SECTION II
RULES AND REGULATIONS

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SECTION 1: BASIC REQUIREMENTS FOR MEDICAL STAFF APPOINTMENT

1.1 GENERAL QUALIFICATIONS

These Medical Staff Rules and Regulations ("MS Rules") supplement the Medical Staff Bylaws ("MS Bylaws") and govern the Conway Regional Medical Center ("CRMC") Medical Staff. Medical Staff appointment and Clinical Privileges are privileges extended by the CRMC Board of Directors ("Board") and are not a right of any Practitioner. Continued exercise of any such privileges is contingent upon compliance with the MS Bylaws and these Rules and Regulations. Appointment to the Medical Staff and associated Clinical Privileges shall be extended only to M.D.'s, D.O's, D.M.D.'s and Oral and Maxillofacial Surgeons who continuously meet the qualifications and requirements, are able to perform the privileges requested, conform to the standards of patient care imposed by law, and continuously demonstrate an ability to work harmoniously with others in the orderly rendering of quality patient care. Every Practitioner who seeks or enjoys Medical Staff Appointment or Clinical Privileges must, at the time that such Clinical Privileges are granted and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board the qualifications as set forth in the MS Bylaws and MS Rules.

1.2 TERM OF STAFF APPOINTMENT AND CLINICAL PRIVILEGES

1.2.1 Duration of Initial Appointments

All initial Medical Staff appointments and granting of Clinical Privileges, and all modifications thereof shall be for a period of not more than three (3) years.

1.2.2 Duration of Reappointments

Reappointments to any category of the Medical Staff and the renewal of Clinical Privileges shall also be for a period of not more than three (3) years.

1.2.3 More Frequent Reappraisal

The Medical Executive Committee ("MEC") of the Medical Staff, with the approval of the Board, may set a more frequent reappraisal period for the exercise of particular Clinical Privileges in general or for specific Practitioners.

1.3 MODIFICATION OF APPOINTMENT STATUS OR CLINICAL PRIVILEGES

Based on the request of a Practitioner or clinical evidence, the Credentials Committee may recommend to the Board that a Practitioner's Medical Staff Category be changed, or that the Practitioner may be granted additional Clinical Privileges subject to the requirements of the MS Bylaws and MS Rules related to the new category or appropriate observation of clinical proficiency in accordance with FPPE and OPPE.

1.4 CALL AND COVERAGE

The Medical Staff holds all physicians to a high degree of ethical standards and requires that all appointees to the Medical Staff make themselves available to their patients with whom they have an established relationship and provide appropriate call coverage as defined below.

Call Coverage is defined as providing coverage twenty-four (24) hours per day, seven (7) days per week through personal availability of the Physician or through a pre-arranged coverage arrangement with a Physician of like specialty.

In addition, each appointee to the Active or Active Affiliate Medical Staff shall be available “on call” or arrange call coverage for unassigned inpatients of CRMC or for unassigned patients that may present to the Emergency Department for treatment and/or admission.

a. response to call shall be within 30 minutes.
b. all inpatients and consults shall be seen within 24 hours of admission or notification of consult and then as appropriate thereafter, as specified in the Rules and Regulations.

“Exception”: Each individual physician in Medical Specialties that have three or less physicians on the Active Medical Staff is required to take a minimum of 10 unassigned call days per month, with two of those days being weekend days. If a physician in this category is not available for unassigned Emergency Department call, they will not be able to see any other Emergency Department patients.

1.4.1 Call Coverage List

1.4.1.1 The unassigned call list shall be electronically mailed to each physician’s office prior to the first day of each month. The electronic mailing of such list shall be the only notification to Practitioners of the date they are responsible for unassigned call. Published call schedules will also be provided to the Medical Exchange, the Emergency Department, and the Nursing House Supervisor or Hospital Administration.

1.4.1.2 Other than for personal emergencies, it is the responsibility of each Physician to notify Hospital Administration (CallSchedules@conwayregional.org) and the Medical Exchange (MedicalExchange@conwayregional.org) prior to the 25th day of the preceding month of any days in which the Physician is unable to provide call coverage. After the 25th day of the month, days not requested off will be assigned at random within the specialty. If a Physician is unable to cover his assigned day, then it will be his responsibility to find and arrange coverage and notify Hospital Administration (CallSchedules@conwayregional.org) and the Medical Exchange (MedicalExchange@conwayregional.org) to revise the schedule.

1.4.1.3 In the event that a Physician is on call must leave town for over twenty-four (24) hours or will be otherwise unavailable, the Physician must notify Hospital Administration (CallSchedules@conwayregional.org) and the Medical Exchange (MedicalExchange@conwayregional.org) and

identify another member of the Medical Staff with appropriate credentials and training with whom prior arrangements have been made by the Physician to provide call coverage.

1.4.1.4 Each appointee to the Medical Staff shall indicate the name of the Physician or Physicians who will be assuming the care of the Physician's patients and Physician's responsibility for unassigned call during his absence:

a. by documenting the same in writing in the medical record of his patients; and
b. by so notifying the Medical Exchange (MedicalExchange@conwayregional.org).

1.4.1.5 Each physician who does not reside within thirty (30) minutes travel time to CRMC main campus shall name an Active Staff Appointee who resides in the area who may be called to attend his patients in an emergency or until he arrives. The name of this alternative physician will be posted on the Call Coverage List.

1.4.2 Specialty Call Coverage

1.4.2.1 All Specialty Care Practitioners shall be required to serve on a rotating call list within their specialty and be available for consultation should the Attending Physician or Emergency Department Physician deem it necessary to refer the patient to a Specialty Care Physician.

1.4.1.2 In the event a patient requires examination or treatment beyond the capabilities and/or Clinical Privileges of the attending physician, the attending physician shall contact one or more physician from the appropriate unassigned on-call list, and each such physician shall assume the care of the patient.

1.4.2.3 The Specialty Care Physician shall notify Hospital Administration (CallSchedules@conwayregional.org) in times of non-availability and shall be responsible for arranging alternative coverage.

1.4.3 Response to Call

1.4.3.1 When the attending physician contacts an Active or Consulting IP Staff physician who is on specialty or unassigned call requesting assistance for a patient, such on-call physician has a duty to respond:

1.4.3.1.1 Initial Phone Consultation. The on-call Physician must return any request for consultation by phone within 15 minutes. This requirement is not negated by his lack of, or potential lack of, competency or Clinical Privileges.

