review Plan is in effect and is reviewed annually; and presented to Medical Staff on an annual basis.
6. Conduct such studies, take such action, submit such reports, and make such recommendations as are required by the Utilization Review Plan;
7. The Utilization Review Committee's reviews may not be conducted by any individual who has a direct financial interest in the hospital; or was professionally involved in the development or execution of the treatment plan of the patient whose case is being reviewed.

11.7 Infection Control Committee.

A. Composition. The Infection Control Committee shall consist of at least one (1) Active Member, the infection control coordinator, a representative of nursing services, the director of the laboratory, Hospital pharmacist, and other personnel as indicated for the purpose of carrying out the infection control functions.

B. Meetings. The Infection Control Committee shall meet at least quarterly.

C. Special Meeting. Special meetings of the Infection Control Committee may be called by the chairperson of the Infection Control Committee, CEO, or by a majority of the members of the Infection Control Committee.

D. Vote. All members of the Infection Control Committee shall have one (1) vote. A member may not vote by proxy.

E. Duties. The Infection Control Committee shall:

1. Appoint infection control officer(s) for the Hospital who is/are a licensed Physician, licensed registered nurse, someone with a bachelor's degree in laboratory science or similar qualifications and has additional training or education preparation in infection control, infectious diseases, epidemiology, and principles of quality improvement;
2. Develop written policies for the Hospital infection control;
3. Develop written policies for medical asepsis to include a definition of infection, for the purpose of surveillance;
4. Develop specific policies, with indications, of the need for and the procedures to be used in isolation. These policies should be distributed and made readily available to all appropriate personnel;
5. Assist housekeeping in developing, evaluating, and routinely revising the policies and procedures for meeting established sanitation techniques and disposal of biological wastes;
6. Assist housekeeping with the evaluation of materials used in the Hospital's sanitation program;
7. Assist nutritional services with food handling sanitation techniques;
8. Assist surgery services with surveillance and periodic testing procedures for culturing of autoclaves and sterilizers;
9. Educate and orientate personnel in the practice of aseptic techniques and infectious disease processes;

10. Develop a practical system for reporting, evaluation, and keeping records of infections among patients and personnel;

11. Develop and maintain the Hospital's employee health program; and

12. Develop policies and provide education for disease outbreaks and pandemic disease situations.

11.8 Pharmacy and Therapeutics Committee.

A. Composition. The Pharmacy and Therapeutics Committee shall consist of at least one (1) Active Member, the Hospital pharmacist, the chief nursing officer, the infection control coordinator, the director of the laboratory, and other personnel as indicated. A representative from medical records and the CEO may serve as ex-officio members at the request of the chairperson of the Pharmacy and Therapeutics Committee.

B. Meetings. The Pharmacy and Therapeutics Committee shall meet at least quarterly.

C. Special Meeting. Special meetings of the Pharmacy and Therapeutics Committee may be called by the chairperson of the Pharmacy and Therapeutics Committee, CEO, or by a majority of the members of the Pharmacy and Therapeutics Committee.

D. Vote. All members of the Pharmacy and Therapeutics Committee shall have one (1) vote. A member may not vote by proxy.

E. Duties. The Pharmacy and Therapeutics Committee shall:

1. Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to obtain optimum clinical results and a minimum potential for hazard;

2. Assist in the formulation of professional policies regarding the evaluation, appraisal, selection, procurement, storage distribution, use, safety procedures, and all other matters relating to drugs in the Hospital;

3. Serve as an advisory group to the Hospital Medical Staff and the pharmacist, on matters pertaining to the choice of drugs;

4. Make recommendations concerning drugs to be stocked on the units and by other Clinical Services;

5. Periodically develop and review a formulary or drug list for use in the Hospital;

6. Prevent unnecessary duplication in stocking drugs, and drugs in combination having identical amounts of the same therapeutic ingredients;

7. Evaluate clinical data concerning new drugs, or preparations requested for use in the Hospital;

8. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

    a. The Pharmacy and Therapeutics Committee shall review the prophylactic use of antibiotics for inpatients, ambulatory care patients, and emergency care patients and develop criteria for the prophylactic use of antibiotics for inpatients, ambulatory care patients, and emergency care patients. Criteria for the prophylactic and therapeutic use of antibiotics should be established in problem areas, and departures from these criteria should be reviewed in a timely manner;

    b. The Pharmacy and Therapeutics Committee shall also approve initially, and review at least annually, any standing orders for medications; and

11.9 Peer Review Committees.

A. <u>All Medical Staff Committees are Peer Review Committees.</u> The Medical Staff as a whole and each committee provided for in these Bylaws are each hereby designated as a Peer Review Committee in accordance with R.S.Mo § 537.035. Such committees shall be responsible for evaluating, maintaining, and/or monitoring the quality and utilization of health care services.

B. <u>Delegation of Peer Review Duties.</u> Such Peer Review Committees may, from time to time and/or as specifically provided herein, appoint the CEO or other personnel as the committees' agent(s) in carrying out the committees' peer review duties.

C. <u>Medical Staff Committee Records are Peer Review Records.</u> The interviews, memoranda, proceedings, findings, deliberations, reports, and minutes of peer review committees, or the existence of the same of this, and all other individuals and committees whose purposes are to assist this committee and the Hospital in evaluating and improving the quality of health care services, are peer review records which are privileged and shall not be subject to discovery, subpoena, or use as evidence in any judicial or administrative proceeding, except as otherwise provided by statute. In addition, all interviews, memoranda, proceedings, findings, deliberations, reports, and minutes or existence of the same made by this and any other committee or individual whose purposes are to assist this committee are confidential and privileged as provided in R.S.Mo § 537.035.

D. Communication of Peer Review Findings. When the findings of any peer review assessment processes are relevant to a Member's performance, the Chief of Staff shall determine the use of the findings in peer review or the ongoing evaluations of competence in accordance with the Corrective Action provisions of these Bylaws. The findings, conclusions, recommendations, and actions taken to improve Hospital performance shall be communicated to appropriate committees and/or the Governing Board.

ARTICLE XII – MEDICAL STAFF MEETINGS

12.1 Annual Meeting. The annual meeting of the Medical Staff shall be held in December. At this meeting, the retiring Officers and committees shall make such reports as appropriate. Officers for the ensuing year shall be elected and installed, to assume duties January 1, subject to the approval of the Governing Board. Recommendations for Physician Advisor for Clinical Services shall be made.

12.2 Regular Meetings. Regular Medical Staff meetings shall be held every month at the time and place specified by the Chief of Staff.

12.3 Special Meetings. Special meetings of the Medical Staff may be called at any time by the Chief of Staff, at the request of the Governing Board, or at the request of at least two (2) Active Members.

A. Calling the Meeting. If the Chief of Staff receives a request from the Governing Board or at least two (2) Members of the Active Medical Staff, the Chief of Staff shall call and provide notice of a special meeting within five (5) days of receipt of such request.

B. Notice of Meeting. Posting of the notice of a meeting on the Medical Staff bulletin Governing Board, by phone, or by electronic mail, at least forty-eight (48) hours before the time set for the meeting shall constitute sufficient notice of the meeting.

C. Business to be Conducted. At any special meeting, no other business shall be conducted except that stated in the notice calling the meeting.

D. Quorum. For a special meeting of the Medical Staff, fifty percent (50%) of the Active Members shall constitute a quorum at any regular or special meeting for taking action or making a recommendation to the Governing Board, except for amendment of these Bylaws as set forth in Article XVI. Actions may be passed by the Medical Staff with a majority vote of the Members present and eligible to vote. Votes may be made by proxy at the discretion of the Chief of Staff.

12.4 Attendance at Meetings by Active Medical Staff Members.

A. Attendance at regular and annual Medical Staff meetings is required of Active Members unless excused by the CEO or his/her designee.

B. Absence from more than fifty percent (50%) of the cumulative total of these Medical Staff meetings in a calendar year shall render the Member subject to reduction of medical staff category from Active to Courtesy Staff.

