Community Health Network Rehabilitation Hospital, LLC

Medical Staff Rules and Regulations

Medical Staff Approval: April 19, 2016
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ARTICLE I – MEDICAL STAFF MEMBERSHIP

Section 1.1. Eligibility and Qualification for Membership. The basic eligibility criteria and qualifications for membership on the Medical Staff of the Community Health Network Rehabilitation Hospital are found in the Medical Staff Bylaws. In addition, the Board may impose further requirements on specific Physicians, Dentists and Practitioners where it believes these are warranted after a review of the credentials file, performance data, or other relevant material.

Section 1.2. Conditions and Duration of Appointment.

1.2.1 Initial Appointment and Reappointment.

(a) Initial appointment and reappointment to the Medical Staff shall be made by the Board. The Board shall act on appointments and reappointments only after there has been a recommendation or an opportunity for a recommendation from the Medical Executive Committee

(b) Appointment to the staff will be for no more than 24 calendar months. Should reappointment be delayed beyond twenty-four months, the Board may approve a limited extension of privileges sufficient to allow for appropriate review of the applicant by Medical Staff Committees and the Board so long as the applicant continues to meet the following criteria:

1. Unrestricted Indiana state license;
2. Unrestricted Federal DEA;
3. Controlled Substance Registration (CSR);
4. Current valid professional liability insurance coverage in a certificate form and in amounts satisfactory to the Hospital; and
5. No new adverse reports filed with the National Practitioner Data Bank since the last appointment (report processed by Hospital).

(c) Appointment to the Medical Staff shall confer on the appointee only such clinical Privileges as have been granted by the Board

1.2.2 Reapplication After Modifications of Membership Status or Privileges. A Member or Practitioner who has received a final adverse decision by the Board regarding membership or Privileges, or who has resigned or withdrawn an application for appointment or reappointment or Privileges while under investigation or to avoid investigation, will be ineligible to reapply to the Medical Staff or for Privileges for a period of two (2) years from the date of such resignation or withdrawal or the date of notice of a final adverse action by the Board unless there is substantial evidence of additional training and/or there is substantial evidence of improvement in the identified problems.

Section 1.3. Leave of Absence (LOA).

1.3.1 Written Notice. Medical Staff member may request, in writing, a voluntary leave of absence from the Medical Staff. Such request shall be received in the Medical Staff Services office, at a minimum of thirty (30) days prior to the requested leave date, except when precipitated by an acute medical condition. Request shall state the reason the Medical Staff member requests the leave and the exact period of leave time requested, which may not exceed one (1) year (exclusive of the time necessary to process an initial request or a request for reinstatement). Such request shall be submitted to the member's Clinical Service Chair who shall make a report to the Credentials Chair who will recommend approval or disapproval to the MEC. The MEC shall review such requests and recommend approval or disapproval to the Board. The Board shall make the final decision whether to approve or disapprove such request. Requests for a leave of absence will not be considered if the requesting Medical Staff member is under investigation. In the event that a request for a LOA is approved, the Medical Staff member shall make necessary arrangements to provide alternate coverage for proper and necessary patient care during his/her absence and shall complete all patient medical records before beginning the leave of absence. During the period of a leave, the Medical Staff member's membership status, Clinical Service affiliation, Privileges and prerogatives, duty to pay Medical Staff dues, if any, and attendance requirements at Medical Staff or Clinical Service meetings shall be suspended. In the event that the Board does not approve such request, the requesting member shall not be entitled to procedural rights as outlined in the Investigation, Corrective Action and Fair Hearing Procedures of the Medical Staff Bylaws.

1.3.2 Obligations. A request for Leave of Absence, except those precipitated by an acute medical condition, shall not be considered until all obligations to the Hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any Emergency Department or other call obligations.

1.3.3 Request to Return from LOA. Not less than forty-five (45) days prior to the expiration of the leave, the Medical Staff member must request, in writing, or electronic communication reinstatement of desired Privileges. The Medical Staff member must submit a written summary of clinically relevant activities during the leave if so requested by members of the Clinical Service, Credentials Committee or MEC. Permission for reinstatement must be reviewed and acted upon by the Board. If the requested return date is past the time for the member's reappointment, the returning physician must submit a reapplication form and be reappointed before resuming his or her staff position.