1.4.3.1.2 In Person Consultation. If, after consultation with the on-call physician, the attending physician so requests, the on-call physician must (a) come to the hospital within thirty (30) minutes of the telephone conversation; and (b) physically examine the patient.

1.4.3.1.3 Not Urgent: “Routine”. If immediate on-site assistance is not requested by the attending physician after the initial phone consultation, then the consult must be seen by the on-call physician in the hospital within 24 hours of the initial notification.

1.4.3.1.4 Lack of Competency. If, after consultation with the attending physician, the on-call physician determines that he is not capable of performing a needed service, it is his responsibility to assist the attending physician in ensuring the patient is stabilized. If so requested by the attending physician, the on-call physician should assist the attending physician in either securing the services of a Practitioner who is capable of performing the needed service or assist with arranging for the transfer of the patient to a hospital where the needed service can be performed.

1.4.4 In cases where the physician on call cannot be located without justifiable cause or such physician refuses to respond, such shall be communicated to the Chief of Staff, in writing, giving all the details involved. The Chief of Staff, or his designee, shall investigate and make appropriate recommendations up to and including as to appropriate disciplinary action.

1.4.5 Exceptions

1.4.5.1 It is recognized that not all specialized physician services may be available at all times; however, if any specialized service is uncovered, alternative procedures or contacts (whether at CRMC or at any other hospital) should be specified on the call coverage list published by Hospital Administration. Examples include where a specialty lacks at least three (3) physicians to provide adequate coverage on a rotating basis. Those exceptions will be approved by the Medical Executive Committee and the Board as needed.

1.4.5.2 All Practitioners with Active Staff appointment shall be required to take unassigned Emergency Department call. However, such Practitioners who have attained the age of 55 years or older, shall have the option of taking unassigned Emergency Department call as allowed under the Bylaws, Rules and/or Policies. A Physician may elect to opt-out of unassigned call after the age of 55 so long as at the time of election, the

number of physicians in that specialty taking unassigned Emergency Department call is equal to or greater than three (3). A sixty (60) day notice shall be required for any Practitioner exercising this option. Once a practitioner elects not to take call, their name shall be excluded from the unassigned Emergency Department call list.

1.5 Admissions

A patient may be admitted to CRMC only by a Practitioner with appointment to the Active Medical Staff who, at the time of the admission, is in good standing and whose admitting privileges have not been suspended through enforcement of any section of these Rules and Regulations or the Bylaws of the Medical Staff. The attending physician shall be designated in the doctor's orders.

In accordance with ethical standards and the American Medical Association Code of Ethics and in order to avoid conflicts of interest and to maintain the patient-professional relationship, it is the policy of Conway Regional Health System CRMC and the CRMC Medical Staff that physicians and other care providers should not treat themselves or their family members, except for emergencies or for short-term minor conditions when other care providers are not readily available to provide care.

1.5.1 Such admitting physician, or his physician representative designee, shall be responsible for the medical care and treatment of the patient, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to a referring Practitioner, to the patient and his relatives, if appropriate.

The designated on-call physician will assume responsibility for the care of patient in the absence of the attending physician.

Call coverage other than published call schedules, will require the attending physician to 1) notify the Medical Exchange of the on-call physician and the time period of coverage; and 2) provide a report for the CRMC patient(s), when appropriate, to the on-call physician.

In the event an emergency arises, and both the attending physician and his designee are unavailable, the Chief of Staff, or the Chief of the applicable department/clinical service will be notified and will direct another Physician/Practitioner to assume immediate care of the patient until the attending Physician/Practitioner or his designee becomes available. Either Chief may serve in such role.

1.5.2 Physicians who admit patients as "emergencies" during times when the beds designated as emergency beds are being used because of heavy patient load must be prepared to justify such admission to the Medical Executive Committee (MEC) and administration of CRMC as a bona fide emergency admission. The history and physical examination must be

recorded in the patient's medical record within twenty-four (24) hours of the patient's admission. Such history and physical examination may not be recorded by the emergency department Physician.

1.5.3 Physicians who admit patients to CRMC shall be responsible for furnishing the admitting department and/or the nursing service of the hospital any information necessary to assure the protection of other patients from those who may be a source of danger from any cause whatever, or to assure the patient protection from self- harm.

1.5.4 Each physician who admits patients to CRMC shall cooperate with CRMC admitting personnel and the utilization review process in determining the general classification of each patient (emergency, urgent, elective, etc.) and in establishing a diagnosis which is able to be coded.

1.5.5 It shall be the responsibility of each Practitioner to cooperate with CRMC to the fullest extent possible, in dismissing their patients as early in the day as possible in order that the business office may follow established procedures in effecting the dismissal and that the nursing and housekeeping services may make the vacated bed ready for incoming patients as early in the day as possible.

1.5.6 Patients placed in observation (twenty-three (23) hours) must be admitted as routine admission or discharged from CRHS by hour twenty-three (23).

1.5.7 Each inpatient at CRMC shall be seen at least one time each twenty-four (24) hours by the physician or, in the event of the physician's absence from CRMC for more than twenty-four (24) hours, a Practitioner with active staff appointment designated by the physician to care for his patients during his absence.

1.6 Consultations

Except in emergency situations, consultations with another qualified Practitioner are required on but not necessarily limited to:

a. Primary Cesarean sections except when the surgeon is Board Certified or qualified in Obstetrics/Gynecology.

b. Curettages or other procedures in which a known or suspected pregnancy may be interrupted.

c. Cases which, in the opinion of the practitioner, present an obscure diagnosis, where the patient is not a good risk for surgery or treatment or where there is doubt as to the best therapeutic measures to be taken.

d. Surgery contemplated by Practitioners who are prohibited from operating without consultation by the rules and regulations of surgery.

e. Psychiatric consultation and treatment shall be requested for or will be offered to all patients who have attempted or have taken an intentional drug overdose or committed a suicidal gesture.

f. Where there are potential medical/legal implications of the treatment.
g. Where the Practitioner orders that extraordinary care cease and/or life support systems be removed from an incompetent patient.
h. Where the attending Practitioner/Physician is unable to obtain the informed consent of the patient due to his belief that full disclosure of the risks and/or consequences of the procedure is not in the best interest of the patient.