C. Reinstatement of Members of the Active Staff to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of original appointment.

12.5 Agenda.

A. Regular Staff Meetings. The agenda at any regular staff meeting shall be:

I. Call to Order

II. Approval of minutes of the last regular and all special meetings.

III. Departmental, Clinical Services, and Committee Reports

1. Medical Staff Committee
2. Credentialing Committee
3. Utilization Review Committee
4. Pharmacy and Therapeutics Committee
5. Infection Control Committee
6. Quality Improvement/ Risk Management Committee
7. Clinical Services Committees
    i. Radiology Services
    ii. Laboratory Services
    iii. Surgery Services
    iv. Family Practice/Medicine Services
8. Health Information Management Department Report
9. Nursing Department Report
10. Administrative Report

IV. Policy Review

V. Old Business

VI. New Business

VII. Adjournment

B. Special Meetings. The agenda at special meetings shall be:

I. Call to Order

II. Reading of the notice calling the meeting

III. Transaction of the business for which the meeting was called

IV. Adjournment

ARTICLE XIII – CLINICAL SERVICES

13.1 Unified, Integrated, Non-Departmental Medical Staff. The Medical Staff shall constitute a unified, integrated staff, without clinical departments. The Medical Staff Committee will periodically re-examine the structure and recommend to the Governing Board desirable or necessary actions in creating a new Clinical Service, or in establishing or reorganizing the staff, in order to promote improved efficiency and patient care.

13.2 Current Services; Affiliation.

A. Identification of Clinical Services. The current Clinical Services are: (1) Family Practice/Medicine, (2) Surgery, (3) Pathology and Laboratory, and (4) Radiology (which includes but is not limited to computed tomography, magnetic resonance, nuclear medicine, PET, x-ray, and ultrasound).

B. Appointment to Clinical Services. Every Member must have a primary affiliation with at least one of the above Clinical Services, which most clearly reflects his or her professional training and experience in the clinical area in which his or her practice is concentrated. A Practitioner or Allied Health Professional may be granted Clinical Privileges in one or more Clinical Services, and his or her exercise of Privileges within the jurisdiction of any Clinical Service is always subject to the policies of that Clinical Services and the individual's Clinical Privileges.

13.3 Physician Advisor; Election Qualifications and Appointment.

A. Physician Advisors for Each Clinical Service. Each Clinical Service shall have (a) Physician(s) Advisor(s) who must be (a) Member(s) of the Medical Staff and of the applicable Clinical Service, remain in good standing throughout his or her term, and be willing and able to faithfully discharge the functions of his or her office. The Physician Advisor shall demonstrate, through the Privilege delineation process, competence in the appropriate area of practice. The Physician Advisor for the surgery Clinical Service shall also be responsible for the direction and control of anesthesia services in the Hospital.

B. Appointment of Physician Advisor. The Physician Advisor shall be appointed by the Chief of Staff, subject to Governing Board approval. The Physician Advisor will serve a one (1) year term commencing upon appointment, and continuing until his or her successor is chosen, unless he or she sooner resigns or is removed from office. The Physician Advisor may be eligible for reappointment.

C. Resignation and Removal. A Physician Advisor may resign at any time by giving written notice to the Medical Staff Committee. Such resignation shall take effect on the date of receipt, or at any later time as specified by the notice. Removal may

be effected by the Governing Board acting upon its own initiative; by a two-thirds (2/3) majority vote of the Medical Staff Committee and subject to approval of the Governing Board; or if the Physician Advisor no longer has Clinical Privileges at the Hospital.

D. Vacancy of Physician Advisor. An unexpected vacancy will be filled by the Medical Staff Committee through appointment of an acting officer subject to Governing Board approval.

13.4 Physician Advisor; Responsibilities and Authority. Each Physician Advisor shall:

A. Oversee professional and administrative activities within his or her Clinical Service, and report on such activities as requested by the Medical Staff Committee, CEO, or the Governing Board;

B. Upon request, transmit to the Credentialing Committee his or her recommendations concerning appointment or reappointment, Medical Staff category, and delineation of Clinical Privileges of all Practitioners in his or her Clinical Service;

C. Assist in monitoring, on a continuing basis, the performance of those with Clinical Privileges in the Clinical Service for adherence to Medical Staff, Hospital and Clinical Service policies and procedures including, but not limited to, requirements for alternate coverage and obtaining consultation, for adherence to sound principles of clinical practice generally, for unexpected patient care management events, and for patient safety;

D. Coordinate with Hospital services and Hospital administration in matters affecting patient care in his/her Clinical Service, including personnel, supplies, special regulations, standing orders, and techniques;

E. Perform such other duties as may be determined by the Medical Staff Committee.

13.5 Service Functions. Each Clinical Service shall perform the following functions:

A. Upon request, review and make recommendations regarding criteria for the granting of Clinical Privileges in the Clinical Service consistent with the policies of the Medical Staff and the Governing Board;

B. Cooperate with the Quality Improvement/Risk Management and the Utilization Review Committees in their retrospective review of medical records of patients and others; and with the process of developing criteria to help assure quality patient care and efficient and effective usage of health care services;

C. Meet as necessary to review and analyze the clinical work of the Clinical Service;

D. Receive and relay reports regarding performance improvement, quality improvement, or risk management issues in the applicable Hospital department for referral to the Quality Improvement/Risk Management Committee;

E. Provide input to the relevant Hospital department's organizational plan to define the Clinical Service's role within the particular Hospital department in which it operates; and

F. Be responsible for making available to its Members, scientific or other educational programs as deemed necessary by the Medical Staff Committee.

ARTICLE XIV – RULES AND REGULATIONS

The Active Medical Staff shall adopt such rules and regulations as may be necessary for the proper conduct of the Medical Staff ("Medical Staff Rules and Regulations", or "Rules and Regulations"). Such Medical Staff Rules and Regulations shall be a part of these Bylaws, except that they may be amended at any regular monthly meeting of the Medical Staff, without previous notice, by a majority vote of the Active Members present and voting, and become effective when approved by the Governing Board. Amended Rules and Regulations shall be consistent with these Bylaws.

Subject to the approval of the Medical Staff Committee and of the Governing Board, committees and Clinical Services may develop additional written policies to govern the conduct of affairs and discharge of duties within their respective Clinical Service areas. Such policies and procedures must be consistent with these Bylaws and with the Rules and Regulations.

ARTICLE XV— INTERPRETATION

A. **Bylaws are Not a Contract.** These Bylaws do not create a contract between the Hospital and any Applicant, Member, Allied Health Professional, or allied health professional applicant.

B. **Headings.** Captions and headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of the Bylaws.

C. **Gender.** Words used in these Bylaws shall be construed to refer to the masculine or feminine gender and to singular or plural, as context requires.

D. **Interpretation by Governing Board.** When necessary, or in case of dispute, the Governing Board shall have the authority to interpret the Medical Staff Bylaws and Rules and Regulations with regard to medical and professional matters. Such an interpretation must be made by a two-thirds (2/3) majority. Such interpretation shall be final except as may become revised by subsequent interpretation, or so nullified by subsequent amendments to these Bylaws.

E. **Waiver.** The Governing Board may waive any of the requirements for Medical Staff membership and Privileges established pursuant to these Bylaws or the Rules and Regulations for good cause shown if the Governing Board determines that such waiver is necessary to meet the needs of the Hospital and the community it serves. The refusal of the Governing Board to waive any requirement shall not entitle any individual to a hearing or any other rights of review and shall not constitute an obligation of the Governing Board to waive the same requirement in the future.

ARTICLE XVI – ADOPTION AND AMENDMENT

16.1 Adoption.

A. A recommendation to adopt these Bylaws shall require a majority vote of those Members present who have voting rights at the Medical Staff meeting in which adoption of these Bylaws is discussed.