1.3.4 Failure to Request to Return from LOA. The failure of a Medical Staff member to request reinstatement from a LOA shall result in automatic relinquishment of membership status and Clinical Service affiliation and Privileges. The affected Member shall not be entitled to any procedural rights of the Bylaws.

Section 1.4. Physical Health Status.

1.4.1 Health Requirements. Members of the Medical Staff and Practitioners holding Privileges must maintain the physical and mental ability to deliver patient care and exercise Privileges safely and at an appropriate level of quality at all times.

1.4.2 Notification of Health Status. A Member or Practitioner holding Privileges must immediately report in writing or electronic communication to the President of the Medical Staff, the Medical Director or CEO when he/she has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform granted Privileges safely and at an appropriate level of quality at all times (as determined by the Practitioner, a treating physician, or a health care facility). Failure to do so may result in Corrective Action.

1.4.3 Health Examination. The expense of any examination or testing required by these Bylaws shall be borne by the Member or Practitioner unless otherwise agreed to in writing by the MEC or Board, and the results of any required examinations must be released without limitations to the requesting committee. The Member or Practitioner agrees to sign any documentation necessary to allow the requesting committee(s) to have access to the examining physician or provider to seek clarification of any issues related to the examination results. At any time that the MEC or Board have any reason to question whether a Member or a Practitioner granted privileges has the requisite physical and/or mental health status to care for patients safely and with an appropriate level of care and skill, it may require that Member or a Practitioner granted privileges to undergo an appropriate health examination. The nature and scope of the exam (including drug or alcohol testing) and the examining clinician will be determined by the MEC and/or Board and communicated to the Member or Practitioner in writing. Where there is a concern that a Member or a Practitioner with privileges may be impaired by use of or addiction to drugs or alcohol, testing and intervention will adhere to the Physician Assistance policy of the Medical Staff and may include the imposition of random drug or alcohol testing. Refusal of a Member or a Practitioner with Privileges to comply with a request to submit to a health examination or provide comparable documentation from a physician or practitioner acceptable to the requesting body (MEC, or Board) will be considered a voluntary resignation from the Medical Staff and/or relinquishment of Privileges

1.4.4 Routine Health Examinations. At the ages of 65, 70, and 75 years, Members and Practitioners shall complete an examination that addresses both the physical and mental capacity for the privileges requested. At the age of 75 and beyond this examination and re-credentialing will occur on an annual basis. The physical and mental exams will include baseline measurements of sensory and motor skills, memory and mobility, plus any specialized skills needed for specific privileges whose exercise demands functions such as strength, fine motor skills or acuity in a particular area (for suggested format see Appendix A). Testing and examination must be conducted by a physician or practitioner acceptable to the MEC (with prior approval of the scope of the exam), and the outcomes must be documented in a format or on a form acceptable to the MEC (see Appendix B). This will be submitted to the MEC within 90 days of the birth

date in question. The exam is a "fitness to work" evaluation and must indicate whether the Member or Practitioner has physical or mental problems that, with or without accommodation could interfere with the safe and effective exercise of the privileges requested, with the discharge of the responsibilities of Medical Staff membership or with the ability to work cooperatively and effectively in a hospital setting.

If after reviewing the report, the MEC finds the applicant in adequate physical and mental health, the MEC will forward its recommendation(s) by the usual reappointment process mechanisms.

If the examination identifies 1) any issues that may preclude the exercise of requested privileges or 2) the need for specific accommodations, the MEC will, by written notice personally delivered or sent by certified mail return receipt requested, alert the applicant of the nature of the issue(s) in question and offer to meet with the Member or Practitioner. The purpose of the meeting(s) is to discuss the findings in light of the requested privileges, determine whether the applicant wants to voluntarily withdraw the request for some or all privileges, and/or is requesting accommodations. If the applicant chooses not to meet with the MEC, a recommendation will be made based on available information. If accommodations are requested they must be provided to the President of the Medical Staff in writing along with the name (if any) of the treating physician or provider who has recommended those accommodations. The MEC, through the Chairman, may ask for clarifying information from the examining physician or provider whether the applicant chooses to appear before the MEC or not. After talking with the Member or Practitioner and (as needed) the examining physician or practitioner, the MEC will make a recommendation to the Board regarding:

(a) the nature of any issues identified;

(b) the likelihood that the issue(s) will impair the safe exercise of privileges, the fulfillment of Medical Staff responsibilities or the ability to work cooperatively and effectively in the hospital setting;

(c) the efficacy of any requested accommodations in relation to the actual or potential problem(s) identified;

(d) any request from the applicant to withdraw his/her request for some or all privileges; and

(e) the Committee's recommendations regarding the granting, restriction or denial of the privileges requested.

