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Rules And Regulations

APPENDIX A – FAIR HEARING PLAN

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

hereunder.

DEFINITIONS

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

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

ARTICLE I - INITIATION OF HEARING

1.1 RECOMMENDATION OR ACTIONS

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

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

15. denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

1.2 WHEN DEEMED ADVERSE

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

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

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the CEO, who will promptly inform the individual by special notice.

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

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

1.4 REQUEST FOR HEARING

A practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Article I, Section 1.3 to file a written request for a hearing. Such request shall be delivered to the CEO either in person or by certified or registered mail and will include, at minimum, the name of the individual's counsel, if any. Together with any request for hearing, the individual making the request shall provide to the Medical Center President written assurance that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside the hearing. The individual shall also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

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

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

ARTICLE II - HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

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

2.2 STATEMENT OF ISSUES & EVENTS

The notice of hearing required by Article II, Section 2.1 shall contain a concise statement of the practitioner's alleged act or omissions, and a list by number of specific patient records in question (if applicable) and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. If adverse action was based on, or included, professional misconduct, specific dates, locations, and details of alleged misconduct shall be included in the notice of hearingThe notice shall further contain a list of witnesses expected to testify in support of the adverse recommendation or action.

2.3 PRACTITIONER'S WITNESSES

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

The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

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

2.4 EXAMINATION OF DOCUMENTS

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

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

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

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

Employment by, or other contractual arrangement with, the Medical Center or an affiliate will not preclude an individual from serving on the Panel.

2.5(b) By Board

A hearing occasioned by an adverse action of the Board pursuant to Article I, Section 1.2(2) or 1.2(3)

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

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

2.5(c) Service on Hearing Committee

Individuals who were involved in the initial investigation, and/or members of the Medical Executive Committee or Board who voted against the provider shall not serve on the Hearing Committee. Employment by, or other contractual arrangement with, the Medical Center or an affiliate will not preclude an individual from serving on the Panel.

ARTICLE III - HEARING PROCEDURE

3.1 PERSONAL PRESENCE

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

3.2 HEARING OFFICER

The Hearing Officer shall be appointed pursuant to Article VIII, Section 8.1. The Hearing Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

The Hearing Officer may participate in the private deliberations of the Hearing Panel and be a legal

advisor to it but will not be entitled to vote on its recommendations.

3.3 REPRESENTATION

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of the Medical Staff in good standing, a member of his/her local professional society, or other individual of the physician's choice. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine the witnesses. Either party may be represented by an attorney at law. The hearing will be restricted to those individuals participating in the proceeding or acting in support thereof. Administrative personnel may be present as requested by the Medical Center President or the Medical Staff President.

3.4 RIGHTS OF THE PARTIES

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

1. Call and examine witnesses to the extent they are available and willing to testify.
2. Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law.
3. Cross-examine any witness on any matter relevant to the issues.
4. Impeach any witness.
5. Rebut any evidence.
6. Have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and
7. Submit a written statement at the close of the hearing.
8. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence

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

3.5 PROCEDURE & EVIDENCE

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

3.6 OFFICIAL NOTICE

In reaching a decision, the Hearing Committee may take official notice, either before or after submission

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

3.7 BURDEN OF PROOF

1. When a hearing relates to the matters listed in Article I, Sections 1.1(1), 1.1(5) or 1.1(8), the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious, or impermissibly discriminatory.
2. For the other matters listed in Article I, Section 1.1, the body whose adverse recommendation or action occasioned the hearing (the Medical Executive Committee or the Board) shall bear the burden of proof, the body must demonstrate by a preponderance of the evidence, that the actions taken were reasonable and appropriate. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

3.8 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that later may be called upon to review the record and render a recommendation or decision in the matter. The method of recording the hearing shall be by use of a court reporter. The cost of the reporter will be borne by the Medical Center. Copies of the transcript will be available at the individual's expense.

3.9 POSTPONEMENT

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

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING

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

3.11 RECESSES & ADJOURNMENT

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

ARTICLE IV

HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

Within fourteen (14) days after the transcript of the proceedings has been delivered to the proper officer of the hearing, or if no transcript is ordered, then thirty (30) days after the hearing ends, the Hearing Committee shall make a written report of its findings and

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

4.2 ACTION ON HEARING COMMITTEE REPORT

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

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

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

4.3(b) Effect of Favorable Result

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

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

   4.3(c) Effect of Adverse Result

   At the conclusion of the process set forth in Section 4.2, if the result continues to be adverse to the practitioner in any of the respects listed in Article I, Section 1.1 of this Plan, the practitioner shall be informed, by special notice of his/her right to request an Appellate Review as provided in Article V, Section 5.1 of this Plan. Said

notice shall be delivered to the practitioner no later than fourteen (14) days from the MEC action, or Hearing Committee report, as appropriate under Section 4.2.

ARTICLE V

INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

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

5.2 GROUNDS FOR APPEAL

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Bylaws of the Medical Center or Medical Staff during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

5.3 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

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

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

5.4 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

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

5.5 APPELLATE REVIEW BODY

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

ARTICLE VI

APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

The proceedings of the Appellate Review Body shall be in the nature of an Appellate Review based upon the record of the hearing before the Hearing Committee, and the committee's report, and all subsequent results and actions thereon. The Appellate Review Body also shall consider the written statements, if any, submitted pursuant to

Article VI, Section 6.2 of this Plan and such other material as may be presented and accepted under Article VI, Sections 6.4 and 6.5 of this Plan. The Appellate Review Body shall apply the standards of proof set forth in Article III, Section 3.7.

6.2 WRITTEN STATEMENTS

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

6.3 PRESIDING OFFICER

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

6.4 ORAL STATEMENT

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements supporting their positions, not to exceed 20 minutes. If the Appellate Review Body allows one of the parties to make an oral statement, the other party shall be allowed to do so. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

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

6.6 PRESENCE OF MEMBERS & VOTING

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

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of consultation. Upon the conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 ACTIONS TAKEN

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

6.9 CONCLUSION

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

ARTICLE VII

FINAL DECISION OF THE BOARD

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

ARTICLE VIII

GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

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

8.2 ATTORNEYS

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

8.3 NUMBER OF HEARINGS & REVIEWS

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

8.4 RELEASE

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

8.5 WAIVER

If any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request of appearance or otherwise

fails to comply with this Fair Hearing Plan or to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

ARTICLE IX – AMENDMENT OF FAIR HEARING PLAN

This Appendix A shall only be amended in accordance with Article XV of the Medical Staff Bylaws.

APPENDIX B – RULES AND REGULATIONS

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

APPENDIX

DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "MEDICAL STAFF-ADVANCED PRACTICE PROFESSIONALS" ("MS-APPs") means individuals other than Medical Staff members who are authorized by law and by the Medical Center to provide patient care services. (e.g.: Physician Assistant-Certified; Advanced Practice Nurses, Certified Nurse Midwife)

(2) "BOARD" means the Board of Directors of the Medical Center, which has the overall responsibility for the Medical Center, or its designated committee.