B. A recommendation of the Medical Staff to adopt these Bylaws shall be communicated to the Governing Board.

C. The Governing Board shall consider and act upon the Medical Staff's recommendation.

D. Adoption so made shall be effective when approved by the Governing Board.

E. The Bylaws shall, when adopted and approved, be equally binding on the Governing Board and the Medical Staff.

16.2 Amendment.

A. The Bylaws may be amended after submission of the proposed amendments at any regular or special meeting of the Medical Staff.

B. For purposes of amending these Bylaws, a quorum shall require seventy-five percent (75%) of the Active Medical Staff Members entitled to vote, and vote may be submitted by proxy.

C. Notice of such proposed amendments shall be submitted to the Active Members at least fifteen (15) days prior to the action.

D. The Bylaws, when adopted, at any regular meeting of the Medical Staff and approved by the Governing Board, shall replace any previous version of the Bylaws.

_____ _____

Chief of Staff, Medical Staff Date

_____ _____

Chair of the Governing Board of Trustees Date

ATTESTATION:

_____ _____

Secretary of the Governing Board of Trustees Date

RULES AND REGULATIONS OF THE MEDICAL STAFF OF CARROLL COUNTY MEMORIAL HOSPITAL

GENERAL

A. Capitalized terms used but not defined in these Rules and Regulations shall have the same meaning as set forth in the Medical Staff Bylaws.

B. Each Active Member of the Medical Staff shall have a continuous duty to designate another Member with equivalent Privileges to be the Active Member's official alternate. In the case of unavailability of such alternate, the Chief of Staff shall have the authority to call any Member of the Medical Staff if necessary.

C. The Medical Staff shall not discriminate against any patient or prospective patient on the basis of race, color, national origin, sex, age, or disability.

ARTICLE I – PROVISION OF PATIENT CARE

Section 1.1 Admissions.

A. General.

1. Authority to admit and supervise treatment of patients is exclusively delegated to Practitioners with Medical Staff status and Privileges required by the Medical Staff Bylaws for admission and treatment of patients. The admitting Practitioner must be in Good Standing under the Medical Staff Bylaws.

2. A provider who is not a Member of the Medical Staff or who does not have Privileges to admit and treat patients at the Hospital may refer a patient to the Hospital. An appropriately credentialed Member must agree to accept the patient and provide medical care for the patient.

3. An attending provider will be designated for each patient admitted to the Hospital for care. Attending providers shall be responsible for:

   a. Coordination of care of the patient among all members of the health care team;

   b. Documenting in the medical record a well-defined plan of care that includes fully integrating all consultant recommendations into the unified care plan;

   c. Prompt completion and accuracy of medical records;

   d. Maintaining primary responsibility for the care of the patient unless and until a transfer of care is arranged and documented.

4. A provisional admitting diagnosis, justification of admission and continued hospitalization, patient's progress, and response to medications and services

must be recorded on all medical records. Where provision of diagnosis is delayed due to emergency, the provisional diagnosis shall be given as soon after admission as possible.

5. The admitting Member will be responsible for giving such information as may be necessary to assure the protection of the patient from self-harm as well as to protect other patients, Hospital personnel, and visitors.
6. For all admissions, the physician must inform the nursing staff of the presence or suspected presence of any infection or infectious disease that requires special considerations.
7. A Member will assign the status of observation, inpatient, or swing bed to each patient prior to admission.
8. The admitting Member shall provide admitting orders meeting regulatory or payer requirements, and which include testing, treatment, special nursing considerations, dietary orders, and activity orders.
9. No patient shall be admitted or detained in the Hospital against his or her will, nor shall a minor under eighteen (18) years of age be admitted or detained against the will of his or her parent(s) for legal guardian(s), except as authorized by law. It is, however, acceptable to encourage a patient to remain in the Hospital when medically indicated and to explain the risk of discharge or transfer based on the best interests of the patient.
10. In no event shall a patient be detained as a patient solely for non-payment of a medical bill.

B. Inpatient Admission Criteria. Patients may be admitted to the Hospital as inpatients if the admitting provider reasonably expects the patient will require hospital care that will span at least two midnights. In making the decision whether a patient is reasonably expected to require hospital care that will span at least two midnights, the provider should consider:

1. The severity of the signs and symptoms exhibited by the patient;
2. The medical predictability of something adverse happening to the patient;
3. The need for diagnostic studies that cannot be done safely as an outpatient;
4. The availability of diagnostic procedures at the time when and at the location where the patient presents.

C. Admission Following Payer Denial. When an insurance carrier denies a patient's admission or continued stay in the Hospital and the responsible Practitioner feels that in his/her judgment, hospitalization is necessary:

1. The Practitioner shall document in the medical record the reasons why the hospitalization is medically necessary compared to other statuses.
2. The physician shall request review by peers to substantiate his/her determination.
3. The patient shall be allowed to remain hospitalized as long as deemed medically necessary, regardless of payment.
4. The Practitioner will be required to cooperate with Hospital staff in providing documentation, if requested, to justify the patient's admission or continued stay and to respond to payer inquiries regarding the same.

D. Patients who present with known diagnoses for specific minor surgical procedures or other treatment expected to keep the patient in the Hospital for less than 24 hours, the patient shall be admitted as an outpatient.

E. History and Physical.

1. A history and physical must be in the medical record for all inpatients within 24 hours of admission and on all patients prior to surgery or a procedure, except in cases of emergency when a history and physical cannot be completed within these timeframes.
2. If a history and physical cannot be completed within the timeframes above due to emergency situations, a brief admission note must be made that includes at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, and vital signs.
3. A history and physical completed before admission is valid for 30 days only. It is acceptable to use a history and physical that was completed within 30 days of admission as long as it is reviewed and updated with any changes or states no changes have occurred.
4. A Practitioner whose scope of practice and Clinical Privileges include performance of history and physical examinations must perform a history and physical within the timeframes set forth in these Rules and Regulations and the Medical Staff Bylaws.
5. If Practitioner other than a Physician performs a patient's history and physical, a Physician Member of the Medical Staff must review and sign the history and physical, and such Physician assumes full responsibility for the history and physical.

Section 1.2 Responsibility for Care, Coordination of Care; Provider Coverage.

A. Responsibility for Care.

1. Medical services shall generally be under the medical direction of a Physician Member of the Medical Staff, provided that Practitioners or Allied Health Professionals with appropriate Clinical Privileges may manage and coordinate such care to the extent permitted by such Privileges and any related Prerogatives or limitations set forth in the Medical Staff Bylaws.
2. Notwithstanding management and coordination of care by non-Physician Practitioners or Allied Health Professionals of a Hospital patient, each patient's general condition shall primarily be the responsibility of a Physician Member of the Medical Staff.
3. The Practitioner who admitted the patient is responsible for the patient during the patient's stay in the Hospital.
4. The attending Practitioner will perform at least daily rounds on observation and inpatients, and more frequently as indicated by the patient's condition.
5. The attending Practitioner will perform at least weekly rounds on swing bed patients.

B. Coordination of Care.

1. When a provider transfers care of a patient to another provider, the transfer shall be documented in the patient's medical record.

C. Provider Coverage.

1. The Active Medical Staff will be responsible for developing an on-call roster to ensure emergency coverage at all times.
2. A Physician Member of the Medical Staff shall be on duty or available within a reasonable period of time for emergency service at all times.
3. The Medical Staff shall participate in on call coverage as required by the Medical Staff and Hospital administration.
4. If a Practitioner is unable to assume his or her assigned call, he or she will secure another physician to take the call and notify the Hospital of the change.
5. During regular business hours, a patient's attending Practitioner may be notified prior to contacting the on-call provider.
6. Contract staff may be utilized as necessary to ensure appropriate coverage.

7. If an urgent situation arises while a patient is hospitalized, Hospital staff will attempt to notify the attending Practitioner first. If the attending Practitioner is unavailable, Hospital staff will notify the on-call provider.

Section 1.3 Informed Consent.