If accommodations have been requested or recommended, the Medical Executive Committee, in conjunction with Hospital management, will meet to determine whether such accommodations(s) would be reasonable based on all circumstances. The Member or Practitioner will be notified by the MEC of its decision. In the event that the requested

privileges are denied, modified or restricted, the applicant will be provided written notice in person or by certified mail, return receipt requested, of the MEC recommendation and may request a Hearing under the Bylaws.

In addition to the physical/mental examination, a Member or Practitioner may be required to undergo proctoring of his/her clinical performance as part of the assessment of his/her capacity to perform the requested privileges. This would consist of a minimum of five (5) consecutive operative procedures, consultations, and/or admissions (as appropriate) observed and/or monitored by a medical staff member acceptable to the MEC. A report shall then be submitted to the Board in terms of the ability of the Practitioner to safely and competently care for patients and discharge the responsibilities of membership. Such proctoring may be required in the absence of any previous performance concerns. The scope and duration of the proctoring may be extended as determined by the Medical Executive Committee.

ARTICLE II - PHYSICIANS, DENTISTS, OR PRACTITIONERS PROVIDING CONTRACTED SERVICES

Section 2.1. Exclusive Agreements. The Board may from time to time determine that specified Hospital clinical services will be provided on an exclusive basis pursuant to a contract or letters of agreement between the Hospital and specific qualified Physicians, Dentists, or Practitioners. Privileges covered by such exclusive agreements will be available only to Physicians, Dentists or Practitioners who are specified under the terms of such agreements. Applications for initial appointment to provide services or requesting Privileges that are covered under the exclusive arrangement will not be eligible for consideration and processing unless submitted in accordance with such arrangements. Physicians, Dentists or Practitioners who have previously been granted Privileges that become subject to an exclusive arrangement made by the Hospital will not be able to exercise those Privileges unless they become a party to the agreement. Any Physician, Dentist or Practitioner who will provide clinical services pursuant to an exclusive agreement issued by the Hospital will be required to meet the same qualifications and undergo the same evaluation and approval process for Privileges as any other applicant. However, the exclusive contract may require such Physician, Dentist or Practitioner to meet higher qualifications for Privileges than those established for applicants who are not subject to the exclusive agreement.

Section 2.2. Termination of Members Under Contract. The process for appointment and reappointment to the Medical Staff provided in these Bylaws shall apply to any Medical Staff member providing or seeking to provide services or medical administrative services through a contractual or employment arrangement with the Hospital or a Physician, Dentist, or Practitioner group to which the physician or dentist belongs. The effect of expiration or other termination of a contract upon a Physician's, Dentist's, or Practitioner's staff appointment and clinical privileges will be governed solely by the terms of the Physician's, Dentist's, or Practitioner's contract with the

Hospital or the contract with the Hospital pursuant to which the Physician, Dentist, or Practitioner practices and provides services at the Hospital. In such event, the termination, limitation or alteration of said medical staff appointment and clinical privileges shall be in the manner provided for in the contract. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the Physician's, Dentist's, or Practitioner's staff appointment status or clinical privileges.

ARTICLE III - ALLIED HEALTH PROFESSIONALS (AHP)

Section 3.1. Eligibility for Privileges. Eligibility for privileges shall be determined on the basis of the following criteria:

3.1.1 Only an AHP holding a license, certificate or other credentials as may be required by applicable state law, and who has had the required training and education appropriate for their special services is eligible to provide specified services in the Hospital within the scope of their recognized professional qualifications and skills. The MEC may establish additional qualifications required of members of any particular category of AHPs.

3.1.2 AHPs exercise judgment within their areas of competence, provided that a physician member of the Medical Staff shall have the ultimate responsibility for patient care.

3.1.3 AHPs participate directly in the management of patients under the supervision or direction of a member of the Medical Staff.