3. "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the Royal College of Physicians and Surgeons (Canada), the American Board of Podiatric Surgery, or the American Dental Association Boards, upon a practitioner, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.
4. "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
5. "CORE PRIVILEGES" or "CORE" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff leaders and Board to require closely related skills and experience.
6. "CREDENTIALS POLICY" means the Medical Center's Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.
7. "DAYS" means calendar days.
8. "DENTIST" means a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.").
9. "MEDICAL CENTER PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.
10. "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

11. "MEDICAL CENTER" means Community Medical Center.
12. "MEDICAL STAFF" means all physicians, podiatrists, and dentists who have been appointed to the Medical Staff by the Board.
13. "MEDICAL STAFF LEADER" means any Medical Staff officer, department chair, section chair, or committee chair.
14. "PATIENT CONTACT" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Medical Center or affiliate, including outpatient facilities.
15. "PHYSICIAN" includes both Doctors of Medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
16. "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
17. "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
18. "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
19. "CHIEF MEDICAL OFFICER" means the individual appointed by the Board to act as the chief medical officer of the Medical Center, in cooperation with the Medical Staff President. (CMO)
20. "PRESIDING OFFICER" means any Medical Staff officer, department chair, section chair, committee chair or their designee.

ARTICLE I-ADMISSION OF PATIENTS

1.1 ADMITTING POLICY

The admission policy is as follows:

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

1.1(b) A patient may be admitted to the Hospital only by an attending member of the Medical Staff or APP staff with admitting privileges. The privilege to admit shall be delineated and is not automatic with Medical Staff membership.

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

1.1(d) Emergency Department Physicians, and physicians providing care in the Intensive Care Unit (ICU), shall be required to maintain documentation regarding current ACLS certification. Physicians admitting to ICU without ACLS certification will be required to co-manage the case with an ACLS certified physician.

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

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

1. An alternate physician (preferably a partner, associate, or designee of the Attending Physician);
2. The Medical Staff President, who may assume care for the patient or designate any appropriately trained member of the staff, whichever is appropriate; or
3. In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.

1.1(g) The provider certification must be completed, signed, dated and documented in the medical record prior to discharge unless otherwise permitted by law. This requires authentication of the order for inpatient admission prior to discharge.

1.2 ADMITTING POLICY PRIORTITIES

Priorities for admission are as follows:

1.2(a) Emergency Admissions

the admitting provider shall have a history and physical dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b) non-elective Preoperative Admissions

This includes all patients scheduled for non-elective surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgical Services may decide the urgency of any specific admission.

1.2(c) Medically Necessary Admissions (non-elective, non-operative)

This will include admissions involving all services.

1.2(d) Elective Preoperative Admissions

This includes all patients scheduled for elective surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgical Service*surgery* may decide the urgency of any specific admission.

1.2 (e) Other Elective Admissions

1.3 PATIENT TRANSFERS

1.3(a) No patients will be transferred between departments, units, or services without notification to the Attending Provider.

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

1.4 SUICIDAL PATIENTS

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

1.4(a) A patient suspected to be suicidal in intent shall be admitted to an appropriate room consistent with the patient's medical needs and Hospital policy. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or Hospital policy. The patient will be afforded psychiatric consultation;

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

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

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

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

1.5(b) If any questions as to the validity of admission to or discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.

1.5(c) The Attending provider is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

1. Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;
2. Estimate of additional length of stay the patient will require; and
3. Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason, therefore. This report must be submitted within

a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

1.5(d) The Attending provider shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending provider and Hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:

1. Conditions that may result in the patient's transfer to another facility or level of care;

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

(4) The anticipated need for continued care following discharge;

(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and

(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.5 (e) DISCHARGE SUMMARIES

A discharge summary is required for all patients hospitalized more than 48 hours. For patients hospitalized less than 48 hours, a final progress note may be substituted for the discharge summary.

1.6 DECEASED PATIENT

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

For all patient deaths, a death summary is required.

1.7 AUTOPSIES

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

1.8 UNANTICIPATED OUTCOMES

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

ARTICLE II - MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

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

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

Admission orders will be entered electronically. Verbal orders will be recorded on the patient's chart and routed to ordering provider for signature, through the EMR.

Use of the Electronic Health Record and Computerized Provider Order Entry (CPOE) will be considered part of the routine practice of medicine at Community Medical Center and as such, will be a condition of securing and maintaining privileges.

All Medical and Medical Staff-Allied Health Staff members will be trained and competent prior to being granted access to the Electronic Health Record applications including CPOE.

Medical and Medical Staff-Allied Health Staff will be required to comply with all the policies and procedures necessary to perform their patient care duties as they apply to the Electronic Health Record systems (e.g., order management, privacy regulations).

All practitioners must maintain the confidentially of passwords and may not disclose passwords to anyone.

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have a complete admission history and physical examination as required by the Medical Staff Bylaws.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam must be recorded before all inpatient surgical and diagnostic procedures, and before all outpatient procedure requiring sedation. When a history and physical examination including ASA risk assessment and airway assessment, NPO status, pertinent ordered laboratory, x-ray and EKG reports, and informed consent are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents the emergent nature of the case such that delay would be a threat to the patient's health.

2.4 PROGRESS NOTES

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

For acute rehabilitation patients, a progress note must be written at a minimum of three times per week.

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural notes shall be written or dictated immediately following surgery and before the patient is transferred to the next level of care, and shall be immediately viewable in the electronic health record A full Operative/procedural report shall be completed within 24hours and include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the procedure/surgical technique, primary surgeon and assistants, estimated blood loss, postoperative diagnosis and tissue or specimens removed or altered. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Medical Staff President for appropriate action.

2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the consultation policy(ies) of this Hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient (when indicated), the consultant's opinion and recommendations. The report shall be made a part of the patient's record.

2.7 OBSTETRICAL PATIENT HISTORIES

The prenatal record for obstetrical patients, when adequately updated with progress notes setting forth the current (last 30 days) history and changes in physical findings that meet the requirements of Bylaws 3.4, shall be accepted as a valid and actual history and physical throughout the Hospital for surgery and

other procedures related to obstetrical patients.

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately and promptly dated, timed, authenticated, and legible. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials, or computer key. The use of a rubber stamp signature is not acceptable.

2.9 ABBREVIATIONS/SYMBOLS

MEC will approve a list of abbreviations and symbols for the "do not use" list. Abbreviations and symbols listed on the "do not use" list may not be utilized in medical records. This list shall be filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.10 FINAL DIAGNOSIS

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

2.11 REMOVAL OF MEDICAL RECORDS

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

2.12 ACCESS TO MEDICAL RECORDS

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

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

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

2.13 PERMANENTLY FILED MEDICAL RECORDS

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

2.14 STANDING ORDERS

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

2.15 COMPLETION OF MEDICAL RECORDS

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

Completion of the medical record refers to the timely completion of all aspects of the medical record, including histories and physicals (H&P), progress notes, discharge summaries, immediate post-operative notes, operative reports, and post-anesthesia evaluations. Timely completion is further defined in 3.4 but includes:

- Discharge Summary - Within 7 days after discharge
- Post-Anesthesia Evaluation - Within 48 hours after surgery or a procedure requiring anesthesia
- Clinic notes within 72 hours

2.16 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will monitor the completion of the medical record and will provide each physician with a list of his/her incomplete medical records and deficiencies every seven (7) days. The twenty-first (21st) day notification for any incomplete medical records, will include a warning that the record(s) will be delinquent at thirty (30) days and the physician's privileges will be suspended if any records become delinquent. Deficiencies will be reported to the appropriate Department chair and/or CMO, who will follow up with the provider.