A. General Requirements.

1. Upon admission to the Hospital, the patient shall be required to sign a general consent form.
2. If the patient lacks capacity to provide the general consent, the patient's legal representative shall sign the consent form.
3. Any questions regarding health care agents, powers of attorney, relatives, parents, legal guardians, or other representatives' authority to make decisions on behalf of patient should be directed to Hospital administration.
4. Informed consent must be obtained prior to performing a non-emergency procedure, surgery, or treatment and prior to the administration of blood or blood products.
5. Informed consent must be obtained by a Member of the Medical Staff with Privileges to perform the procedure, surgery, treatment, or administration of blood or blood products.
6. Alternatively, in cases where the procedure, surgery, treatment, or administration of blood or blood products is to be performed by an Allied Health Professional with appropriate Privileges, such Allied Health Professional may obtain the required informed consent.
7. The applicable Member or Allied Health Professional shall discuss, at a minimum, the risks, benefits, and alternatives to the proposed procedure, surgery, treatment, or administration of blood or blood products.
8. The anesthesia provider, if any, shall advise the patient regarding the procedure contemplated, the type of anesthesia to be administered, and the risks involved with each.
9. The anesthesia provider, if any, shall be responsible for documenting such informed consent which shall become part of the patient's medical record.
10. The applicable Member or Allied Health Professional responsible for obtaining informed consent shall be responsible for documenting the informed consent discussion and completing any required hospital forms in the patient's medical record.

11. In any circumstance when informed consent cannot be obtained by the patient or a legal representative, the circumstances preventing informed consent shall be documented in the patient's medical record. The applicable Member or Allied Health Professional may render the proposed procedure, surgery, treatment, or administration of blood or blood products so long as doing so would not contradict any prior expressed wishes of the patient.

B. Persons Who May Consent.

1. Patients with the capacity to make health care decisions who are eighteen (18) years old or older may consent to their own treatment.

2. If the responsible Member is uncertain whether a patient has the capacity to consent to treatment, a psychiatric evaluation may be ordered to make the determination.

3. If the patient is unable to provide informed consent, consent will be obtained from an appropriate representative such as a power of attorney, legal guardian, parent, or other appropriate individual.

4. A patient under the age of eighteen (18) who is emancipated, lawfully married, or seeking treatment related to pregnancy, birth control, sexually transmitted diseases, or drug or alcohol abuse may consent to his or her own treatment and consent of the parent is not required.

5. For all other situations when a minor cannot consent to his or her own treatment, the Member shall seek such consent from the appropriate representative such as a parent or legal guardian.

C. Right to Refuse Treatment.

1. An individual with the capacity to provide informed consent as set forth in the preceding provisions shall also have the right to refuse medical treatment. This includes the ability to refuse or request the withdrawal of life-saving treatment.

2. The responsible Member or Allied Health Professional shall document a patient's refusal of care or treatment in the patient's medical record.

3. Any living will or advance directive of the patient known or available to the Member or Allied Health Professional shall be followed to the greatest extent permitted by law.

D. Contents of the Consent. Properly executed informed consents should contain at least the following:

1. Name of the patient;
2. Name of the Hospital;
3. Name of procedure(s);
4. Name of Practitioner(s) or Allied Health Professional(s) performing the procedure(s);
5. Signature of the patient or other responsible party;
6. Date and time consent is obtained;
7. A statement the procedure was explained to the patient or other responsible party;
8. Signature of person witnessing the consent;
9. Name/signature of the Practitioner or Allied Health Professional who explained the procedure to the patient or guardian.

Section 1.4 Pharmacy Services and Medication Management.

A. Physician will provide specific written indications with each drug ordered. These will include name, dosage, route, and schedule of medication. The physician will order a stop date or the medication will be stopped by protocol.

B. Schedule II-V Narcotic, Anti-neoplastic unfractionated agents, Warfarin, and Heparin that are ordered without the limitation of dosage will be automatically discontinued after seven days on all observation, acute, and swing bed patients.

C. Antibiotics that are ordered without the limitation of dosage will be automatically discontinued after ten days on all observation, acute, and swing bed patients.

D. All other medications that are ordered without the limitation of dosage will be automatically discontinued after thirty days on all observation, acute, and swing bed patients.

E. Except for patients admitted for same-day procedures and for non-hospitalized patients who will not remain in the Hospital overnight, reconcile the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.

F. Medication reconciliation will occur within 24 hours of admission and at discharge.

G. The admitting Practitioner or Allied Health Professional will obtain the list of home medications while performing the admission history and assessment.

H. The medication history should include prescribed, over the counter medications; herbal or dietary supplements and vitamins; those taken at scheduled times and those taken on an as needed basis; all listed medications will include name, dosage, frequency, route, and date/time of last dose.

I. If the current pre-hospital medication list is not available or the patient/family member are not considered to be a reliable source of information, the most recent medication list may be obtained from the following sources:

1. Other family members;
2. From the transferring or discharging facilities;
3. The patient's current pharmacy;
4. The patient's primary care physician;
5. Recent hospital records, including most recent discharge instructions, and/ or the discharge medication list followed by verification by either the patient's current pharmacy or the patient's primary care physician.

F. A home medication wallet card can be used as an initial reference. However, it should be validated with one of the above sources.

G. The patient's medications will be entered into the electronic record by an individual authorized to create such entries in the patient's medical record.

H. Prior to discharge, the current hospital medications and prior to admission list will be reconciled and entered into the patient's medical record.

Section 1.5 Orders.

A. <u>General.</u>

1. All orders for treatment shall be entered into the patient's medical record.
2. Only individuals authorized to enter orders into the patient's medical record shall do so.
3. Documentation of all orders shall include the date and time when the order was received.
4. Respiratory services may only be provided under the order of a Practitioner or Allied Health Professional with Clinical Privileges to order respiratory services.
5. Influenza and pneumococcal vaccines may be administered by Hospital personnel without an order after an assessment for contraindications.

B. Orders for Outpatient Services.

1. Outpatient services must be ordered by a practitioner or allied health professional who:

   a. Is responsible for the care of the patient;

   b. Is licensed in the State where he or she provides care to the patient;

   c. Is acting within his or her scope of practice;

   d. Is authorized to order the applicable outpatient services, including practitioners or allied health professionals not appointed to the Medical Staff or granted Privileges but who satisfy the above criteria and are authorized by the Medical Staff or Hospital policy to issue the order(s).

C. Verbal Orders.

1. Verbal orders are permitted when the Practitioner or Allied Health Professional issuing the order is unavailable to document or enter an order personally; is actively involved in a procedure where personally documenting or entering an order would involve unnecessary delay and/or breaking the sterile field; or is involved in rendering critical care.

2. A verbal order shall be considered a valid and actionable order when given by a Practitioner or Allied Health Professional with appropriate Privileges to issue orders for care, and when given to an authorized individual functioning within the individual's level of training, education, and qualifications as set forth herein.

3. Only authorized staff can accept and record verbal order which relate to their respective specialty.

4. The individual receiving a verbal order will verify the identity of the Practitioner or Allied Health Professional before acting on a verbal order.

5. Any verbal or telephone order will be read back to the Practitioner or Allied Health Professional for verification of accuracy.

6. All verbal orders must be authenticated in writing or in an electronic record as soon as possible after the verbal order is given, generally within seventy-two (72) hours of discharge or thirty (30) days from the date of creation, whichever is less.

7. If it is impractical for the Practitioner or Allied Health Professional to authenticate the verbal order within forty-eight (48) hours of issuing the order, it is acceptable for another Practitioner or Allied Health Professional

who is responsible for the care of the patient to authenticate the verbal order.

D. Standing Orders.

1. Standing orders may be formulated by conference between the Medical Staff, directors of nursing and pharmacy, and Administrator.
2. The Medical Staff must approve the standing order through vote in a Medical Staff meeting.
3. Standing orders can only be changed through vote in Medical Staff Meeting.
4. A Practitioner or Allied Health Professional responsible for the care of the patient must authenticate standing orders.
5. All standing orders will be reviewed at least annually.