3.1.4 AHPs record reports and progress notes on the patient's records and write orders or recommendations to the extent established for them by the Medical Staff.

3.1.5 AHPs perform services in conformity with the applicable provisions of the Medical Staff Bylaws, including the section on rules and regulations.

3.1.6 AHPs shall be legally licensed to practice in the state.

3.1.7 Members of Allied Health Professions shall carry out their activities subject to policies and procedures that foster optimal achievable patient care.

3.1.8 A copy of the Medical Staff Bylaws, including the section on rules and regulations will be provided to each Allied Health Professional. Each member of the Allied Health Profession staff shall sign, on notification of appointment to the Medical Staff, an agreement to abide by the current Medical Staff Bylaws, including the section on rules and regulations.

3.1.9 In those cases involving use by physicians of established health professionals functioning in an expanded medical support role, the organized Medical Staff shall work closely with members of the appropriate discipline in delineating such functions, e.g., MEC liaison(s), the Medical Director, the administration, patient care services, etc.

3.2 Procedure for Specification of Service: Written guidelines for the performance of specified services by AHPs will be developed by the appropriate disciplines to which they are assigned, or by the assigned physician who has the final responsibility for the welfare of the patient. For each category of AHPs such guidelines must include, without limitation:

3.2.1 Specification of the classes of patients that may be seen (e.g., only those of the employer-physician, only those referred by or from a particular clinical service, or any referred by a physician or other authorized practitioner); and,

3.2.2 A description of the services to be provided and procedures to be performed, including the equipment or special procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient's medical record; and,

3.2.3 Definition of the degree of assistance that may be provided to a practitioner in the treating of patients on Hospital premises and any limitations thereon, including the degree of practitioner supervision required for each service.

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

ARTICLE IV - POLICIES

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

ARTICLE V – ADMISSION AND DISCHARGE OF PATIENTS

Section 5.1. Admission. A patient may be admitted to the Hospital only by a physician member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting office will notify the attending practitioner whenever such consent has not been obtained.

Section 5.2. Physician Responsibility. A physician member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

Section 5.3. Division of Fees. The practice of division of fees under any guise whatsoever is forbidden.

Section 5.4. Assignment of Patient. A patient to be admitted on a transfer basis who does not have a private practitioner may request any practitioner on Medical Staff to attend them. Where no such request is made, or if the requested physician not on call does not assume care of the patient, then a member of the active or provisional staff on duty "on call" for the service will be assigned to the patient. If the "on call" practitioner for good cause cannot assume care of the patient, then the practitioner who is next "on call" will be assigned to the patient. The Medical Director shall provide a schedule of "on call" assignments.

Section 5.5. Physician Residence. Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area who may be called to attend their patients in an emergency, or until they arrive. In case of failure to name such associate, the CEO of the Hospital or Medical Director of the Medical Staff shall have authority to call any member of the active staff in such event.

Section 5.6. Call Coverage. Each practitioner must assure timely, adequate professional care for their patients in the Hospital by being available or having available through their office eligible alternate practitioners with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements may result in loss of clinical privileges. When a practitioner is out of town or not available, the on-call schedule shall indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during their absence.

Section 5.7. Appropriate Admissions. The MEC shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be approved by the Board.

Section 5.8. Admitting Priorities. In the event that sufficient beds are unavailable when approved patients are ready for admission, the Clinical Liaisons will confer with the CEO to determine the priority of admission for those patients. Factors to be considered in determining priority include:

5.8.1 Length of time the patient has been awaiting a bed;

5.8.2 Urgency of need for rehabilitative care, for example, patients whose care may be compromised if they remain in their current setting;

5.8.3 Special needs of the patient and our ability to accommodate those needs with the available beds; and

5.8.4 Medical stability

Section 5.9. Patient Transfers. No patient will be transferred without such transfer being approved by the responsible practitioners (transferring and receiving). Transferring physician shall retain responsibility for patient until receiving physician in this Hospital accepts patient. Procedures for the referral and/or transfer of patients exhibiting severe psychiatric symptoms shall be as follows:

Section 5.10 Psychiatric Patient Transfer. As soon as it is recognized that a patient's behavior represents a hazard to their personal security and safety or the security and safety of their surroundings or other persons in the Hospital, they will be transferred to an appropriate facility.