2.16(a) **Suspension**. A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible physician's privileges. When a provider is notified of suspension, the provider may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended provider may not cover Emergency Room call, may not provide coverage for partners or another provider, nor admit under a partner's or other provider's name. Any exceptions must be approved by the President of the Medical Staff and the CEO.

Failure to complete the medical records that caused suspension within 3 months will result in an automatic voluntary resignation of clinical privileges and membership.
2.16(b) The suspended provider is obligated to provide to the Hospital CEO and the President of the Medical Staff the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations, and any other services that physician provides. In the event that no provider is specified, the process as defined in 8.3 of the Bylaws will be followed.
2.16(c) All Hospital departments shall be notified of a suspension to enable the enforcement of the suspension.
2.16(d) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.
A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the appropriate department chair, the CEO, or the chairperson of the Quality Management Committee, or equivalent Medical Staff committee. If notice is provided to the Health Information Department regarding vacations or absences, an extension may be granted.

2.17 TREATMENT & CARE WRITTEN ORDERS

Orders for treatment and care of patients may be written by any practitioner who has been granted privileges to do so, within the scope of their licensure.
Preoperative orders must be cosigned by the appropriate physician prior to being followed unless the orders are verbal telephone orders given by the physician as prescribed in Article III, Section 3.2 of these Rules & Regulations.

2.18 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

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

2.19 COMPUTERIZED PHYSICIAN ORDER ENTRY

CPOEs shall be utilized by providers to the extent available and operational.
Use of the Electronic Health Record and Computerized Provider Order Entry (CPOE) will be considered part of the routine practice of medicine at Community Medical Center and as such, will be a condition of securing and maintaining privileges.
Medical and Medical Staff-Allied Health Staff will be required to comply with all the policies and procedures necessary to perform their patient care duties as they apply to the Electronic Health Record systems (e.g., order management, privacy regulations).
All practitioners must maintain the confidentiality of passwords and may not disclose passwords to anyone.

ARTICLE III - GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of presentation for admission. The patient business office should notify the Attending Physician whenever such consent has not been obtained. When so

notified it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing, dated, timed, and authenticated. Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, occupational therapists, speech therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and LPNs may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has recorded the order and shall read the verbal order back to the provider and indicate that the individual has confirmed the order. The provider who gave the verbal order or another provider (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate, time and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than forty-eight (48) hours from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

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

3.3 ILLEGIBLE TREATMENT ORDERS

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

3.4 PREVIOUS ORDERS

All previous orders are suspended and must be reviewed for continuation, reinstatement, or cancellation when a patient changes levels of care (including surgery).

3.5 ADMINISTRATION OF DRUGS/MEDICATIONS

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

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

3.6 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route, and frequency of administration. Drugs shall be dispensed from and reviewed by the Hospital pharmacist, or as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the Hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other

contraindications; and variation from Hospital dispensing criteria. When the patient brings medication to the Hospital with him/her, those medications which are clearly identified may be given to and administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. The physician must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

3.7 QUESTIONING OF CARE

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

3.8 PATIENT CARE ROUNDS

Hospitalized patients shall be seen by the attending physician or his/her designated alternate at least daily and more frequently if their status warrants. Patients in the Inpatient Rehabilitation Facility shall be seen at least every three days, and more frequently if their status warrants, by the Attending Physician or his/her designated alternate. Patients admitted to Critical Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, per medical staff policy.

3.9 ATTENDING PROVIDER UNAVAILABILITY

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

3.10 PATIENT RESTRAINT ORDERS

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

3.11 PRACTITIONERS ORDERING TREATMENT

Licensure and Medicare/Medicaid eligibility will be verified for all practitioners ordering treatment (i.e., home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the practitioner's Medical Staff status or lack thereof. Orders for outpatient services may only be made by practitioners who are (1) responsible for the care of the patient; (2) licensed in, or holds a license recognized in, the jurisdiction where he/she provides care to the patient; (3) acting within his/her scope of practice under State law; and (4) authorized by the Medical Staff to order the applicable outpatient services under a written Hospital policy that is approved by the Board. This includes both practitioners who are on the Hospital Medical Staff, as well as other practitioners who are not on the Hospital Medical Staff, but who satisfy the Hospital's policies for ordering applicable outpatient services.

3.12 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

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

ARTICLE IV - GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

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

4.2 ADMISSION OF DENTAL CARE PATIENT

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

4.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

1. To provide a detailed dental history justifying Hospital admission;
2. To provide a detailed description of the examination of the oral cavity and preoperative diagnosis;

(3) To complete an operative report describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the Hospital pathologist for examination;

(4) To provide progress notes as are pertinent to the oral condition; and

(5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

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

(3) To supervise the patient's general health status while hospitalized. and be responsible, through consultation, for the care of any other medical problems that may be present on admission or that may arise during hospitalization

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

4.3 ADMISSION OF PODIATRIC PATIENTS

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

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

1. To provide a detailed podiatric history justifying hospital admission;
2. To provide a detailed description of the podiatric findings and a preoperative diagnosis;

3. To complete an operative report describing the findings and technique. Any tissue shall be sent to the Hospital pathologist for examination;
4. To provide progress notes as are pertinent to the podiatric condition; and
5. To provide a clinical summary.

4.3(b) Physician's Responsibilities

The responsibilities of the physician are:

1. To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;
2. To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
3. To supervise the patient's general health status while hospitalized and be responsible, through consultation, for the care of any other medical problems that may be present on admission or that may arise during hospitalization.

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

4.4 INFORMED CONSENT

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

Each consent form shall include the name of the Hospital where the procedure is to take place; the name of the specific procedure for which consent is being given; the name of the responsible practitioner who is performing the procedure; a statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative; and the signature of the patient or the patient's legal representative. The form must also comply with the requirements of applicable state law.

4.5 PATIENT REQUESTS & REFUSAL OF TREATMENT

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on

the patient's behalf, must be documented in the patient's permanent Hospital record.

Patients have the right to request any treatment at any time, and such requests shall be documented in the patient's permanent chart. However, such requests may be declined if determined to be medically unnecessary by the treating physician or his/her designee.

4.6 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff and documented in writing.

4.7 ELECTIVE SURGERY SCHEDULING

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

4.8 POST-OPERATIVE EXAMINATION

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

4.9 ANESTHESIA

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

4.9(a) Anesthesia services throughout the Hospital shall be organized into one anesthesia service under the direction of a qualified physician. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. The director of anesthesia services will be an anesthesiologist member of the Medical Staff. Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services.

4.9(b) The Hospital shall maintain policies and procedures governing anesthesia services provided in all Hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate or deep sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

4.9(c) Only credentialed and qualified individuals as defined in the policies and procedures of the Hospital may provide anesthesia services. The Department of Surgery shall approve credentialing

guidelines consistent with federal regulations and Joint Commission standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

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

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

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

4.10 POST-ANESTHESIA EVALUATION

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. This evaluation is required any time general, regional, or monitored anesthesia has been administered to the patient. This evaluation is not required for those patients receiving moderate sedation. This post-anesthesia evaluation must be completed and documented by an Anesthesiologist; however, this does not need to be the same Anesthesiologist who administered the anesthesia to the patient. This post-anesthesia evaluation will contain the following:

• Respiratory function

• Cardiovascular function, including vital signs

- Mental status
  • Temperature
  • Pain
  • Nausea and vomiting
  • Postoperative hydration

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

4.11 ORGAN & TISSUE DONATIONS

The Hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases (term birth to age 75) to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability and shall comply with all CMS conditions of participation for organ, tissue, and eye procurement.
No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.
The attending physician shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient's medical record shall reflect the results of this notification.