Section 1.6 Consultations.

A. Consultation shall be at the discretion of the individual Physician, except as defined under specific departmental policies. Examples when consultations may be appropriate include, but are not limited to those when:

1. A diagnosis is obscure, or outcome is unclear;
2. The problem is outside the normal scope of practice, education, training, or experience of the Practitioner;
3. A patient is not a good candidate for a recommended procedure;
4. Resolving unclear or obscure diagnoses or treatment plans requires a Practitioner with Privileges in the applicable specialty in order to properly manage the patient's care and treatment;
5. The patient exhibits severe psychiatric symptoms;
6. The patient does not respond to conventional treatment;
7. Requested by the patient or family;
8. A department or Clinical Service policy requires a consultation.

B. A consultant must be qualified in the field in which the consultant's opinion is sought.

C. A consultant must be a Member of the Medical Staff with appropriate Clinical Privileges to render the consultation requested.

D. The patient's Physician shall write the request for consultation in the patient's record or give a verbal order that is also documented in the medical record. The specific Physician or group he/she prefers, and the type of opinion request shall be

part of the consultation order.

E. An order for consultation should include whether the requesting provider is transferring care for (a) specific condition(s) or requesting another provider's advice or opinion with an intent to continue management of the patient once the consultant's advice or opinion is rendered.

F. The consultant shall respond to the request for consultation within a reasonable time, considering whether the patient's condition is urgent.

G. The consultant shall examine the patient and patient's record and document the results of his or her evaluation.

H. Any transfer of care between the requesting Practitioner and consultant shall be documented in the medical record in accordance with the provisions of the preceding section.

I. If both the consultant and the requesting provider continue to manage and treat the patient throughout the patient's hospitalization, the medical necessity of both Practitioners' services shall be documented in the medical record to justify the need for ongoing concurrent care.

J. A Practitioner with Privileges at the Hospital may seek opinions from providers at other institutions. In these cases, the Practitioner is responsible for calling and discussing the case with the provider, documenting which provider the Practitioner spoke with, and documenting recommendations in the patient's medical record.

Section 1.7 Surgical and Anesthesia Services.

A. Surgical Services.

1. Surgical services shall be under the medical direction of a qualified Physician Member of the Medical Staff.

2. Any Member or Allied Health Professional with Privileges to perform surgical procedures shall be required to follow any Hospital rules governing the quality and scope of surgical services.

3. The surgical suite shall be directed by a qualified registered professional nurse with relevant education and experience.

4. A qualified registered professional nurse with relevant education and experience shall be assigned circulating duties for surgical procedures performed.

5. All Hospital staff, including Members and Allied Health Professionals, involved in surgical procedures within the Hospital, shall follow accepted

standards of patient care, sterility, and aseptic techniques.

6. A roster of Medical Staff Members with surgical Privileges shall be available in the surgical suite.
7. Except in emergencies, history and physical exams must be performed, documented, and entered into the patient's medical record before surgical procedures may be performed.
8. Surgical assistants may be used at the discretion of the operating surgeon. Any such assistants must have appropriately Clinical Privileges at the Hospital.
9. Use of surgical assistants, other than operating room/surgical technicians and nursing staff, may be subject to limitations established by the Hospital.
10. Written informed consent must be obtained by the operating surgeon prior to the procedure, except in emergency circumstances when informed consent cannot be obtained due to the patient's condition.
11. Patients or their authorized representatives shall sign such written, informed consent.
12. Informed consents must be made part of the patient's medical record.
13. The operating surgeon may not delegate discussion of the risks, benefits, and alternatives of informed consent, but may delegate obtaining patients' signatures on consent forms.
14. The operative site and procedure shall be identified following Hospital policy and procedure, including identifying and verifying the correct site, correct procedure, and correct person. The responsible Member or Allied Health Professional shall ensure documentation of this identification and verification are recorded in the patient's medical record.
15. Every procedure is preceded by verification of patient identification, procedure, and site of procedure.
16. Any question of a missing object in the operating room requires site appropriate radiographic imaging prior to patient departure from the operating room.
17. All surgical procedures performed shall be accurately and timely documented by the operating surgeon into the patient's medical record.
18. All operative reports must include:
    a. Name of the patient and the Hospital's account, medical record, or other identification for the patient;
    b. Dates and times of surgery;

c. Name and nature of the procedure;

d. Pre- and post-operative diagnoses;

e. Clinical indications;

f. Name of the surgeon and identification of any assistants who performed surgical tasks;

g. Descriptions of specific surgical tasks conducted by individuals other than the primary operating surgeon;

h. Techniques used;

i. Complications;

j. Blood loss;

k. Prosthetic grafts, tissues, transplants, or devices implanted, if any;

l. Gross findings;

m. Organs/tissue removed.

19. All tissues removed at operation, except foreskins and placements, shall be sent to the hospital pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis and he/she shall sign his report. The following specimens do not require submission, unless requested by the surgeon:

    a. Orthopedic appliance

    b. Bone fragments from foot surgery

    c. Bone chips, disc from laminectomies

    d. Cartilage removed during arthroscopies

    e. Cataracts

    f. Adipose tissue from plastic surgery

    g. Vaginal mucosa from vaginal plastic surgery

    h. Fragments from fractures (except pathological fractures)

    i. Foreskin under 20 years of age

    j. Hernia Sacs

    k. Intrauterine contraceptive devices

    l. Nasal bones and cartilage

    m. Teeth

n. Prosthesis (breast, joint, nasal)

o. Pacemakers

p. Radioactive source

q. Toenails

r. Items considered evidence such as bullets and other foreign substances

s. Ribs incidental to thoracic procedure

t. Plaque form vascular procedure

u. Tonsils and/or adenoids

v. Total knee and total hip tissue

w. Exostosis (tori)

x. Bone and soft tissue during routine alveoplasty or perio-osseous reconstruction

y. Carious tissue

z. Bone removed from Le Forte or sagittal split osteotomies for treatment of malocclusion

aa. Hyperplastic gingiva induced by drugs i.e. Dilantin

bb. Varicose veins

cc. Vagina from a/p repair

dd. Foreign bodies

20. All tissues and specimen removed during an operation shall be the property of the Hospital and shall be examined by a competent Physician who shall prepare a report that is made part of the patient's medical record.

21. An operating room record documenting the patient care provided shall become a part of the patient's medical record. The record shall contain at least the name and hospital identification number of the patient; date and times of the surgery; name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks; pre-operative and post-operative diagnosis; name of the specific surgical procedure(s) performed; type of anesthesia administered; any complications; description of techniques, findings, and tissues removed or altered; any prosthetic devices, grafts, tissues, transplants, or devices implanted; and the verification of countable materials.

B. Anesthesia Services.

1. Anesthesia services shall be under the medical direction of a qualified Physician Member of the Medical Staff.

2. Any Member or Allied Health Professional with Privileges shall be required to follow any rules of the Hospital governing the quality and scope of anesthesia services.

3. Anesthesia shall be administered only by qualified anesthesiologists, Physicians or Dentists trained in anesthesia, or certified nurse anesthetists with appropriate Clinical Privileges, or supervised students in an approved educational program.

4. Except in the case of a life-threatening emergency certified by the operating Practitioner, a pre-anesthesia evaluation must be performed by a Physician within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia and shall include the history and physical examination; anesthetic, drug and allergy history; essential laboratory data; and other diagnostic test results to establish potential anesthetic risks.

5. Each patient's condition shall be reviewed immediately prior to induction of anesthesia.

6. Following the procedure during which anesthesia was administered, the anesthesia provider or a qualified designee shall remain with the patient as long as required by the patient's condition relative to the patient's anesthesia status and until responsibility for patient care has been assumed by other individuals.

7. A Practitioner with Privileges to administer anesthesia shall perform a post-anesthesia evaluation no later than forty-eight (48) hours after a procedure requiring anesthesia services.