1.6.1 Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This record shall be made a part of the patient's medical record. Limited statements such as "I concur" do not constitute an acceptable report of consultation. When operative procedures are involved, except in emergencies, consultations shall be documented on the record and/or dictated prior to surgery. Consultations shall be requested by the attending physician in the doctor's orders/or progress notes and the consultant's report shall be dictated/or labeled as "Consultation report" when written in the progress notes.

1.6.2 The patient's physician is responsible for arranging for consultations when indicated or when required by these policies and procedures Rules and Regulations. It shall be the duty of the Chairman of the Department and the MEC to make certain that Practitioners do not fail to obtain consultations which are indicated or required.

2.1 APPLICATION FOR INITIATL APPOINTMENT

2.1.1 Application Request Form

a. All requests for application for appointment to the Medical Staff will be forwarded to the Medical Staff Office and Credentials Committee Chairman. Upon receipt of a request for application, the Medical Staff Office will provide the potential applicant with an application request form.
b. The potential applicant must meet the Basic Requirements for Medical Staff appointment as expressed in Article 3 of the Medical Staff Bylaws.
c. Upon receipt of a completed application request form, the Medical Staff Office will verify its contents. In the event that the basic requirements for appointment are not met, the potential applicant will be notified and given an opportunity for an informal discussion with the Chief of Staff, the Chief Executive Officer.
d. If the potential applicant meets the licensure, education, training and certification requirements of Article 3 of the Medical Staff Bylaws and the Clinical Privileges sought are not subject to an exclusive contract with a physician or group of physicians not including this person or if the Clinical Privileges sought are

consistent with CRMC's written Medical Staff Development Plan, then the Medical Staff Office may forward a Medical Staff Application Form to the applicant.

e. If there is a question as to whether the potential applicant meets the basic requirements for medical staff admission set forth in Article 3 of the Medical Staff Bylaws, the application request form shall be forwarded to the Credentials Committee for final decision.

2.1.2 Application

a. Each application for appointment to the Medical Staff shall be on the prescribed Medical Staff Application Form, completed in full, typed or legibly written and signed by the applicant.
b. Each applicant shall have access to a copy of the MS Bylaws and the MS Rules.
c. Applicants may request an update on the status of their credentialing application from the Medical Staff Office in writing, once a week through facsimile or electronic mail.

2.1.3 Content

The Medical Staff Application Form shall include:

a. Those items required by MS Bylaw 3.7.7;
b. An Authorization and Release form as well as an Attestation Form for the Arkansas State Medical Board's Centralized Credentialing Verification Service (CCVS), authorizing the Medical Staff Office to obtain detailed information as mandated by the Arkansas State Medical Board.
c. A separate Authorization and Release Form to allow the Medical Staff Office to obtain peer references from other physicians and staff references from other facilities where the applicant has been granted privileges.
d. Submission of the $200 application fee for Active or Consulting appointment to the Medical Staff. For Allied Health Professionals (AHP), AHP I applicants shall submit a fee of $75 and AHP II and AHP III have a $200 application fee. Outpatient Courtesy and Dental staff applicants have no fee.

2.1.4 Exception- Application for Outpatient Courtesy Staff

A brief application for Outpatient Courtesy Privileges will be completed by the applicant and kept by the Medical Staff Office. This application information includes:

a. Pertinent Physician information including name, office address, office phone and office facsimile
b. Valid Arkansas License Number (will be verified by the Arkansas State Medical Board); DEA license number, and Unique Physician Identification Number (UPIN), and National Practitioner Identification Number (NPI). **Exception – Active Duty Military*

Physicians in Arkansas need only supply CRMC with a copy of a valid state medical board license issued from any state in the USA and their NPI number. Military uses a standard UPIN.

c. Written order for test or procedure.

d. Annual report to MEC and Board.

2.2 Effect of Application

By applying for appointment to the Medical Staff, each applicant:

a. consents to the inspection of records and documents pertinent to his licensure, specific training, experience, current competence, and ability to perform the privileges requested and, if requested, appears for an interview.

b. agrees to be bound by the provisions of the MS Bylaws and MS Rules.

c. represents and warrants that all information provided by him is true, correct, and complete in all material respects and agrees to notify CRMC of any change in any of the information furnished to CRMC in his application.

2.3 Applicant's Burden

An applicant applying or reapplying for appointment or reappointment to the Medical Staff shall have the burden of completing and submitting all authorizations required in MS Rules 2.1.3 and all other information requested in the Medical Staff application.

Failure to meet these requirements constitutes a basis of denial of the application or reapplication and granting of clinical privileges.

2.4 Processing the Application

2.4.1 Upon receipt of the completed application, the Medical Staff Office will begin considering the application by verifying the information provided, including, but not limited to, information from:

a. The Arkansas State Medical Board's CCVS for verification of credentialing information;

b. The National Practitioner Data Bank;

c. Professional liability insurers, present and past, on any and all liability claims filed;

d. Professional references from past and present hospital affiliations;

e. Relevant quality data related to an Applicant's request for Clinical Privileges as determined by the Credentials Committee.

f. Case logs relevant to privileges requested.

2.4.2 The applicant shall have the responsibility to provide a complete application and any additional information requested or any evaluation of his professional competence, ethics, and physical and mental health. Failure of an applicant to complete the application, including the

submission of all requested information within ninety (90) days from the date the application is received by the Medical Staff Office shall terminate any further consideration of the application and, in such event, the applicant will not be entitled to the procedural rights of MS Bylaw Article Six. No application will be submitted to the credentialing process until all required information is complete and appropriately verified.

2.5 Department Chairman Review

2.5.1 Upon receiving the completed application and supporting material, the appropriate departmental chairman will review the entire file and document findings on a report to the Credentials Committee within forty-five (45) days stating whether the Department Chairman finds the Applicant's education, training and experience are appropriate for the Clinical Privileges requested or that the Applicant's application, education, training or experience are lacking for the Clinical Privileges requested.