ARTICLE V - GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 CARE OF HIGH RISK NEWBORNS

Subject to other state or accreditation requirements, only by those physicians or APPs who have training in neonatal resuscitation and NICU care, with a current Neonatal Resuscitation Program certification from the American Academy of Pediatrics will provide care for newborns at high risk for complications or neonates in the NICU

5.2 LABOR & DELIVERY

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

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents unscheduled to the Hospital requesting medical evaluation, regardless of the location to which the female presents, this presentation is considered a presentation for medical screening evaluation (MSE) pursuant to the facility's EMTALA policy. An MSE is required to be conducted face-to-face by a licensed independent provider. In late pregnancy, defined as gestation greater than sixteen weeks (16), the initial triage nurse will consider best location for the MSE to occur. Pregnancy related complaints in late pregnancy may be evaluated in the Hospital's Labor and Delivery Unit, considered an extension of the emergency department for purposes of compliance with EMTALA. The decision regarding best location for the MSE is based upon the patient's gestational age and presenting condition. For those patients who are referred to the Labor and Delivery Unit for MSE, an RN trained in obstetrics, as defined by Hospital policy, will initiate the order of the obstetric provider to determine the onset of labor or obstetrical conditions that may require immediate medical intervention. For the patient who is determined not to be in active labor, a face-to-face medical screening exam by qualified medical personnel is required to determine the diagnosis and the

disposition

5.4 PATIENTS PRESENTING TO LABOR & DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating physician or otherwise shall undergo the screening described in Section 5.2, above. The nurse shall contact the admitting physician upon any change in the patient's condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital within twenty (20) minutes upon being contacted by the nurse and requested to come to the Hospital due to a change in condition or deviation from the standard course of progress. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician at any time that her condition warrants, and per approved medical staff policy.

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

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a)Screening

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

6.1(b)Stabilization

1. Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.

a. A patient is Stable for Discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or, the patient requires no further treatment and the treating physician has provided written documentation of his/her findings.

b. A patient Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician

reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

c. A patient does not have to be stabilized when:
    i. the patient, after being informed of the risks of transfer and of the Hospital's treatment obligations, requests the transfer and signs a transfer request form; or
    ii. based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification which includes a summary of risks and benefits to this effect.

(2)If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1(c)Transfer

(1)The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.

(2)The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.

(3)Upon transfer, the Emergency Department shall provide ***a copy of*** appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

(4)All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

6.2(a)When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient's medical record

6.2(b)The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department and that person will document the time of the contact in the patient's medical record.

6.2(c)An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

1. Attempted to reach the physician in the Hospital;
2. Called the physician at home;
3. Called the physician at his/her office; and
4. Called once on the physician's pager or cell phone.

Twenty minutes (20) will be considered a reasonable time to carry out this procedure.

6.2(d)The rotation call list, containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient's request to come to the Emergency Department, or the physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient.

A physician who has been called from the rotation list may not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the CEO and Medical Staf President for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

Patients reporting to the Emergency Department for treatment and who do not identify a personal physician will, when appropriate, have the appropriate Unassigned Patient Call physician assigned for their outpatient follow-up.

Unassigned Patient Call Violations:

If a physician neglects to respond to Unassigned Patient Call as published, in final version, the Community Medical Center House Supervisor will be notified by the staff. The House Supervisor will document on the Medical Staff Episode Form* and forward to Medical Staff Services. The House Supervisor will then notify the Medical Center President and/or Administrator on call, as well as the Chief Medical Officer. After review, the Medical Executive Committee will take appropriate actions.

*The Episode Form will be maintained as part of the physician's peer review records and process.

6.2(e)The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the physician's office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

6.2(f)All members of the Active Staff shall participate in the on-call backup to the Emergency Department if and as required by the Board, upon recommendation of the MEC. Participation in the on-call backup to the Emergency Department is not a right. The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or specialty represented on the Active Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital's ability to fulfill its obligations as outlined above.

Physicians called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in, they are required to do so within twenty (20) minutes after responding by telephone.

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

ARTICLE VII - ADOPTION & AMENDMENT OF RULES & REGULATIONS

7.1 DEVELOPMENT

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

7.2 ADOPTION, AMENDMENT & REVIEWS

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

7.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

7.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Medical Staff President, the CEO, the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel; or

7.3(b) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last

restatement, which restated Rules & Regulations shall be dated and signed by the Medical Staff President, the CEO, the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel.

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

7.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

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

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

1.1 PURPOSE & OBJECTIVE

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

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

This policy is applicable to all medical staff members and all APPs (collectively referred to in this policy as "Practitioners").

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

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

2.1 BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

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

2.1(a) Rude, abusive, or intimidating behavior or comments to Hospital personnel, other Practitioners, Hospital visitors, patients or their families, or other behavior that negatively affects the ability of others to do their jobs. Such behavior can include the failure to cooperate, the refusal to return calls, or other passive activities when such substantially impacts the culture of safety

2.1(b) Attacks, verbal or physical, directed at other Practitioners, Hospital personnel, patients, or visitors, that are personal, inappropriate, irrelevant, or beyond the bounds of fair professional conduct

2.1(c) Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the Hospital, or attacking particular Practitioners, nurses, other Hospital employees, or Hospital policies

2.1(d) Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

2.1(e) Refusal to accept, or causing a disturbance of, medical staff assignments or participation in committee or departmental affairs.

2.1(f) Interference with Hospital operations, Hospital or Medical Staff committees, or departmental affairs, or placing quality care at the Hospital in jeopardy.

2.1(g) Knowingly making false accusations or falsifying any patient medical records or Hospital documents

2.1(h) Verbal or physical maltreatment of another individual, including physical or sexual assault or battery, or retaliation of any kind for making a report under this policy.

2.1(i) Sexual, racial, or other harassment, including words, gestures and actions, verbal or physical, that interferes with a person's ability to perform his or her job

2.1(j) Behavior that adversely affects or impacts the community's confidence in the Hospital's ability to provide quality patient care

3.1 REPORTING OF UNDERMINING BEHAVIOR

3.1(a) Hospital employees who observe, or are subjected to, Undermining Behavior by a Practitioner should notify their supervisor about the incident. If the supervisor's behavior is at issue, the employee should notify the Chief Executive Officer (or his/her designee) or the Hospital Human Resources Director. Any Practitioner who observes Undermining Behavior of another Practitioner shall notify the Chief Executive Officer or President of the Medical Staff directly. Supervisors who have received a report of

Undermining Behavior shall report the same to the Chief Executive Officer (or his/her designee) and encourage documentation by the reporting individual.

3.1(b) If a reporting individual is uncomfortable with reporting Undermining Behavior directly, then a report of the incident must be made to the Hospital's Ethics & Compliance Officer or the LifePoint Ethics Line at 1-877-508-LIFE (5433).