8. An anesthesia record documenting the care given, including pre-anesthesia evaluation, evaluation immediately prior to induction of anesthesia, delivery and monitoring of anesthesia, and post-anesthesia evaluation shall be created and made a permanent part of the patient's medical record.

Section 1.8 Emergency Services.

A. Hospital emergency services shall be under the medical direction of a qualified Physician Member of the Medical Staff who is board-certified or board-admissible in emergency medicine and maintains a knowledge of current ACLS and ATLS standards or a Physician who is experienced in the care of critically ill and injured patients and maintains current verification in ACLS and ATLS.

B. Members and Allied Health Professionals are required to follow Hospital rules governing patient safety and the quality and scope of emergency services.

C. A qualified registered nurse shall supervise and evaluate the nursing and patient care provided in the emergency area by nursing and ancillary personnel.

D. Any individual assigned to the emergency services department administering medications shall be a Physician, registered nurse, EMT-paramedic or appropriately licensed or certified Allied Health Professional and shall administer medications only within his or her scope of practice except for students who are participating in a training program to become Physicians, nurses, emergency medical technician-paramedics who may be allowed to administer medication under the supervision of their instructors as a part of their training.

E. The Hospital shall have a call roster which lists the name of the Physician Member or Allied Health Professional who is on call and available for emergency care and the dates and times of coverage.

F. A Physician Member or Allied Health Professional who is on call and available for emergency care shall respond in a manner which is reasonable and appropriate to the patient's condition after being summoned by the Hospital.

G. If the Hospital has the ability to perform emergency surgery, it shall have a general surgical call roster which lists the name of the general surgeon who is on call for emergency surgical cases, and the dates and times of coverage.

    1. The surgeon who is on call for emergency surgical cases shall arrive at the Hospital within thirty (30) minutes of being summoned.

    2. If the Hospital at any point in time does not provide emergency surgical services, any patient who present to the Hospital and are found upon examination to require emergency surgery shall be immediately transferred to a hospital with the necessary services.

H. Any Member or Allied Health Professional is required to cooperate with the Hospital’s quality improvement program, including the periodic evaluation of at least the following: length of time each patient is in the emergency room, appropriateness of transfers, physician response time, provision for written instructions, timeliness of diagnostic studies, appropriateness of treatment rendered, and mortality.

I. All individuals presenting to the Hospital emergency department will be triaged according to priority by the Emergency Room Nursing Staff.

J. The emergency service medical record shall contain patient identification, time and

method of arrival, history, physical findings, treatment and disposition and shall be authenticated by the Physician. These records, including an ambulance report when applicable, shall be made a part of the patient's medical record.

K. All Members and Allied Health Professionals involved in providing emergency services are required to be familiar with and follow the Hospital's diversion plan.

L. All patients admitted to the emergency service shall be assessed prior to discharge by a Physician or Allied Health Professional.

M. All individuals who present to the emergency department and request an examination must be provided an appropriate medical screening by a qualified medical person to determine whether the individual has an emergency medical condition. Such screening examination shall be provided regardless of an individual's ability to pay for services.

    1. Physician Members, certain Allied Health Professionals with appropriate Clinical Privileges, and registered nurses may be qualified medical persons eligible to perform this screening examination.

    2. If the qualified medical person determines in good faith an emergency medical condition exists, the patient's emergency medical condition must be stabilized or provided an appropriate transfer, regardless of ability to pay.

N. If discharged from the emergency department, other than to the inpatient setting, the patient or responsible person shall be given written instructions for care and an oral explanation of those instructions. Documentation of these instructions shall be entered on the emergency service medical record.

O. If a patient leaves the emergency department against the applicable Physician Member or Allied Health Professional's medical advice, the Physician Member or Allied Health Professional shall advise the patient of the risks of refusing care and request the patient sign a form acknowledging he or she is leaving against the medical advice of a healthcare professional.

P. The Physician Member or Allied Health Professional shall document that such advice has been given, and/or include the acknowledgment form in the patient's medical record.

Section 1.9 Pathology and Medical Laboratory Services.

A. Outside reference laboratories used must be accredited by the College of American Pathologists (CAP) or The Joint Commission (TJC) and agree to adhere to applicable standards.

B. Laboratory studies will not be performed without a valid order.

C. The laboratory may accept a telephone order for outpatient laboratory studies. The signed order shall be faxed or it may be brought with the patient.

D. Requests for laboratory services shall contain reasonable information from the requesting practitioner, identifying diagnosis, the specific study or panels requested, and other such information as may be necessary to carry out the request and bill for the study.

Section 1.10 Radiology Services.

A. Use of radiology equipment and administration of radiology procedures is limited to personnel considered qualified per requirements established with the approval of the Medical Staff.

B. The director of radiology services shall be a qualified Physician Member of the Medical Staff and appointed by the governing body. This Physician shall be responsible for implementing the rules of the Medical Staff governing the quality and scope of radiology services and safety precautions to protect patients and personnel.

C. All Members and Allied Health Professionals providing radiology services are required to follow rules governing the quality and scope of radiology services and safety precautions to protect patients and personnel that are established by the Hospital.

D. A qualified radiologic technologist shall be on duty or on call at all times. Emergency radiologic services shall be available at all times.

E. Requests for radiological services or studies shall contain specific information from the requesting provider identifying the patient's diagnoses, reason for the examination, the specific study to be performed, including views if applicable, and any other such information as may be required to perform or bill for the test.

F. Requests for radiology services shall be authenticated in the patient's medical record by the attending Physician or other Medical Staff Member authorized to request radiologic services.

G. Radiotherapy services shall be administered only under the supervision of a Physician appropriately qualified by special training and experience.

H. For outpatient services, practitioner without Privileges to the Hospital may order nuclear medicine studies or procedures if within the ordering practitioner's scope of practice. In these cases,

I. For inpatient services, only Practitioners with Privileges to the Hospital may order nuclear medicine studies or procedures.

J. The interpretation of all radiologic examinations shall be made by Physicians qualified by education and experience in radiology.

K. A written report of the findings and evaluation of each radiological examination performed or course of treatment conducted shall be authenticated by a radiologist or other Medical Staff Member with appropriate Privileges.

L. Each written radiology report shall be signed by the attending Practitioner or other Allied Health Professional responsible for the patient's care and shall be made a part of the patient's permanent medical record.

Section 1.11 Other Services.

1. Rehabilitation services must be ordered by a qualified and licensed practitioner who is responsible for the care of the patient. The practitioner must have medical staff privileges to write orders for these services or, for outpatient services, if hospital policy permits acceptance of orders from outside practitioners, the practitioner's order must meet the requirements in these Rules and Regulations for the order of outpatient services.

2. Respiratory care services must be ordered by a qualified and licensed practitioner who is responsible for the care of the patient. The practitioner must have Privileges to write orders for these services or, for outpatient services, if Hospital policy permits acceptance of orders from outside practitioners, the practitioner's order must meet the in these Rules and Regulations for the order of outpatient services.

Section 1.12 Discharge From Care.

A. Any patient may leave the Hospital of his/her accord unless under custody of the law or court ordered commitment.

B. Patients shall be discharged only upon order of the attending Practitioner, or Allied Health Professional responsible for the management of the patient.

C. Should a patient leave the Hospital against the advice of the attending Practitioner or Allied Health Professional responsible for the management of the patient:

   1. The responsible Practitioner or Allied Health Professional shall be informed of the patient's desire to leave the Hospital against medical advice;

   2. If a patient leaves the Hospital against the applicable Member or Allied Health Professional's medical advice, the Member or Allied Health Professional shall advise the patient of the risks of refusing care and request the patient sign a form acknowledging he or she is leaving against the medical advice of a healthcare professional;

   3. The Member or Allied Health Professional shall document that such advice has

been given, and/or include the acknowledgment form in the patient's medical record;

4. In the event of patient's (or relative's) refusal to sign the release, the refusal must be documented in the patient's record; and
5. The medical record must contain full documentation of the entire incident.