2.6 Credentials Committee Action

2.6.1 Upon receiving the completed application, supporting material and the report of the Department Chair, the Credentials Committee shall:

a. Conduct a full review of the application. Upon completion of the review, the Credentials Committee will determine if any additional information is required of the Applicant. If additional information is required, the Credentials Committee will inform the Applicant of the needed information and the timeframe it must be provided to the Credentials Committee.

b. If after review of the application, the Credentials Committee determines that the Applicant is not qualified for Medical Staff Appointment or otherwise should not be appointed to the Medical Staff or granted the requested Clinical Privileges, the Credentials Committee shall make its recommendation to the MEC stating with specificity the basis for denial.

c. If after review of the application, the Credentials Committee determines that the Applicant meets the qualifications for Medical Staff Appointment and the requested Clinical Privileges, The Chair of the Credentials Committee shall sign the Application and notify the MEC of the Credentials Committee's recommendation.

d. Upon receipt of the Credentials Committee's recommendation, the MEC shall either accept the Credentials Committee's recommendation, reject the Credentials Committee's recommendation, or modify the Credentials Committee's recommendation. The MEC's action will be forwarded to the Board for final action along with the Credentials Committee's recommendation.

2.7 Notice of Board Action

a. The applicant shall receive written notice of the Board's final action through the CEO.

b. The written notice shall include the action of the Board regarding Appointment and delineation of Clinical Privileges, whether favorable or unfavorable, the rationale for any unfavorable action and the following as applicable:

1. the Medical Staff category to which the applicant is appointed;
2. the Department to which he is assigned;
3. any special conditions attached to the appointment or the exercise of said privileges;
4. any procedural rights for which the practitioner is eligible relative to a decision not to grant appointment or requested privileges or any conditions attached to the appointment or the exercise of granted privileges.

2.8 Adverse Action

2.8.1 For the purposes of Appointment, an adverse or unfavorable action means a decision to deny Appointment, or to deny or restrict requested Clinical Privileges. A failure to complete an application or to provide a completed application is not a denial of Appointment and is not an adverse action.

2.8.2 An applicant who has received a final adverse decision to deny Appointment may reapply after a period of two (2) years from the date of the adverse action. Any reapplication for Appointment shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or Board may require demonstrating that the basis for the earlier adverse action no longer exists. Information gathered in the previous application process shall also be considered in the reapplication process.

2.8.3 An applicant who has received any other final adverse action as defined above may reapply to change such action when he can document that the reason for the initial adverse action no longer exists. The applicant must make such request in writing on the appropriate form and shall submit such additional information as the Medical Staff or Board may require demonstrating that the basis for the earlier adverse action no longer exists. Information gathered in the previous application process may also be considered in the reapplication process.

2.9 Rights Pursuant to Adverse Action

An applicant whose appointment process results in an adverse or unfavorable action as defined above shall have access to the Fair Hearing Process as set forth in Article Six of the MS Bylaws.

2.10 Denial Because of CRMC's Lack of Need or Inability to Provide Support

In addition to other bases specified herein, applications for Medical Staff Appointment or applications for particular Clinical Privileges may be denied on the basis of the Medical Staff and Board's decision:

a. that CRMC is presently unable to provide adequate facilities, supportive services or patient population for the Practitioner and his patients; or
b. that there is a lack of patient care need for additional Practitioners with the skill and training of the applicant; or
c. that the application is inconsistent with CRMC's written Medical Staff Development Plan, including the mix of patient care services to be provided, as currently being implemented; or
d. that CRMC has made a decision to contract exclusively for the provision of services with a physician or a group of physicians other than the applicant.

Such denial shall not be considered adverse in nature.

2.11 Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Disciplinary Action

2.11.1 a present or former Applicant or Practitioner shall not be eligible to apply or reapply for Medical Staff Appointment and/or Clinical Privileges affected by a previous action for a period of at least two (2) years who has:

a. received a final adverse decision regarding application or reapplication for Medical Staff Appointment or Clinical Privileges.
b. withdrawn his application or reapplication for Medical Staff Appointment or Clinical Privileges following an adverse recommendation by the Credentials Committee, MEC or Board.
c. received a final adverse decision resulting in suspension or termination, limitation or restriction of Medical Staff Appointment or Clinical Privileges.
d. resigned, surrendered, or failed to reapply for Clinical Privileges following an automatic suspension or an adverse recommendation by the Credentials Committee or Board. Such ineligibility shall extend for a period of at least two (2) years from the date the adverse decision became final, the date the application or request was withdrawn, or the date resignation became effective, whichever is applicable.

2.11.2 For the purpose of this Section, a decision shall be considered to be adverse only if it is based on the type of occurrences, which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse for the purpose of this Section include actions based on a failure to maintain a practice in the area (which can be cured by a

move) or to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by securing such insurance). Further, this Section shall not prohibit reapplication by a Practitioner whose Medical Staff Appointment or Clinical Privileges have been limited or restricted from reapplying for said Appointment and Clinical Privileges upon the expiration of their normal term, subject to continuation of any applicable limitation or restriction. For the purpose of this Section, an adverse decision shall only be considered to be final at the time of completion or waiver of: (1) all hearing and appellate review by the CRMC committee bearing on the decision and (2) all judicial proceedings bearing upon the decision which are filed and served within two (2) years after the completion of CRMC Medical Staff proceedings described in (1) above.

2.11.3 After the two (2) year period, the former Applicant, Practitioner, or former Practitioner may submit an application for Medical Staff Appointment and/or Clinical Privileges which shall be processed as an initial application. The former Applicant, Practitioner or former Practitioner shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such application shall not be processed unless the Applicant, Practitioner or former Practitioner submits satisfactory evidence to the Credentials Committee that he has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or provisional conditions.

2.12 Reappointment

2.12.1 Duration of Appointment

Duration for all appointments shall be for a period not to exceed three (3) years.

2.12.2 Reappointment Generally

Only the Board has the power to take final action on reappointment to the Medical Staff and renewal of Clinical Privileges. The fact that a Practitioner has had Medical Staff appointment and Clinical Privileges in the past or that the Credentials Committee has made a favorable recommendation shall not be deemed reason to renew Medical Staff Appointment or Clinical Privileges in the absence of action by the Board. Denial of reappointment to the Medical Staff shall be based on the provisions found in the MS Bylaws and the MS Rules.