4.1 DOCUMENTATION

4.1(a) Documentation of Undermining Behavior is critical since it is ordinarily a pattern of conduct, rather than one (1) incident, which justifies disciplinary action. Practitioners, nurses, and other Hospital employees who observe and report Undermining Behavior by a Practitioner must document the behavior or in the alternative, the supervisor/Chief Executive Officer shall document the incident as reported. That documentation shall include:

(1) The date and time of the questionable behavior;

(2) A statement of whether the behavior affected or involved a patient in any way; and if so, the medical record number of the patient;

(3) Known circumstances which precipitated the situation;

(4) A description of the questionable behavior limited to factual, objective language;

(5) Known consequences, if any, of the Undermining Behavior as it relates to patient care or Hospital operations;

(6) The names of other witnesses to the incident; and

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

4.1(b) The report shall be submitted to the President of the Medical Staff, who shall provide the report to the Chief Executive Officer. In performing all functions hereunder, the Chief Executive Officer and President of the Medical Staff, and their designees, shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

4.1(c) After a report of Undermining Behavior, the Chief Executive Officer or his or her designee shall insure those making the report are aware of the Hospital's standards of behavior and process for assuring professional and appropriate behavior in the Hospital. Individuals that reported the potentially undermining behavior will be advised of policies preventing retaliation and will be requested to report any perceived acts of retaliation to the CEO or his or her designee. This follow-up discussion with individuals that made a report will occur as soon as practical after each report of Undermining Behavior.

5.1 INVESTIGATION

Once received, a report will be investigated by the Chief Executive Officer and/or the President of the Medical Staff. The Chief Executive Officer or Medical Staff President may delegate this investigation to the Hospital's Human Resources Director, Chief Nursing Officer, Department Chair or Assistance

Committee, Or other individual who may have applicable expertise or skill. This investigation may include meeting with the individual who reported the behavior and any other witnesses to the incident. If the Chief Executive Officer and Medical Staff President determine after investigation that the report lacks merit, this conclusion shall be documented, and no further action is necessary. Those reports considered accurate will be addressed through the procedure set out below. This documentation shall be placed in the Practitioner's confidential peer review file.

If at any time it appears to the Medical Staff President, the Chief Executive Officer, or any committee charged with implementation of this policy that a physician's behavior may result from impairment, the procedure set forth in the Practitioner Wellness Policy shall be followed

6.1 MEETING WITH THE PRACTITIONER

6.1(a) A first confirmed incident requires a discussion with the offending Practitioner. The Medical Staff President and Chief Executive Officer, or designee, **shall** initiate a meeting with the Practitioner and emphasize that such behavior is inappropriate and violates Hospital policy and the Medical Staff bylaws.

6.1(b) These individuals shall discuss the matter informally with the Practitioner, emphasizing that if the behavior continues, more formal action will be taken to stop it. The identity of the individual who made the report of Undermining Behavior shall not be disclosed at this time, unless the Chief Executive Officer and Medical Staff President, after consulting with legal counsel, agree in advance that legal requirements or unusual circumstances make it appropriate to do so. The following guidelines shall be followed regarding the meeting:

(1) The initial approach should be collegial and designed to be helpful to the physician;

(2) The parties should emphasize that if the behavior continues, more formal action will be taken to stop it

(3) Informal meetings shall be documented with a written summary of the meeting. This documentation shall be maintained in a confidential peer review file of the Practitioner;

(4) A follow-up letter to the physician (summary of the meeting) shall state that the physician is required to behave professionally and cooperatively, along with a copy of this Hospital policy on Undermining Behavior; and

(5) Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident should the Medical Staff President and/or the Chief Executive Officer determine that the seriousness of the incident justifies such action

6.1(c) If an additional incident of Undermining Behavior occurs, or if the Medical Staff President or the Chief Executive Officer determines it to be necessary, the Chief Executive Officer and the Medical Staff President or designee, **shall** meet with and advise the physician that such behavior is intolerable and must stop. This meeting constitutes the physician's final warning. It shall be followed with a letter reiterating the warning and summarizing the meeting. The Practitioner may prepare a written response to the letter. This documentation shall be maintained in the Practitioner's confidential peer review file. More formal corrective action may be pursued at this juncture if deemed warranted by the Medical Staff President and/or Chief Executive Officer.

6.1(d) Every meeting with the Practitioner shall include a review of the Hospital's policy against retaliation. Such discussions shall be explicitly documented.

6.1(e) All meetings with the Practitioner shall be documented.

6.1(f) After each meeting with the Practitioner, a letter shall be sent to the Practitioner confirming the Hospital's and medical staff leadership's position - that the Practitioner is required to behave professionally and cooperatively, and which also shall include the potential consequences of continued non-compliance or retaliation against individuals the Practitioner believes to have reported the behavior in question

7.1 DISCIPLINARY ACTION PURSUANT TO BYLAWS

7.1(a) A single additional incident of behavior that undermines a culture of safety, after the above process has been completed, shall result in initiation of formal disciplinary action pursuant to the medical staff bylaws. The Chief Executive Officer and Medical Staff President shall be responsible for presenting the history of behavior to the Medical Executive Committee.

7.1(b) Summary suspension may be appropriate pending this process, depending upon the seriousness of the offense, and after consultation with operations counsel.

7.1(c) The Medical Executive Committee must be fully advised of all of the previous meetings and warnings, if any, and must take them into account, so that it may pursue whatever action is necessary to cease the Undermining Behavior.

7.1(d) The Medical Executive Committee must take action or refer the matter to the Board with a recommendation as to action. This recommendation shall be processed as provided in the administrative corrective action section of the Medical Staff Bylaws. The Board will review and may initiate action if the Medical Executive Committee fails to take action, refer the matter, or make a recommendation as to action regarding the matter.

7.1(e) Although the above outline is a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, damaging Hospital property, or jeopardizing patient care may result in immediate corrective action. As such, if they deem it appropriate based upon the circumstances, the Hospital's Chief Executive Officer, Medical Staff President or Board Chairperson may initiate formal disciplinary action under the Bylaws for a single incident of Undermining Behavior without first resorting to the progressive disciplinary approach set forth herein.

7.1(f) The Hospital's Human Resource Director may be formally included as an ex-officio member of the applicable committee without vote. If the Human Resource Director is so included, the minutes of the applicable committee shall so indicate. To the extent possible, the Hospital's Human Resource Director should be advised of the action taken against a Practitioner resulting from a report of Undermining Behavior by a Hospital employee.

APPENDIX "D" –PROVIDER WELLNESS POLICY

It is the policy of this Hospital to properly review and act upon concerns that a provider, as defined in the Medical Staff Bylaws, is suffering from an illness or impairment. The Hospital will conduct its review and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act. For purposes of this policy, impaired shall mean inability to practice with reasonable skill and safety without jeopardy to patient care due to acute and ongoing physical, psychiatric, and emotional illness or injury, as well as health issues due to alcohol and drugs.

As part of the Hospital's commitment to the safe and effective delivery of care to patients, the Hospital and Medical Staff shall conduct education sessions concerning provider health and impairment issues, including illness and impairment recognition issues specific to providers ("at-risk" criteria).

Impaired Providers shall be referred to the Assistance Committee for confidential assistance. Providers may self-refer or be referred by Medical/Allied Health members or Medical Center employees.