D. The attending Practitioner or Allied Health Professional responsible for the patient's care may discharge the patient the next day by an order. The patient may then be discharged without being seen by the attending Practitioner or Allied Health Professional on the day of discharge as long as the patient's condition has not changed from the time of the previous visit.

E. Transfer of Patients. Patients may be transferred to another facility in order to meet the indicated needs of the patient or to assist in the effective utilization of resources.

1. The patient and/or family must agree to the transfer.
2. The transferring Physician or Allied Health Professional responsible for the patient's care will contact the facility and obtain medical consent for acceptance of the patient.
3. A copy of applicable records shall be sent with the patient.

ARTICLE II – MEDICAL RECORDS

Section 2.1 Procedures Governing Records.

A. General.

1. A medical record must be created for each inpatient or outpatient evaluated or treated in any part or location of the Hospital.
2. Original medical records are the property of the Hospital and shall not be removed from the building except by court order, subpoena or statute.
3. Copies of medical records, other records and/or radiology images may be removed from the building pursuant to policies approved by Hospital administration.
4. In case of readmission of a patient, all previous records shall be available for use of the attending Practitioner or Allied Health Professional. This shall apply whether the patient is attended by the same or a different provider.
5. Unauthorized removal of medical records from the Hospital is grounds for initiating Corrective Action against the Practitioner or Allied Health Professional.
6. The Practitioner or Allied Health Professional caring for the patient shall be responsible for preparing complete and legible medical records.
7. The content of the record shall be organized in a manner that facilitates continuous care, permits consultants to render an opinion, allows another practitioner to assume patient care and allows for the retrieval of information for utilization review and performance improvement activities.
8. If a patient does not change facilities when discharged from acute care services and admitted to swing bed care, the same chart can be utilized but the swing - bed section of the chart must be separate with appropriate admission orders, progress notes, and supporting documents.
9. Safeguards must be taken to ensure the medical record is not lost, stolen, destroyed, altered, or reproduced in an unauthorized manner.
10. Medical records shall be retained for at least ten (10) years from the date of the last entry, or longer in accordance with State law and/or Hospital record retention policies.
11. A certificate of live birth shall be prepared for each child born alive and shall be forwarded to the local registrar within seven days after the date of delivery. If the attending Practitioner or responsible Allied Health Professional does not

certify to the facts of birth within five days of the birth, the Administrator will complete and sign the certificate.

12. When a dead fetus is delivered, the administrator of his/her representative will prepare and, within seven days of delivery, file a report of fetal death with the local registrar.

13. Medical records of deceased patients will contain the date and time of death, autopsy permit, if granted, organ donation forms, disposition of the body, by whom received and when. The State Anatomical Board shall be notified of an unclaimed dead body. A record of this notification will be maintained.

Section 2.2 Contents of the Medical Record.

A. General. The medical record must contain complete information and documentation regarding the patient's medical history, assessment of health status and health care needs of the patient, and a summary of the episode, disposition, and instructions to the patient.

1. *History and Physical.* A complete history and physical, performed and recorded within the timeframes set forth in the Medical Staff Bylaws and these Rules and Regulations, should contain the following:

   a. Chief complaint;

   b. History of present illness;

   c. Relevant past medical, social, and family histories;

   d. Review of systems;

   e. Physical examination;

   f. Assessment/clinical impression;

   g. Plan of care including orders, procedures, and/or course of action planned for patient during hospitalization.

2. An admission note shall be recorded in the physician progress notes stating the reason for admission and pertinent findings.

3. *Operative Report.*

   a. Operative reports must be documented accurately and timely must include:

      i. Name of the patient and the Hospital's account, medical record, or other identification for the patient;

      ii. Dates and times of surgery;

iii. Name and nature of the procedure;

iv. Pre- and post-operative diagnoses;

v. Clinical indications;

vi. Name of the surgeon and identification of any assistants who performed surgical tasks;

vii. Descriptions of specific surgical tasks conducted by individuals other than the primary operating surgeon;

viii. Techniques used;

ix. Complications;

x. Blood loss;

xi. Prosthetic grafts, tissues, transplants, or devices implanted, if any;

xii. Gross findings;

xiii. Organs/tissue removed.

b. A brief operative note shall be created and entered immediately after the procedure if a full operative report will not be prepared until a late time.

4. *Discharge Summary.*

a. A discharge summary shall be created and entered into the medical record for all patients hospitalized over forty-eight (48) hours.

b. Discharge summaries are required for discharges from acute care services to swing bed services, even if the patient does not leave the Hospital facility.

c. Patients hospitalized for less than forty-eight (48) hours, and ambulatory or observation patients, shall have either a dictated discharge summary or a final progress note which includes the outcome of hospitalization, case disposition, provisions for follow-up care and final diagnosis.

d. Discharge summaries shall be prepared on discharge from a swing-bed stay.

e. The Practitioner who admitted the patient and was responsible for the patient during the patient's stay in the Hospital is responsible for developing and entering the discharge summary.

i. The Practitioner responsible for developing and entering the discharge summary may delegate this responsibility to another

Practitioner or Allied Health Professional with appropriate Privileges or other authority granted by the Medical Staff or Hospital to prepare discharge summaries.

ii. The Practitioner responsible for developing and entering the discharge summary may also delegate this responsibility to another Physician Member who is familiar with the patient.

f. The discharge summary shall include:

i. Reason for admission;

ii. Significant findings;

iii. Documentation of assessment of health status and health care needs of the patient;

iv. Summary of the episode of care;

v. Condition and disposition on discharge;

vi. Final diagnoses; and

vii. Discharge instructions (diet, medications, physical activity and follow-up, procedure(s) performed, treatment rendered).

5. In addition to the preceding items, and any others required in the Medical Staff Bylaws or these Rules and Regulations, all medical records must contain, as applicable:

a. Identification of the patient;

b. Social data;

c. Properly executed informed consents;

d. Medical histories;

e. All vital signs;

f. Assessment of the health status and health care needs of the patient;

g. All orders, properly authenticated;

h. All nursing notes;

i. All reports of treatment including complications and CAH-acquired infections;

j. All medication records;

k. All radiology reports;

l. All laboratory reports;

m. Discharge summaries; and

n. All other information necessary to monitor the patient's condition.

Section 2.3. Principles of Documentation.

A. Timeliness. All medical records must be promptly completed.

1. Pertinent progress notes shall be recorded at the time of observation, or as soon as practicable thereafter, sufficient to permit continuity of care and transferability.

2. All records must be completed within thirty (30) days of discharge from the Hospital.

B. Abbreviations. Symbols and abbreviations may be used only as defined in the adopted Hospital reference for identifying appropriate abbreviations. Each such symbol or abbreviation shall have only one meaning.

C. Authorship and Authentication.

1. All entries into a medical record shall be complete, accurately documented, legible, accurately identify the date of service, authenticated by the person making the entry, and timed.

2. The author of each entry in the medical record must be identifiable.

3. All entries in the medical record must be authenticated; automatic authentication processes are not permitted.

4. Parts of the medical record that are the responsibility of the Physician must be authenticated by this individual.

5. When a non-Physician has been approved for such duties as taking medical histories or documenting aspects of a physical exam, such information shall be appropriately authenticated by the responsible Practitioner or Allied Health Professional.

6. There shall be no sharing of signatures, electronic passwords, signature codes, or other methods for authentication of entries in the medical record.

7. No rubber stamp signatures may be used, unless required to accommodate a disability and in those circumstances, only in compliance with state and federal requirements.

8. All signatures must meet one of the following requirements:

a. Legible full signature;

b. Legible first initial and last name;

c. Illegible signature or initials over a typed or printed name; or

d. Illegible signature or initials matching a signature log maintained on file by the medical records department.

9. Authentication of entries more than thirty (30) days from the date of creation must be treated as late entries. Hospital-approved late entry/signature attestation language must be used to authenticate entries in these circumstances.

10. Co-Signatures. Documents authored by non-Physician providers must be co-signed by a responsible Physician Member of the Medical Staff when appropriate and required by law.