5.10.1 Although the responsibility for the referral and transfer of patients is the attending physician's, when an emergency arises and the physician is not immediately available, the order can be issued by the Medical Director or other member of the Medical Staff. The Director of Nursing will be contacted and asked to provide assistance in obtaining the properly authorized order.

5.10.2 Notification of the Psychologist will be routine and is the responsibility of the charge nurse. Upon the request of the attending physician or their representative, a Psychologist will provide assistance in family instruction, selection of facilities and resources and other matters relating to the transfer of the patient.

5.10.3 If the patient's need for acute rehab care is so urgent as to mitigate against the patient's transfer, the attending physician will immediately notify the CEO or Director of Nursing and apprise them of their recommendations and plans concerning the care of the patient. The ultimate disposition of the patient will then be determined by the

attending physician in consultation with representatives of the administration, nursing service and other members of the Medical Staff as indicated or requested.

Section 5.11. Discharge. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the event shall be made in the patient's medical record.

Section 5.12. Orders. All physician orders shall be (i) in writing or acceptable computerized form; and (ii) authenticated by the responsible individual in accordance with hospital and medical staff policies; All verbal orders must be authenticated by the responsible individual in accordance with applicable hospital and medical staff policies. The individual receiving the verbal order shall date, time and sign the verbal order in accordance with hospital policy. Any such process must require that the individual receiving the order shall immediately read back the order to the ordering physician or Licensed Practitioner who shall immediately verify that the read back order is correct. Authentication of a verbal order must occur within 48 hours unless a read back and verify process under items (i) and (ii) is utilized. If a patient is discharged within 48 hours of the time that a verbal order is given, authentication shall occur within 30 days after the patient's discharge.

ARTICLE VI – USE OF RESTRAINTS

Section 6.1. Use of Restraints. The safety of the patients admitted is of utmost concern; therefore, all patients admitted to Community Health Network Rehabilitation Hospital will be cared for in a safe environment. A physician's order is necessary for the use of restraints. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy. The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria as specified in Hospital policies at the intervals specified in Hospital policy. When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention the Physician or other licensed practitioner that have completed the training criteria specified in Hospital policy, with follow up at the intervals defined in such policies. Details about the use of restraints are found in the Provision of Care Manual under "Restraint" policy. Notification shall be as follows:

6.1.1 Notify Director of Nursing or CEO on Call of patient's condition and of actions taken and pending.

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

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

ARTICLE VII – CODE OF CONDUCT FOR PHYSICIANS

Through practicing the **ART** of Health Care – ***A****dvocacy,* ***R****espect and* ***T****ruth-telling*- we build the foundation on how the Hospital serves our customers and conducts its business. Through acting with ***Integrity***, we build strong relationships, the respect of the communities we serve, and the trust of all of our customers.

While we serve many customers with diverse needs and expectations, our focus has always been and continues to be on our patients. With everything we do, every day, our focus on our patients must never be compromised. Keeping in mind that one of the predominant challenges is balancing the business interests of the Hospital with the best interest of our patients, the following principle shall guide us: Patient access to care, clinical judgment, and decision-making shall not be compromised, nor patient care jeopardized by financial considerations. This Code of Conduct provides guidance to building integrity on the job and improving the processes we own within the Hospital.

Interact with all Hospital customers – patient/families, physicians, and other health care professionals, employers, employees, regulators, accreditors, subcontractors, and vendors – honestly and fairly; with ***A***dvocacy, ***R***espect, and ***T***ruth-telling, best to serve their needs;

Never use Hospital assets, information, or relationships for unauthorized personal gain;

Treat all confidential information that belongs to the Hospital or to any of our customers with the highest possible protection and respect;

Ensure that potential or suspected violations of federal and state laws, rules, regulations, ethical standards, accreditation and licensure standards, and Hospital policies and procedures are brought to leadership and that there are no acts of retribution or retaliation against those who have done so;

Generate records of all transactions and services honestly, ***accurately*** and on a timely basis;

Refrain from conflicts of interest, both real and perceived, and declare those that exist;

Initiate and maintain processes that result in consistent compliance with all federal and state laws, rules, and regulations, with accreditation, certification and licensure standards' and with Hospital policies and procedures that govern how we conduct our business; Seek guidance as needed.