Assistance Committee Duties:

The Committee shall develop individual plans for monitoring Medical/ APP Staff members with impairment to maximize patient protections while assisting the member.

Such activities shall be confidential and privileged. However, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical/ APP Staff member poses an unreasonable risk of harm to hospitalized patients or others, that information may be referred for corrective action, both internally and through a professional assistance program provided by the state of Montana.

1.1Report & Review

If any individual in the Hospital has a reasonable suspicion that a provider appointed to the Medical or APP Staff and/or with clinical privileges is impaired, the following steps shall be taken:

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

1.1(b)Notwithstanding the foregoing, in the event that any person observes a provider who appears to be currently impaired that person shall report the events to the Medical Staff President and/or CEO immediately. The Medical Staff President and CEO may order an immediate drug or alcohol screen if, in their opinion, circumstances so warrant. Failure to submit to required testing will result in automatic suspension.

1.1(c)If, after discussing the incidents with the individual who filed the report, the Chief Executive Officer and Medical Staff President believe there is sufficient information to warrant further inquiry, the Chief Executive Officer and Medical Staff President may:

1. Meet personally with the provider or designate another appropriate person to do so; and/or

2. Direct in writing that a review be instituted, and a report thereof be rendered by the Assistance Committee.to the committee will review the issue within five (5) days of receipt of the request.

1.1(d)In performing all functions hereunder, the Chief Executive Officer and Medical Staff President shall be deemed authorized agents of the MEC and the Assistance committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

1.1(e)Following a written request to review, the Assistance committee shall review the concerns raised and any and all incidents that led to the belief that the provider may be impaired. The assistance committee's review may include, but is not limited to, any of the following:

1. A review of any and all documents or other materials relevant to the review;
2. Interviews with any and all individuals involved in the incidents or who may have information relevant to the review, provided that any specific inquiries made regarding the provider's health status are related to the performance of the provider's clinical privileges and Medical Staff duties and are consistent with proper patient care or effective operation of the Hospital;
3. A requirement that the provider undergo a complete medical examination as directed by the Assistance committee, so long as the exam is related to the performance of the provider's clinical privileges and Medical Staff duties and is consistent with proper patient care or the effective operation of the Hospital; and
4. A requirement that the provider take a drug test to determine if the provider is currently using drugs illegally or abusing legal drugs.

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

1.1(g)Based on all of the information reviewed, the Assistance committee shall determine:

1. Whether the provider is impaired, or what other problem, if any, is affecting the provider;
2. Whether the provider would benefit from professional resources, such as counseling, medical treatment, or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and if so, what services would be appropriate;
3. If the provider is impaired, the nature of the impairment and whether it is classified as a disability under the ADA;
4. If the provider's impairment is a disability, whether a reasonable accommodation can be made for the provider's impairment such that, with the reasonable accommodation, the provider would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of Medical Staff appointment;
5. Whether a reasonable accommodation would create an undue hardship upon the Hospital,

such that the reasonable accommodation would be excessively costly, extensive, substantial, or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and

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

1.1(h)If the review produces sufficient evidence that the provider is impaired, the CEO or Assistance Committee shall meet personally with the provider or designate another appropriate individual to do so. The provider shall be told that the results of a review indicate that the provider suffers from an impairment that affects his/her practice. The provider should not be told who filed the report, and does not need to be told the specific incidents contained in the report

1.1(i)If the Assistance committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the provider, so long as that arrangement would neither constitute an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer and Medical Staff President shall be kept informed of attempts to work out a voluntary agreement between the Committee and the provider and shall approve any agreement before it becomes final and effective.

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

1.1(k)The original report and a description of the actions taken by the Assistance committee shall be included in the provider's confidential file. If the initial or follow-up review reveals that there is no merit to the report, the same shall be noted on the report and no further action shall be taken. If the initial or follow-up review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the provider's file and the provider's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem

1.1(l)The Chief Executive Officer shall inform the individual who filed the report that follow-up action was taken but shall not disclose confidential peer review information or specific actions implemented.

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

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

1.1(o)Nothing herein shall preclude commencement of corrective action, including summary suspension under the Medical Staff Bylaws, or termination of any contractual agreements between the Hospital and the provider, including any employment agreement, in the event that the provider's continued practice constitutes a threat to the health or safety of patients or any person.

1.1 (p) The hospital may seek the advice of hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

2.1Rehabilitation & Reinstatement Guidelines

2.1(a)Substance Abuse - If it is determined that the provider suffers from a drug or alcohol related impairment that could be reasonably accommodated through rehabilitation, the following are guidelines for rehabilitation and reinstatement:

1. Hospital and Medical Staff leadership shall assist the provider in locating a suitable rehabilitation program. A provider who may benefit from counseling or rehabilitative services, but who is not believed to be impaired in his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the Hospital. In cases where the provider's ability is believed to be impaired, the provider shall be allowed a leave of absence if necessary. A provider who is determined to have an impairment which requires a leave of absence for rehabilitation shall not be reinstated until it is established, to the satisfaction of the Assistance committee, the MEC and the Board, that the provider has successfully completed a program in which the Hospital has confidence.
2. Upon sufficient proof that a provider who has been found to be suffering from an impairment has successfully completed a rehabilitation program that provider may be considered for reinstatement to the Medical Staff.
3. In considering an impaired provider for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.
4. The Assistance Committee must first obtain a letter from the physician director of the rehabilitation program where the provider was treated. The provider must authorize the release of this information. That letter shall state:
    i. Whether the provider is participating in the program;
    (ii)Whether the provider is in compliance with all of the terms of the program;
    (iii)Whether the provider attends AA meetings or other appropriate meetings regularly (if appropriate);
    (iv)To what extent the provider's behavior and conduct are monitored;

(v)Whether, in the opinion of the director, the provider is rehabilitated;
(vi)Whether an after-care program has been recommended to the provider and, if so, a description of the after-care program; and
(vii)Whether, in the director's opinion, the provider is capable of resuming medical practice and providing continuous, competent care to patients.

5. The provider must inform the Assistance Committee of the name and address of his or her primary care physician and must authorize that physician to provide the Hospital with information regarding his or her condition and treatment. The Assistance Committee has the right to require an opinion from other physician consultants of its choice.
6. From the primary care physician, the Assistance Committee needs to know the precise nature of the provider's condition, and the course of treatment as well as the answers to the questions posed above in (4)(e) and (g).
7. Assuming all of the information received indicates that the provider is rehabilitated and capable of resuming care of patients, the Assistance Committee, MEC and the Board shall take the following additional precautions when restoring clinical privileges:
    i. The provider must identify another provider who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and
    ii. The provider shall be required to obtain periodic quarterly reports for the Assistance Committee from his or her primary physician-for a period of time specified by the Chief Executive Officer-stating that the provider is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.
8. The provider's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of that monitoring shall be determined by the Assistance Committee after its review of all of the circumstances.
9. The provider must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chairperson of the Assistance Committee or the pertinent department chair.

(10) All requests for information concerning the impaired provider shall be forwarded to the Chief Executive Officer for response.