Corrections and Addendums.

1. When an error in documentation is made on a paper medical record, the following steps must be taken:

   a. One straight line should be drawn through the entry;

   b. The original entry should not be scratched out, covered with correction fluid or table or obliterated to the point that it is illegible;

   c. Corrected reports and records shall be designated as such; the original shall be placed in the back of the record and clearly marked indicating the report or record has been corrected and replaced;

   d. The word "error" should be written next to the entry;

   e. The entry should be dated with "today's date"; and

   f. The entry should be initialed by the author.

2. When an error is identified in the electronic record, the Hospital's policy for correcting electronic entries shall be followed:

   a. The individual correcting an entry may only do so by amendment to the medical record in a manner that preserves the original version of the entry or record.

   b. The amendment must be authenticated by the individual making the entry, with the date and time of the amendment recorded.

3. When an addendum to a medical record is made, the following steps must be taken:

   a. The entry should be labeled "addendum";

b. The entry should be dated with the date of the entry; and

c. The entry should be signed and dated by the author.

E. When an autopsy is performed, the provisional anatomic diagnoses are recorded in the medical record within three (3) days and the complete report is made part of the record within sixty (60) days. Findings from an autopsy requested by the Medical Examiner will not be placed on the record, as these are the property of the Medical Examiner.

F. Filing Incomplete Medical Records.

1. No medical record shall be filed until it is complete and properly authenticated.

2. In the event that a medical record remains incomplete by reason of death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the director of medical records shall consider the circumstances and may administratively close out the record and file it, although it may remain incomplete.

Section 2.4 Privacy and Security of Medical Records.

A. All Medical Staff and Allied Health Professionals are expected to abide by the Hospital's Corporate Compliance Plan and related policies and procedures, including those related to the privacy and security of patient information.

B. All Medical Staff and Allied Health Professionals are expected to abide by state and federal laws and regulations with respect to the privacy and security of patient information.

C. Medical Staff and Allied Health Professionals must only use, disclose, and/or access the minimum information needed to accomplish legitimate business purposes.

D. Medical Staff and Allied Health Professionals must not share passwords to any device or application of any kind which may create, receive, maintain, or transmit patient information.

E. Medical Staff and Allied Health Professionals must use caution to prevent incidental disclosures of patient information.

F. Medical Staff and Allied Health Professionals must use discretion with the location and nature of conversations regarding patients.

ARTICLE III – RESTRAINTS AND SECLUSION

Section 3.1 Definitions of Restraints and Seclusion.

A. Restraint. Includes either a physical restraint or a drug that is being used as a chemical restraint.

B. Physical Restraint. Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that the patient cannot easily remove that restricts freedom of movement or normal access to one's body.

C. Chemical Restraint. A medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

D. Items and Methods that are Not Restraints. A restraint does not include devices, such as orthopedically prescribe devices, surgical dressing or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

E. Seclusion. The involuntary isolation of a patient alone in a room where the patient's freedom to leave is restricted.

Section 3.2 Patient Rights.

A. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by any Hospital personnel, including Medical Staff and Allied Health Professionals.

B. Restraint or seclusion may only be used to ensure the immediate physical safety of the patient, Hospital personnel, Staff Members, or others and must be discontinued at the earliest possible time.

C. Restraint or seclusion shall never be used as a punishment or for the convenience of the staff.

Section 3.3 Use of Restraints or Seclusion.

A. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, Hospital personnel, or others from harm.

B. Seclusion may only be used for the management of violent or self-destructive behavior.

C. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, Hospital personnel, or others from harm.

D. The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph F of this section at an interval determined by hospital policy.

E. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

F. When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

1. By a Physician or other licensed independent practitioner; or registered nurse or physician assistant who has been trained on the Hospital's restraint and seclusion policies;

2. To evaluate the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion.

G. If the evaluation in the preceding paragraph is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1–hour face-to-face evaluation.

H. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored

1. Face-to-face by an assigned, trained staff member; or

2. By trained staff using both video and audio equipment in close proximity to the patient.

Section 3.4 Physician Order Required.

Use of restraint or seclusion must be in accordance with the order of a Physician or other licensed independent practitioner responsible for the care of the patient and with appropriate Privileges or order restraint or seclusion. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed (PRN) basis. The order for restraint or seclusion must be:

A. Followed by consultation with the patient's attending Practitioner or Allied Health Professional, as soon as possible if the attending Practitioner or Allied Health Professional did not order the restraint or seclusion;

B. In accordance with a written modification to the patient's plan of care;

C. Signed within one (1) hour of implementation;

D. Implemented in the least restrictive manner possible;

E. In accordance with safe and appropriate restraint or seclusion techniques;

F. Ended at the earliest possible time;

G. Time limited;

H. In the case of use for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, only renewed in accordance with the following limits for up to a total of 24 hours:

   1. 4 hours for adults 18 years of age or older;

   2. 2 hours for children and adolescents 9 to 17 years of age; or

   3. 1 hour for children under 9 years of age; and

   4. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a Physician or other licensed independent practitioner who is responsible for the care of the patient with Privileges to order restraint or seclusion must see and assess the patient.

I. Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by Hospital policy.

Section 3.5 Documentation of Restraint or Seclusion.

When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

A. The 1–hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

B. A description of the patient's behavior and the intervention used;

C. Alternatives or other less restrictive interventions attempted (as applicable);

D. The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and

E. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

ARTICLE IV –DEATH AND AUTOPSIES

Section 4.1 Securing Autopsies.

A. Each member of the Medical Staff shall be actively interested in securing autopsies and should attempt to secure an autopsy in all cases of unusual deaths and of medical-legal and educational interest.

B. No autopsy shall be performed without written consent of a relative or legally authorized agent.

C. Autopsies shall be performed by the Hospital pathologist or by a pathologist to whom the Physician may delegate the duty.

D. The attending Practitioner or Allied Health Professional shall be notified when an autopsy is being performed.

E. The attending Practitioner or Allied Health Professional record in the death summary whether an autopsy was requested from the family.

F. When the family or a legal authorized agent consents, the order shall be documented on the chart and the necessary consent signed.

Section 4.2 Reporting Deaths.

A. If a patient dies in the Hospital or is brought to the Hospital deceased and is believed to have died in Carroll County due to any of the following, the medical examiner must be notified:

   1. Violence by homicide, suicide, or accident;
   2. Thermal, chemical, electrical, or radiation injury;
   3. Criminal abortion, including those self-induced;
   4. Disease thought to be hazardous and contagious or which might constitute a threat to public health;
   5. When any person dies:
      a. Suddenly when in apparent good health;
      b. When unattended by a Physician or chiropractor during the thirty-six (36) hours preceding death;
      c. While in the custody of the law or while an inmate in a public institution;
      d. In an unusual or suspicious manner.

B. The medical examiner shall be told the time, place, manner, and circumstances of the death. If death occurs while the patient is being transferred from one

county to another for medical treatment and such person dies while being transferred, or dies while being treated in the emergency room of the receiving facility, the place which the person is determined to be dead shall be considered the place of death.

C. The attending Practitioner or Allied Health Professional shall be notified when an autopsy is being performed and when results are available.

ARTICLE V – MEDICAL STAFF CONDUCT

A. Medical Staff Members and Allied Health Professionals shall treat Hospital staff, patients, visitors, vendors, contractors and others they encounter in the course of their professional duties with respect.

B. Unprofessional or inappropriate conduct includes, but is not limited to:

   1. Disruptive behavior;
   2. Using verbal or written foul language, racial and ethnic slurs, sexual comments or abusive language;
   3. Humiliating, intimidating, or degrading others;
   4. Engaging in unwelcome or inappropriate contact or otherwise making unwelcome comments or advances;
   5. Physical abuse.

ARTICLE VI - REVIEW AND REVISIONS

These Rules and Regulations shall be adopted and amended in accordance with the processes set forth in the Medical Staff Bylaws, as amended from time to time.