2.12.3 Application for Reappointment

The reappointment application form shall include elements necessary to evaluate the professional capabilities and conduct of the applicant since the last appointment, including:

a. a completed Arkansas State Medical Board Authorization and Release Form for CRMC to access the CCVS as well as current Arkansas State Medical Board Attestation statement.
b. completed Ability to Perform Statement signed by a physician (not the applicant);
c. and results of most recent annual TB skin test;
c. professional performance;
d. evidence of current ability to perform privileges, as indicated in part by the results of performance improvement activities concerning the individual's professional performance, judgment and clinical or technical skills, i.e., mortality rates, infection rates, complication rates, other specialty specific rates as determined by the Credentials committee, peer review results and numbers and types of procedures performed;
e. maintenance of timely, accurate and complete medical records;
f. attendance at required Medical Staff meetings;
g. compliance with all applicable MS Bylaws and MS Rules and CRMC Bylaws and Policies;
h. performance in working harmoniously with others;
i. previously successful or currently pending challenges to any licensure or registration (state or DEA) or the voluntary relinquishment of such licensure or registration;
j. any voluntary or involuntary termination of appointment to the Medical Staff or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, clinic or health care institution;
k. Proof of 20 hours of CME with at least 50% being Category I At least 50% of all CME submitted must be in the practitioner's area of expertise. Failure to meet this requirement will result in provisional appointment to the medical staff.
l. Board Certification or Board Recertification or continued Board Qualification. Exception: Those Practitioners appointed to Active Medical Staff with proven clinical competence who were appointed to the Active Medical Staff prior to 1990. Exception to all of the above: OP Courtesy Staff submits the approved form for that status.

2.12.4 Submission of Reappointment Application

a. shall be by birth month plus one hundred twenty (120) days to allow for the CCVS credentialing verification. Example: If a Practitioner's birthday is in January, the reappointment package will be sent in January and requested returned to the Medical Staff Office in February. The Practitioner's CCVS can then

be requested March 1st with a target turnaround time of 45 working days from the Arkansas State Medical Board. The Practitioner would then go before the Credentials Committee, MEC and Board in May.

The following table outlines the process for each month:

Birth Month Reappointment	Return to CRMC Med Staff Office	Available for Request from CCVS	Physician Reappointment before the Committees and Board
January	February	March 1	May
February	March	April 1	June
March	April	May 1	July
April	May	June 1	August
May	June	July 1	September
June	July	August 1	October
July	August	September 1	November
August	September	October 1	December
September	October	November 1	January
October	November	December 1	February
November	December	January 1	March
December	January	February 1	April

b. at least forty-five (45) days prior to the Practitioner's birth month, a reappointment package will be sent to the Practitioner. We ask that this reappointment package be completed and sent back to the Medical Staff Office one hundred twenty (120) days prior to the final scheduled Board meeting preceding the expiration of the Practitioner's term of appointment. The Medical Staff Office shall give notice of such expiration date to the Practitioner.

c. Includes a $200.00 reappointment fee for Active and Consulting Medical Staff.

d. AHP-I professional staff will pay a fee of $75.00 for reappointment.

e. AHP-II and AHP-III professional staff will pay a fee of $200.00 for reappointment.

f. There will be no fee for Honorary, Dental, or Outpatient Courtesy Staff.

2.12.5 Failure to Reapply

Failure without good cause to provide this information shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Appointment and Clinical Privileges at the expiration of the

Appointee's current term of Appointment, unless explicitly extended for not more than ninety (90) days by action of the Credentials Committee.

a. Responsibility of the Practitioner in Reapplying

1. a Practitioner who wishes to be reappointed must apply for reappointment by completing and submitting a reappointment form in accordance with the time frames and requirements specified in this procedure.
2. The Practitioner shall have the responsibility to provide the information specified in the MS Bylaws and/or MS Rules and any additional information deemed necessary for proper evaluation of the Practitioner's clinical competence, ethical behavior, physical and mental health. The burden of proof as to why he should be reappointed to the Medical Staff or granted Clinical Privileges to practice at CRMC rests solely with the Practitioner.
3. It is the appointee's responsibility to notify the Medical Staff Office prior to any change of address or practice location, which will be in effect for a period greater than ninety (90) days, including moves within and outside the defined geographic practice area. CRMC assumes no responsibility for lost or misdirected communications due to failure to make such notification. Failure to make such notification may result in termination of Medical Staff Appointment and Clinical Privileges.

2.12.6 Processing of Reappointment Application and Reappraisal Information

a. Upon receipt of a complete application, the Medical Staff Office will verify the contents and notify the Practitioner of any information inadequacies or verification problems. The Practitioner then has the burden of producing the requested information within the time period specified in the notification.

b. The Medical Staff Office shall collect and place in the Practitioner's file additional information from internal and external sources regarding the individual's professional and collegial activities, performance and conduct in CRMC and/or other hospitals and compliance with the MS Bylaws and MS Rules.

c. When such collection and verification are complete, the Medical Staff Office shall transmit the information form and supporting materials to the Department Chair to which the Medical Staff Practitioner requests Clinical Privileges and to the Chair of the Credentials Committee (or the entire Credentials Committee). Pursuant to MS Rule 2.6, the Department Chair shall forward his findings and recommendation to the Credentials Committee prior to a final determination upon the application.

2.12.7 Effect of Credentials Committee Action

a. Favorable recommendation: When the Credentials Committee's recommendation is favorable to the applicant for reappointment, all information shall be forwarded to the MEC for approval, then to the Board for final approval.

b. Unfavorable recommendation: When the Credentials Committee's recommendation is adverse to the applicant for reappointment, the Chief Executive Officer shall promptly give written notice to the applicant by delivery either in person or by certified mail, return receipt requested. Thereafter Article Six of the MS Bylaws shall apply.

2.12.8 Board Action

Only the Board has the power to take final action on an application for reappointment to the Medical Staff or for Clinical Privileges.

2.13 Voluntary Leave of Absence and Resignation

2.13.1 Leave of Absence Status

a) A Practitioner may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Chief Executive Officer stating the reason for the leave of absence, the time the leave of absence is to commence, the approximate period for the leave of absence, and what alternate arrangements have been made for the Practitioner's patients and on-call responsibilities.

b) With the exception of the Practitioner's responsibility to complete medical record documentation, the Practitioner's Clinical Privileges, prerogatives and responsibilities shall be suspended during the leave of absence.

c) If during the leave of absence, a Practitioner's Staff Appointment would naturally expire, the Practitioner may reapply for Staff Appointment and renewal of Clinical Privileges during the leave of absence.

d) The Credentials Committee or Board in its discretion may, but is not required to, suspend processing of any reapplication during a leave of absence.

e) Should a Practitioner be under investigation pursuant to the MS Bylaws and MS Rules, the Credentials Committee in its discretion may, but is not required to, suspend its investigation during the pendency of the leave of absence. If an investigation is so suspended, it will resume upon

termination of the leave of absence. However, if such investigation continues, the Practitioner is subject to all of the provisions of the MS Bylaws and MS Rules regarding investigation, hearings and appeals.