Treat all of our customers fairly, ensuring equal opportunity and freedom from discrimination, harassment or violence of any kind; and

Your recognition that even the appearance of misconduct or impropriety can be very damaging to the Hospital's reputation and our ability to serve our customer is critical. With that recognition, act accordingly.

When each of us observes and conducts ourselves in accordance with these guidelines every day in everything we do, we build and reinforce our commitment to excellence, and we contribute to fulfilling our mission of "making a difference."

ARTICLE VIII – CALL RESPONSIBILITIES

Section 8.1. Call Schedules. Members of the active Medical Staff shall participate in call schedules as assigned by the Medical Director. Members of the provisional staff shall participate in call schedules at the discretion of the Medical Director and after approval by an Executive Committee. Requests for exclusion from the on-call schedule shall be approved by the Executive Committee, and are subject to review each time the practitioner is reappointed.

Section 8.2. Duties. The on call physician or dentist shall respond to calls by other practitioners who have patients that require consultation or care, or to the Medical Director and shall assist in the patient's care. The need to respond and assist will be determined by the requesting practitioner or staff member. If the on call physician or dentist, for good cause, cannot assist, then the practitioner next on call will be called and shall be expected to respond and assist. Questions or disputes regarding the call schedule shall be directed to the Medical Director.

Section 8.3. Schedules. On call schedules will be developed on a scheduled basis by the Medical Director and provided to the CEO for Hospital distribution.

ARTICLE IX – DRUGS AND MEDICATIONS

Section 9.1. Drug Administration. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations. Exceptions are those drugs used in clinical investigation; the latter can be used when in full accordance with the Statement of Principles Involved in the Use of Investigational

Drugs in Hospitals and when used in accordance with the rules and regulations of the Food and Drug Administration.

Section 9.2. Controlled Medications. All controlled medications classified as Schedule II drugs by federal or state laws; whether ordered orally, IV or rectally, shall be renewed or discontinued after seven (7) days. Exceptions to this rule are: (a) when day seven (7) occurs on a weekend or legal holiday (in this event the order must be renewed or discontinued on the first working day after the weekend or legal holiday); or (b) when the scheduled drug is part of an approved standing order to be used on an "as necessary" basis (Example: "Morphine Sulfate 2.0-4.0 mg. Intravenously PRN for chest pain not relieved by nitroglycerin" as part unit standing orders.)

Section 9.3. Antibiotics. All open-ended antibiotic orders shall be renewed or discontinued after fourteen (14) days unless otherwise specified by the ordering physician.

Section 9.4. Miscellaneous. As far as possible, the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, they will be secured and a special charge made to the patient. No medicines shall be brought into the Hospital by the patient without physician order and pharmacist confirmation of the identity of the drug. Medicines received by inpatients shall be ordered from the Hospital pharmacy.

ARTICLE X- AUTOPSY

Section 10.1. Autopsies. It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever possible. An autopsy may be performed with a written consent signed in accordance with State law.

Section 10.2. Autopsy Criteria. Possible criteria to be utilized as a guide to select meaningful autopsy cases are:

10.2.1 Deaths in which autopsy may help explain unknown and unanticipated complications to attending physician;

10.2.2 All deaths in which the cause of death is not known with certainty on clinical grounds;

10.2.3 Cases in which autopsy may help allay concerns of the family/public regarding the death, and to provide reassurance to them regarding same;

10.2.4 Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedure/therapy;

10.2.5 Unexpected or unexplained deaths, which are apparently natural and not subject to a forensic medical jurisdiction;

10.2.6 Natural deaths, which are subject to, but waived by, a forensic medical jurisdiction such as:

(a) A person dead on arrival at hospital;

(b) Deaths occurring in hospital within 24 hours of admission; and

(c) Deaths in which the patient sustained or apparently sustained an injury while hospitalized.

10.2.7 Deaths resulting from high-risk infectious and contagious diseases;

10.2.8 Death occurring within 48 hours after surgery or an invasive diagnostic procedure;

10.2.9 Death where the cause of death is sufficiently obscure to delay completion of the death certificate;

10.2.10 Any death from which an autopsy might contribute to the quality of medical care for a patient with the same condition in the future; and/or

10.2.11 Deaths associated with restraints.

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

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. Provisional anatomic diagnosis shall be recorded on the medical record within three (3) days, and the complete protocol should be made a part of the record within sixty (60) days.