2.1(b)Physical, Psychiatric or Emotional Illness - If it is determined that the provider suffers from an acute or ongoing physical, psychiatric, or emotional illness or injury that is not drug or alcohol related and could be reasonably accommodated through rehabilitation or treatment, the following are guidelines for rehabilitation or treatment and reinstatement:

1. If applicable, the Hospital and Medical Staff leadership shall assist the provider in locating a suitable rehabilitation program or treatment plan. A provider who may benefit from counseling or rehabilitative services, but whose illness or injury is not believed to interfere with his ability to competently and safely perform his/her clinical privileges or the duties of Medical Staff membership, may be referred for assistance while still actively practicing at the Hospital. In cases where the provider's ability is believed to be undermined, the provider shall be allowed a

leave of absence if necessary. A provider who is determined to have an illness or injury which requires a leave of absence for rehabilitation or treatment shall not be reinstated until it is established, to the satisfaction of the committee, the MEC and the Board, that the provider has successfully completed any necessary rehabilitation or treatment in which the Hospital has confidence.

2. Upon sufficient proof that a provider who has been found to be suffering from an illness has successfully completed treatment or has been cleared for return to practice by his/her treating physician (as applicable), that provider may be considered for reinstatement to the Medical Staff.
3. In considering a provider for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.
4. If requested by the committee, the provider must provide the name and address of his or her primary care physician and must authorize that physician to provide the Hospital with information regarding his or her condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.
5. Assuming all of the information received indicates that the provider is rehabilitated or recovered and capable of resuming care of patients, the committee, MEC and the Board may take the following additional precautions when restoring clinical privileges:
    i. The provider must identify another provider who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability; and
    ii. The provider may be required to obtain periodic reports for the committee from his or her primary physician, for a period of time specified by the Committee, stating that the provider is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.
6. The provider's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of that monitoring shall be determined by the committee after its review of all of the circumstances.

(7)All requests for information concerning the impaired provider shall be forwarded to the Chief Executive Officer for response

APPENDIX "E" – PROFESSIONAL PERFORMANCE REVIEW POLICY

1.1PURPOSE

1.1(a)To define the process for conducting performance evaluations, establish the method and duration of monitoring, and circumstances under which monitoring by an external source or focused review may be required;

Mechanisms utilized to accomplish this evaluation include:

1. Individual Record Review
2. Ongoing Professional Practice Evaluation

3. Focused Professional Practice Evaluation

1.1(b)To define the type of data (criteria/indicators), outlined in Addendum A, to be collected for the ongoing and focused professional practice evaluation and ensure this information is integrated into performance improvement initiatives and used to determine whether to continue, limit or revoke any existing privilege(s);

1.1(c)To ensure reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by the organization and applicable laws; The purpose of peer review is to ensure quality medical services at Community Medical Center. The Medical Staff seeks to ensure a uniform and consistent method of review, evaluation and documentation of provider occurrences and peer review for the purpose of performance improvement, risk reduction, patient safety, appropriate utilization, and reduction of morbidity and mortality.

1.1(d)To measure, assess, and resolve clinical performance issues on an organization-wide basis and to promote high quality patient care; and

1.1(e)To conduct an effective peer review process that is evidence-based, consistent, timely defensible, balanced, useful, and ongoing.

2.1SCOPE

This policy applies to all Medical Staff and APPs privileged through the medical staff credentialing process of the Hospital. However, providers who, by virtue of staff category (e.g., consulting, honorary, affiliate, etc.), have not been granted privileges and have no volume at the facility are exempt from the OPPE and FPPE requirements contained herein.

3.1DEFINITIONS

3.1(a)Focused Professional Practice Evaluation (FPPE) – A time-limited (for a specific period of time OR a specific volume/number of procedures, admissions, encounters, etc.) evaluation of practitioner or APPP's competence in performing a specific privilege. This process is implemented for (1) all newly requested privileges, and (2) whenever recommended by the applicable committee or department when a question arises regarding a practitioner's ability to provide safe, high quality patient care, or a "trigger" event, as outlined in Addendum A, occurs.

3.1(b)Ongoing Professional Practice Evaluation (OPPE) – A documented summary of ongoing data collected for the purpose of assessing a practitioner or APP's clinical competence and professional behavior. The information gathered during this process factors into the decision to maintain, revise or revoke existing privileges

3.1(c)Peer – An individual who possesses the same or similar medical specialty knowledge and training as the individual being reviewed. ***Note that an individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants that were involved in the patient's case.***

Only those providers who have successfully completed and/or are not currently under FPPE for the same privileges are able to conduct FPPE for another provider.

3.1(d)Practitioner – The definition of "practitioner" shall be the same as in the Medical Staff Bylaws.

4.1POLICY

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

The review process involves monitoring, analyzing, and understanding those special

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

If behavior that undermines a culture of safety or practitioner wellness is identified as a potential concern, the Behavior that Undermines a Culture of Safety Policy or Practitioner Wellness Policy, as appropriate, may be implemented in conjunction with this Policy. However, nothing herein limits the appropriate committee, MEC or Board's obligations or authority under either Policy.

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

5.1 SCREENING

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

6.1 RESPONSIBILITIES

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

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

The department chair, or his/her designee peer review screener, will review the medical record, score the case using the rating scale contained herein, identify opportunities for improvement and make recommendations whether any further intervention/action is needed. All cases scored as 3, 4 or 5 will be referred for a higher level of departmental review or by a special panel of peers assigned by the Department Chairperson, Medical Staff President, Multi-Specialty peer review committee (MSPR) or MEC.

Functions and duties of the MSPR committee will be to:

a. Review all charts that are referred to the committee;

b. Review any significant fallout from the peer review indicators identified by the medical staff;

c. Oversee all Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE);

d. Provide recommendation to the MEC for any sanctions related to a medical staff

members performance on the medical staff and

(e) Review physician and other practitioner related hospital wide quality data.

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

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

7.1 CRITERIA/INDICATORS FOR REVIEW

The following are six (6) areas of general competence that may be considered in review:

- Patient care;
- Medical/clinical knowledge;
- Practice-based learning and improvement;
- Interpersonal and communication skills;
- Professionalism; and
- Systems-based practice
  The Medical Staff, in conjunction with the applicable departments, will develop and update the criteria/indicators to be collected for OPPE and the "triggers" for FPPE, attached hereto as Addendum A
  III.A.2. The Medical Staff Departments and Committees establish criteria and indicators against which medical records are screened for reviewable circumstances. The indicators and criteria may apply to a single event, a series of events, or to practice patterns.
  III.B.4.Trauma Committee Peer Review

    a. Trauma Peer Review will be conducted during the Trauma Committee and not follow the Multispecialty Peer Review Committee process as outlined above. This process is as follows:

i. The Trauma Committee Chair and the Trauma Coordinator will identify charts for peer review using the Peer Review Trauma indicators.

FPPE may also be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care as an outcome of the peer review process.

8.1REVIEW PROCESS

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

- Periodic chart reviews;
- Use of external peer review;

- Simulation;
- Proctoring by direct observation;
- Extension of monitoring period to further evaluate competency and/or performance evaluation;
- Evaluation of medical assessment and treatment of patients;
- Consultations/discussions with other individuals involved in the care of the patient;
- Adverse privileging decisions;
- Use of medications;
- Use of blood and blood components;
- Operative and other procedures;
- Appropriateness of clinical practice patterns;
- Significant departures from established patterns of clinical practice;
- Use of developed criteria for autopsies;
- Monitoring of diagnostic and treatment techniques;
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.
  The Chair of the MPRC or designee will assign FPPE/peer review case to a member of the MPRC for review prior to Committee discussion.
  To this aim, the Multispecialty Peer Review Committee (MPRC) functions as the peer review arm of the Medical Staff.
  8.1(b) Duties of the MPRC Peer Reviewer:
    a. Cases are to be reviewed timely (should be within 30 days of referral or by the next committee meeting).