2.14 Resignation

Resignation of Appointment, Clinical Privileges and/or Medical Staff office must be in writing and delivered to the Chief Executive Officer and Chief of Staff. A resignation is effective on the date specified therein or, if no date is specified, immediately upon receipt by the Chief Executive Officer. Once delivered to the Chief Executive Officer a resignation is irrevocable.

2.15 Special Conditions for Contracted Physicians

In the event CRMC contracts to provide specific services with an individual, or group of Physicians, ("Contractor") on an exclusive basis, and unless such contract so specifies to the contrary, the following provisions shall apply:

a) Each Practitioner providing services under the contract must also be affiliated with (i.e., be a member of, employee of, or independent contractor of) the Contractor.

b) Each such Practitioner's Staff Appointment and Clinical Privileges automatically terminates (without the rights provided for in the MS Bylaws and MS Rules) in the event that he ceases to be affiliated with the Contractor or if the Exclusive Contract with the Hospital is terminated.

2.16 Qualifications Generally

Every Practitioner who seeks or enjoys Staff Appointment or Clinical Privileges must satisfy, at the time of Appointment and continuously thereafter, the basic qualifications set forth above as well as any additional qualifications and requirements of MS Bylaws, MS Rules, and Hospital Bylaws and Policies. The Board may waive any qualification or requirement when, in its discretion, such waiver will serve the best interest of patient care in the Hospital or is appropriate to the orderly administration of the Hospital and will not be contrary to law.

SECTION 3: CLINICAL PRIVILEGES

3.1 Exercise of Clinical Privileges

Every Practitioner providing clinical services at CRMC by virtue of Medical Staff Appointment or otherwise shall be entitled to exercise only those Clinical Privileges specifically granted to him by the Board and shall include any limitations to admit patients or direct the course of treatment for the conditions for which the patients were admitted. These Clinical Privileges must be within the

scope of the license, certificate or other legal credentials authorizing him to practice in Arkansas and consistent with any restrictions thereon and within his ability to perform.

3.2 General Privileges

3.2.1 All Physician appointees of the Medical Staff may:

a. Perform History & Physicals
b. Order diagnostic and therapeutic services
c. Chart in Patient's Medical Records
d. Make referrals and consultations
e. Order medications / prescriptions consistent with CRMC formulary
f. Provide consultations within the scope of the Practitioner's training
g. Render Care in life threatening emergency

As of July 1, 2016, Conway Regional Medical Center requires that all authorized prescribers utilize Computer Physician Order Entry (CPOE) for all hospitalized patients on the certified and approved order entry application. CPOE encompasses all electronic orders, including but not limited to: medication, lab, and radiology orders; nursing care and instructions; ancillary department orders such as respiratory therapy treatments and care and physical therapy consults as well as other provider consults.

3.2.2 Exception: Emergency physician may not admit or write orders for care in the special units without consultation with the attending physician. Emergency physicians may admit patients to the 23-hour observation unit. If a patient requires inpatient admission from the Observation Unit, a Primary Care Physician will be consulted to take responsibility for the patient, and appropriate specialists will be consulted as needed.

Anesthesiologists and Pathologists may not admit patients or provide emergency room coverage except in a life-threatening emergency. Anesthesiologists may admit patients to the Observation Unit following procedures. If a patient requires inpatient admission from the Observation Unit, a Primary Care Physician will be consulted to take responsibility for the patient, and appropriate specialists will be consulted as needed.

Other selected staff categories may use the Observation Unit if he consults with an Active Medical Staff Practitioner of CRMC prior to admitting a patient for 23-hour observation. These categories include but are not limited to, Podiatrists, Dentist, and Oral Surgeons.

Practitioners with Consulting and Outpatient Courtesy staff privileges may not admit patients of any status to CRMC.

3.2.3 Regardless of the level of Clinical Privileges granted, each Practitioner must obtain consultation when the condition of the patient exceeds the privileges of the Practitioner.

3.2.4 Practitioners with Dental Staff privileges who have delineated surgical privileges may order standard labs and x-rays. Practitioners with Dental Staff privileges may not admit patients.

3.2.5 Practitioners with Podiatry Staff (AHP-II) privileges who have delineated surgical privileges may order standard labs and x-rays. Practitioners with Podiatry staff privileges may not admit patients.

3.3 Basic Rules for Delineation of Privileges

3.3.1 Each application for appointment or reappointment to the Medical Staff must contain a request for specific Clinical Privileges desired by the applicant. Specific requests must also be submitted for modification of privileges in the interim between reappraisals.

3.3.2 Requests for Clinical Privileges will be considered only when submitted on the prescribed form and when accompanied by all requested information, including evidence of education, training, experience and demonstrated current competence as specified in the MS Bylaws and MS Rules to include data supporting the results of treatment and types and numbers of cases/procedures performed. In the event all requested information is not provided, the request for Clinical Privileges will be considered incomplete and will not be processed.

3.3.3 It shall be the responsibility of the Department Chair to which the appointee is assigned to make recommendations to the Credentials Committee on criteria for Clinical Privileges, which fall within the scope of service of their respective Department. It shall be the responsibility of the Credentials Committee to oversee this development of criteria for Clinical Privileges, including the development of criteria for privileges which cross-departmental and specialty lines and to make recommendations for all criteria to the MEC. When Clinical Privileges are included in the scope of service of more than one department, criteria shall be developed by those affected departments which will assure that the same level of care will be provided to all patients in CRMC regardless of the departmental assignment or specialty of the Practitioner providing the service.

3.3.4 Criteria for Clinical Privileges shall be adopted by the Board upon recommendation of the MEC (after consultation with the Credentials Committee and Department Chair) and shall specify the education, training, experience, and evidence of current competency required. No privilege will be granted until objective criteria have been established to determine the necessary qualifications to exercise such privilege. In the event a request is submitted for a privilege for which no criteria has been

developed, the request will be tabled for a reasonable period of time during which the Board will, after consultation with the MEC (pursuant to the process defined above), adopt the necessary criteria. Once criteria have been established, the original request will be processed as described.