ARTICLE XI – TREATMENTS AND CONSENTS

Section 11.1. Periodic Review. All orders, treatments, and/or consents which by federal or state law or TJC standards require periodic review shall be reviewed and renewed or discontinued after seven (7) days. An exception to this rule is when day seven (7) occurs on a weekend or legal holiday; in this event, the orders, treatments, and/or consents must be renewed or discontinued on the first working day after the weekend or legal holiday.

Section 11.2 Renewal Process. To simplify the renewal process (when technically feasible) and after the formulation of rules acceptable to both the Medical Staff and administration: on any one patient all orders and treatments will be combined and shall be renewed or discontinued every seven (7) days after the date of patient admission. Exceptions to this rule are: (a) when day seven (7) occurs on a weekend or legal holiday; in this event the order must be renewed or discontinued on the first working day after the weekend or legal holiday; and (b) when the order or treatment is part of an approved standing order.

ARTICLE XII – EMERGENCY SERVICES

Section 12.1. Emergency Care Procedures. The Medical Staff shall establish policies and procedures governing the acceptance and care of emergency patients in the event that someone presents to the Hospital with a medical emergency, or in the event of community disaster situation.

Section 12.2. Appraisal. The Medical Staff shall recommend and approve written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

Section 12.3. Nurse in Charge. The Hospital will ensure that the assigned "Nurse in Charge" on all shifts will be qualified to initiate immediate appropriate lifesaving measures after they have met the clinical qualifications for that designation.

Section 12.4. Patient Transfer. The Medical Staff shall establish policies and procedures regarding the safe and timely transfer of patients to other facilities for definitive care pursuant to applicable state and federal laws, rules, regulations and procedures.

ARTICLE XIII – PEER REVIEW

Section 13.1. Performance. In both focused and ongoing professional practice evaluation, Physicians evaluate their colleagues' performance to ensure it is consistent with the standard of high quality, safe care.

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

When a performance issue is identified, the individual whose performance is being reviewed is allowed to participate in the review process which shall be determined by the Medical Executive Committee. Relevant information from the review process

should be incorporated into performance improvement initiatives and be consistent with confidentiality and privilege of information.

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

Section 13.2. Focused Professional Practice Evaluation. A period of focused professional practice evaluation is implemented for all physicians requesting initial privileges. Additionally, a focused review should be completed when a practitioner's performance raises issues affecting the provision of safe, high quality patient care. The MEC will determine:

13.2.1 Triggers that will require review

13.2.2 Criteria to evaluate performance when issues affecting safe, high quality patient care are identified.

13.2.3 Committee or physicians who will oversee and conduct evaluations.

13.2.4 Duration of performance monitoring

13.2.5 Circumstances requiring external review, if indicated

Section 13.3. Ongoing Professional Practice Evaluation. Ongoing professional practice evaluation is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. Criteria used in the ongoing professional practice evaluation may include the following:

13.3.1 Blood and blood products usage

13.3.2 Pharmaceutical usage

13.3.3 Requests for tests and/or procedures

13.3.4 Length of stay patterns

13.3.5 Mortality and morbidity data

13.3.6 Medical Necessity review data

13.3.7 Other relevant criteria as determined by the MEC

ARTICLE XIV – CONFLICTS OF INTEREST

Hospital policy prohibits members of the Medical Staff from having a material financial relationship with or other material conflict of interest as a result of a relationship with a health system (or its controlled entity) not affiliated with Community Health Network Rehabilitation Hospital.

For purposes of this policy, a "material financial relationship" shall include, but shall not be limited to:

(a) An employment relationship;

(b) An independent contractor relationship whereby the individual receives more than de minimis compensation (it being understood that an individual providing services on an infrequent basis shall not be deemed to have such a material financial relationship); or

(c) A contractual relationship pursuant to which an individual's professional practice or the professional practice employing the individual is managed by a health system (or an entity controlled by such health system) not affiliated with Community Health Network Rehabilitation Hospital.