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

- Monitoring clinical practice patterns
- Complications
- Complaints/Compliments
- Volume
- Length of stay patterns
- Morbidity and mortality data
- Peer review cases/chart reviews
- Suspensions
- Medical record deficiencies
- Patient, peer, family, staff complaints
- Pharmacy, Therapeutics/Infection Control Committee
- Medical Records/Utilization Review Committee
- Patient Care Conferences

- Blood and Tissue Reviews
- Patient Safety data
- Quality Core Measures
- Occurrence reports
- Sentinel event data
- Mortality Reviews
- Other relevant criteria as determined by the organized medical staff
  Data Sources for Evaluation: Data for FPPE must include activities performed at the organization where privileges have been requested whenever possible. Low volume practitioners may request that supplemental data be used from another CMS-certified organization where they hold the same privileges.
  8.1 dTrauma Committee Peer Review

    a. Trauma Peer Review will be conducted during the Trauma Committee and not follow the Multispecialty Peer Review Committee process as outlined above. This process is as follows:

i. The Trauma Committee Chair and the Trauma Coordinator will identify charts for peer review using the Peer Review Trauma indicators.

ii. The Trauma Committee Chair will present those identified peer review charts to the Trauma Committee for discussion and the Committee will determine the recommended action.

iii. The Trauma Committee meeting minutes will reflect the rationale for the recommendation made for each peer review chart reviewed.

iv. The Trauma Committee Chair or the Trauma Coordinator will report all Trauma peer review recommendations to the Multispecialty Peer Review Committee.

v. The Multispecialty Peer Review Committee reserves the right to conduct a second peer review of trauma cases.

9.1OPPE

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

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

10.1FPPE

The Medical Executive Committee will determine the number of cases and type of evaluation to be completed for all initially granted privileges.

FPPE is implemented (1) for all newly requested privileges, and (2) whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care, or a "trigger" event occurs. The Credentials Committee, a Department, a Department Chairperson, any peer review committee, the MEC, or the Board may recommend FPPE.

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

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

10.1(a)Review of certain cases/procedures (e.g., all laparoscopic cholecystectomy cases; or all cesarean sections) during an identified period of time;

10.1(b)Review of an identified number of cases or procedures performed; or

10.1(c)Review of a randomly selected percentage of cases during a specified time period.

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

11.1RATING SCALE

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

Rating Score	Definition
0	Quality of care, treatment, or services meets or exceeds medical standards of practice
1	Medical management in variance with acceptable standards of practice but it is **without** potential for: • Anatomical or physiological impairment, disability or death • Unnecessary prolonged treatment, complications, or readmissions
2	Medical management in variance with standards of medical practice and it is **with** the potential for adverse consequence: • Anatomical or physiological impairment, disability or death • Unnecessary prolonged treatment, complications, or readmissions
3	Medical management does not meet acceptable standards of practice (disease, or symptoms caused, exacerbated or allowed to progress) resulting in:

	• Anatomical or physiological impairment or disability • Unnecessary prolonged treatment, complications or readmissions
4	Medical management does not meet acceptable standards of practice resulting in: • Adverse Outcome
5	Medical management does not meet acceptable standards of practice resulting in: • Death

MPRC will refer concerns as follows directly to The Assistance Committee or referred to the CMO and handled by the Collegial Intervention process identified previously in this document:

I. Malevolent or Willful Misconduct
II. Possible Unintended Human Error
III. Possible System Induced Error

12.1ACTIONS BASED ON THE RATINGS

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

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

RATING	ACTION
0, 1	Case approved. • Results used for trending only • Case review sheet to Medical Staff Coordinator for physician's reappointment file

LEVEL 2—REVIEW BY APPROPRIATE CLINICAL DEPARTMENT

2, 3	Further review indicated • Department Chair may decide to track and trend • Presented at appropriate department meeting **Recommendation of the department may include** A. Case found to be acceptable – No further action needed • Results used for trending only • Case review sheet to Medical Staff Coordinator for physician's reappointment profile

	A. Further review indicated—Refer to MEC • A focus review plan is proposed

LEVEL 3—MEDICAL EXECUTIVE COMMITTEE REVIEW

2, 3, 4, 5	Further review indicated by the department. • Responsible physician notified case to be reviewed by MEC and given notice of the meeting **Recommendation of the MEC may include:** A. Require additional education B. A review of additional cases I. Assignment of proctor for certain procedures I. Require consultation for specific diagnoses A. Institute a focused professional practice evaluation (FPPE) or specified scope and duration A. Limit, modify, restrict, suspend, or revoke existing privilege(s) • MEC notifies responsible physician by special notice of recommendation(s) made • Case review sheet to Medical Staff Coordinator for physician's reappointment file

13.1EXTERNAL PEER REVIEW

The Board of Trustees, the Medical Executive Committee, the Medical Staff President, CEO or a Department Chairperson or CHAIR of PEER REVIEW has the authority to request external peer review. Circumstances that may indicate an external review may include, but are not limited to:

There is no member who qualifies as a "peer", or expertise is lacking;

- Conflict of interest exists that cannot be appropriately resolved by the MEC or Board;
- Professional standards are not clear, non-existent, or inconsistent;
- Need for opinion from an impartial, expert outsider due to confusing, ambiguous, or conflicting internal review opinion;
- There is potential for medical malpractice suit or significant compliance issue, legal counsel or risk management may recommend external review;
- When a matter has the potential to lead to an action that would require a hearing pursuant to the Health Care Quality Improvement Act of 1986.

14.1DOCUMENTATION

Cases presented at meetings will be referred to and referenced by the medical record number/patient

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

15.1REPORTING

Department-specific case review results are reported quarterly in aggregate to the respective clinical department. Composite case review ratings for all departments are presented to the Medical Executive Committee and Board quarterly

16.1CONFIDENTIALITY & MAINTENANCE OF FILES

No copies of peer review documents will be created or distributed, unless required and authorized by applicable law or allowed the Medical Staff Bylaws or Fair Hearing Plan. A practitioner or APP may review his/her quality file by making an appointment with the Medical Staff Office and Medical Staff President, provided that the Medical Staff President and CEO may, in their sole discretion, redact any personal information (e.g., reviewer, patient, or employee identities) from the file before the practitioner or APP reviews the file.

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

Any physician can access their quality files under the supervision of the Chief Medical Officer and/or a member of the Quality Risk Management department. All quality records are confidential and will be retained in the Quality Department. Arrangements will be made for a review location on a case-by-case basis.

The Medical Staff President, the Medical Staff President Elect, the Credentials Chair, the Department Chair, CEO, Chief Medical Officer, and the Director of the Quality department may access the files of medical/allied health staff members only for performance of the responsibilities of the position as it relates to peer review.

Approval Signatures

Step Description	Approver	Date
Board	Bonnie Stephens: CMO	09/2022
MEC	Bonnie Stephens: CMO	09/2022
Bylaws Committee	Bonnie Stephens: CMO	09/2022
Department Committee Approval	Bonnie Stephens: CMO	09/2022