3.3.5 The basis for determination of privileges or for modification of privileges shall include education, training, experience, clinical performance, documented results of quality monitoring and peer review activities, and/or information obtained from other sources where an applicant exercises clinical privileges, or which have access to information pertinent to professional competence. Such information shall be maintained in the Practitioner's file.

3.3.6 All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in Appointment and Reappointment.

3.3.7 Any Practitioner who is engaged to provide services under exclusive contract to CRMC must meet the same requirements as all appointees to the Medical Staff.

3.3.8 No Practitioner shall be permitted to perform a procedure unless it is documented that he holds Clinical Privileges to do so.

3.4 Special Conditions for Dentists and Podiatrists

3.4.1 Requests for Clinical Privileges from Dentists and Podiatrists shall be processed in the manner specified in this description. The scope and extent of surgical procedures that each dentist and podiatrists may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. All surgical procedures performed by Dentists and Podiatrists shall be under the overall supervision of the Chair of the Specialty Care Department. All dental and podiatry patients shall receive the same basic medical appraisal as patients admitted for other surgical services. Patients presenting for services by Dentists or Podiatrists must have a current history and physical examination done by an Active Medical Staff Practitioner who is also responsible for the care of any medical problems that may be present at the time of the procedure or that may arise during the procedure.

3.4.2 Oral and Maxillofacial Surgeons may perform the history and physical examination if they have been credentialed to do so.

3.5 Temporary Clinical Privileges

3.5.1 Upon written request for specific temporary Clinical Privileges on the proper form at least five (5) business days (or less with respect to an important patient care need, if necessary) prior to the proposed date for the Clinical Privileges and with the written concurrence of the Chief of

Staff, Chair of the Credentials Committee and the Department Chair, the Chief Executive Officer or his designee may grant temporary Clinical Privileges in the following instances:

a. The justification for the request of temporary Clinical Privileges should be limited to fulfilling an important patient care need. Temporary Clinical Privileges can be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the Practitioner's full credentials information is verified and approved. Situations that may require temporary Clinical Privileges include, but are not necessarily limited to, situations where (i) a current Practitioner of the Medical Staff becomes ill or takes a leave of absence and a Practitioner would need to cover his/her practice until he/she returns, and (ii) a specific Practitioner has the necessary skills to provide care to a patient that a Practitioner currently privileged does not possess.

b. Process.

Temporary Clinical Privileges may be granted by the Chief Executive Officer or designee upon recommendation of the applicable Department Chair with concurrence of the Chief of Staff as follows:

1. If the requestor is not an appointee to the Medical Staff: Temporary privileges may be granted provided, that, there is documentation and verification of current unrestricted Arkansas Professional License, relevant training, current competence to perform the privileges requested, Malpractice Insurance Coverage of specified amounts, a valid unrestricted DEA Certificate (where applicable), and the applicant is Board Certified or Board Qualified. Special requirements of consultation and reporting may be imposed by the Department (or Section) Chairman for the supervision of a practitioner granted temporary Clinical Privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he has_ received, or has been given access to, and read the MS Bylaws and MS Rules and that he agrees to be bound by the terms thereof in all matters relating to his temporary Clinical Privileges.

2. If the requestor is a Licensed Independent Practitioner appointed to the Consulting-Staff, he may perform the requested Clinical Privilege on a specific patient if the following conditions are met:

(a) Active Medical Staff Practitioner assumes responsibility for the patient's total care.
(b) Evidence is provided of current competence to perform the privileges requested.
(c) The procedure requested is an integral part of the procedure being performed by the Active Medical Staff
(d) The Active Medical Staff Practitioner is physically present when the Clinical Privilege is exercised.
(de) This special privilege may be considered only a six times each year by a member of the Consulting Staff.

c. Duration
Temporary clinical privileges shall be granted for a period of (30) days. In the event that the clinical need requiring the temporary clinical privileges persists, an additional period of thirty (30) days may be granted.

3.6 Emergency Credentialing In the Event of a Mass Disaster

In the event of a mass disaster, Practitioners and other healthcare providers may not be able to provide all the care required by individuals seeking treatment at CRMC. Under such circumstances and when CRMC's emergency management plan has been activated, the following persons are authorized to grant emergency Clinical Privileges or authorization to physicians or other professionals to treat patients upon receipt of satisfactory evidence that such individuals are licensed or otherwise capable of providing services to patients. Such credentialing is discretionary, not mandatory and will be decided on a case-by-case basis:

- the CEO, as agent of the Board, or his designee
- the Chief of Staff
- any Department Chair
- the ER physician in charge at the time

Satisfactory evidence of qualification may include:

1. A government –issued photo ID
2. A valid license to practice in Arkansas
3. An ID indicating membership or participation in a government-sponsored disaster management team
4. An ID indicating that the individual has been granted authority to render care under disaster circumstances
5. Personal knowledge by appropriate hospital personnel of the individual's identity and qualifications.

Once a practitioner obtains approval for emergency Clinical Privileges, CRMC will issue appropriate identification. The Practitioner will then report to and practice under the auspices of the Department Chair to which he is assigned.

The Medical Staff Office will begin the verification process of the credentials and privileges of individuals who receive emergency Clinical Privileges within seventy-two (72) hours of the immediate situation being under control. The verification process is identical to the process established in MS Bylaw 4.4.1.3 for granting Locum Tenens privileges to meet an important patient care need, and is a high priority. The same individuals referenced above that are eligible to call the event as a mass disaster will also have the authority to deem the situation under control.

When the disaster situation is deemed to be resolved, these emergency Clinical Privileges shall automatically be terminated. Individuals wishing to continue rendering patient care must then apply for appropriate privileges according to the mechanisms set forth in the MS Bylaws and MS Rules.

Notwithstanding any existing delineation of privileges or scope of authority, Practitioners and other CRMC healthcare providers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or the public health during a mass disaster.

3.7 Telemedicine

Definitions

Telemedicine: The use of medical information exchanged from one site to another via electronic communications.

Originating site: The site where the patient is located at the time the service is provided.

Distant site: The site where the practitioner providing the service is located.