For purposes of this policy, a "material financial relationship" shall include, but shall not be limited to, an individual's holding a position (paid or unpaid) as an administrator, director or trustee with any hospital, health system and/or other healthcare entity not affiliated with Community Health Network Rehabilitation Hospital.

The Board of Managers may grant individual exceptions to this policy for appropriate reasons. The reasons for such exceptions will be documented in writing, and in the judgment of the Board of Managers the benefits accruing to the Hospital must sufficiently outweigh the risks presented by the economic conflict of interest caused by the material financial relationship between the Medical Staff member and the competing entity. Documentation of such determination by the Board of Managers shall become part of the Medical Staff member's credentialing file.

Appendix A: Suggested Elements of a Screening Evaluation for Practitioners, Mar. 2013

Note to the examining physician:

The following elements of a medical evaluation, including history, physical examination and laboratory assessment, should be modified as appropriate to address the age, clinical condition, and privileges requested by the practitioner. *Therefore please be sure to review the practitioner's requested privileges before conducting this evaluation.*

In order to respect the confidentiality of the practitioner's medical information, hospital medical staff does not expect you as the examining physician to submit the complete results of your medical evaluation. The medical staff is only interested in and should only receive a report on those aspects of the practitioner's health that have the potential to adversely affect his/her ability to carry out the requested privileges. Please use the form attached to this document in submitting the results of your assessment to the medical staff rather than submitting a complete history and physical examination.

Name

Current clinical privileges with requirements (call, extended surgeries, potential uninterrupted hours of work, etc.)

Medication list

Allergies

Past medical history

Past surgical history

Family history

Social history

Immunization history

Physical exam:
- Vital signs
- HEENT with visual and auditory acuity
- Heart
- Lungs
- Abdomen

Genital

Rectal

Pulses

Extremities (evidence of circulatory or neurological deficits)

Neurological exam (cranial nerves, motor, sensory, cerebellar)

Mental status exam: (this or an alternative exam)
Orientation: year, season, date, day, month

Orientation: state, county, town, building, floor

Registration: name 3 objects and record the number of trials required to learn

Attention and calculation: serial 7 subtraction from 100. Stop after 5 answers

Spell “world” backwards

Recall: recall the 3 objects registered above

Language: name 2 objects (i.e. pencil and watch)

Repeat: “no ifs, ands, or buts”

Follow a 3 step command

Read and obey: Close your eyes (written in print large enough for the patient to see clearly)

Write a sentence

Draw a clock face

Copy a picture of intersecting pentagons

Immunizations: pneumococcal vaccine, influenza, tetanus/diphtheria booster, hepatitis B vaccine

Potential interventions: PPD

Laboratory/radiology:
CBC with differential, BMP, HIV screen if indicated

EKG if indicated

More advanced studies predicated upon focused past medical history and positive findings

Requirement for follow up based on positive findings

Quality issues would require a more customized approach with a comprehensive physical/neurological evaluation with interpretation by a specialist aware of the impairments and their effect upon the capacity to perform granted privileges in this specific area of concern.

Appendix B: Suggested Screening Evaluation Report Form March 2013

Patient: _____

On history there are symptoms or conditions that raise concern about this clinician's ability to consistently perform the requested privileges in a safe and effective manner:

No: _____

Yes: _____ If yes, please enumerate

_____
_____
_____

On physical examination there are findings that raise concern about this clinician's ability to consistently perform the requested privileges in a safe and effective manner:

General No: _____ Yes: _____

Cognitive abilities No: _____ Yes: _____

Motor skills No: _____ Yes: _____

Sensory functioning No: _____ Yes: _____

If you answered yes to any of the concerns on physical examination, please enumerate:

_____
_____
_____
_____

Tests and studies performed on this clinician raise concern about this clinician's ability to consistently perform the requested privileges in a safe and effective manner:

No: _____ Yes: _____ If yes, please enumerate:

_____
_____
_____
_____

Recommendations for further study or evaluation:

_____
_____
_____

I attest that I have performed a complete history and physical exam on _____ _____on this date and have reviewed the privileges requested by this practitioner.

I recommend that this practitioner is:

____ Capable of all privileges requested

____ Capable of all privileges requested except _____

____ Incapable of all privileges requested

____ Requires further evaluation regarding _____

____ Requires proctoring for further evaluation

Signature: _____ Date: _____

Please print name: _____