Proxy Credentialing: The practice of relying upon the credentialing and privileging decisions of the distant site contracted to provide telemedicine services when making recommendations on privileges to be granted at the originating site.

3.7.1 The originating site (CRMC) has an agreement with the distant site of services being provided.

3.7.2 Clinical care (diagnosis and treatment) or consultation provided to CRMC patients via telemedicine will be reviewed and recommended by the Credentials Committee and MEC and approved by the Board. (CRMC as the originating site)

3.7.3 Proxy Credentialing applies to practitioners who provide services through a telemedicine link and are not physically present on the originating site (CRMC as the originating site).

3.7.4 Telemedicine practitioners must be credentialed by a distant site who is Joint Commission Accredited or approved by the survey of the Arkansas State Department of Health. In either case, the distant-site hospital shall provide the Medical Staff Office with verification for each practitioner's scope of privileges and a Statement of Primary Source Credentialing. The telemedicine practitioner shall have a current Arkansas license (as required under regulation 17-95-206 Arkansas State Medical Board). This regulation is applicable regardless of the location of the telemedicine practitioner.

3.7.5 A telemedicine practitioner who wishes to provide consultation from a distant location must apply for and be granted the privilege.

3.7.6 The following information is reviewed by the Credentials Committee, MEC and, if accepted, approved by the Board:

- Completion of a telemedicine privilege request form
- Verification of current license
- Privileges granted by the distant-site hospital
- Statement of Primary Source Credentialing from the distant-site hospital where the practitioner is privileged
- Query of the National Practitioner Data Bank
- Evidence of malpractice insurance
- The telemedicine practitioner will sign a release allowing the distant site hospital to release his privileging information and shall complete an Authorization & Release and Attestation, allowing CRMC to access the CCVS.

3.7.7 When CRMC is the originating site, the telemedicine practitioner's performance will be reviewed consistent with reappointment evaluations, performance improvement, and patient safety activities. CRMC will notify the distant site and the telemedicine practitioner (1) in the event of serious, reviewable adverse patient events associated with the telemedicine service and (2) of complaints about the telemedicine practitioner from patients.

3.8 Residents

CRMC provides a Residency Program and participants in the Residency Program are House Staff subject to MS Bylaw 3.6. Members of the House Staff do not have independent privileges to admit or treat patients at CRMC. The House Staff are employees of CRMC, and their scope of practice is defined by the Graduate Medical Education Committee ("GMEC"). Specific policies and procedure governing the oversite of House Staff within CRMC are set forth in the Resident Policies and Procedures manual. House Staff will act under the supervisions and credentials of a Medical Staff member in accordance with all

CRMC policies. An official list of current House Staff Members will be kept in the Residency Program office and presented to the Credentials committee as set forth in the MS Bylaws.

3.8.1 House Staff may write patient care orders upon consultation and supervision by their supervising physician. All patient care orders written by members of House Staff must be counter-signed by a physician with Active Staff privileges at CRMC.

3.8.2 For Residents that are not part of the Residency Program, but may be rotating through CRMC, a copy of their sponsoring institution policies related to patient care orders must be on file with the CRMC Medical Staff Office. Their designated supervising physician must have Active Staff Privileges at CRMC. Any orders entered by the Resident must be in compliance with their sponsoring institution policies and counter-signed by their supervising physician.

3.8.3 Upon completion of two (2) years of the Residency Program, House Staff can be granted an expansion of Clinical Privileges upon application. In order to qualify for expansion of Clinical Privileges, the House Staff Practitioner must be in good standing with the Residency Program and have a written verification from the Program Director as to the specific Clinical Privileges for which the House Staff Practitioner is qualified to perform. The House Staff Practitioner must additionally provide proof of DEA registration, an unlimited Arkansas medical license, and malpractice insurance. The Credentials Committee may approve the application or reject the application. As House Staff are not appointees of the Medical Staff, any rejection of an application for Clinical Privileges is not subject to fair hearing and appeal rights set forth in Article Six of the MS Bylaws.

SECTION 4: DEPARTMENTS AND SECTIONS

4.1 Departments

4.1.1 In compliance with the Bylaws of the Medical Staff, departments shall exist. There shall be two departments of the Medical Staff--Primary Care Department and Specialty Care Department. All Active Medical Staff Practitioners shall have a primary affiliation with and appointment to the department, which most closely reflects his professional training and experience and the clinical area in which his practice is concentrated.

a. Primary Care Department--Family Practice, Internal Medicine, Pediatrics, Emergency Medicine, Ob-Gyn.
b. Specialty Care Department--General Surgery, Otolaryngology, Plastic Surgery, Maxillofacial Surgery, Pathology, Anesthesiology, Orthopaedic Surgery, Urology, Neurological Surgery, Cardiology, Pulmonology, Gastroenterology, Radiology, Psychiatry, Ophthalmology, and Dermatology. Ob-Gyn shall have one (1) representative in this Department.

4.1.2 Removal and resignation and vacancy of Department Chairman

a. A Department Chairman or Member at Large may resign at any time by giving written notice to the MEC effective on the date of receipt or at any later specified time.
b. A Department Chairman or Member at Large may be removed for physical or mental impairment for failure to meet and carry out the requirements and responsibilities. Such removal may be affected by direct Board action or by secret vote by 2/3 of the attendees at a monthly or special Department meeting. Removal becomes effective when ratified by the Board.
c. Vacancy of the Department Chairman term shall be fulfilled by the the Member at Large. If this change should occur, the Department shall elect a new qualified physician to assume the remaining vacancy for the duration of the term.

4.2 Sections

At the request of the Department Chairman and on approval by the MEC, a group of physicians with common interests may be formed to meet together informally. Sections have no responsibilities or attendance requirements, but may be asked by the MEC or their department for assistance and input on certain matters such as delineation of privileges.

SECTION 5: COMMITTEES

5.1 MEC

5.1.1 Composition and duties in accordance with MS Bylaws section 7.1.

5.2 CREDENTIALS COMMITTEE

5.2.1 Composition

a. At least three Active Medical Staff Practitioners.
b. Appointed by the COS.
c. Term of two years.
d. COS designates Chairman who may be re-appointed.
e. No member may serve on the MEC simultaneously.
f. Must have been an Active Staff Practitioner for three years.
g. Chairman must have served on the Credentials Committee for two years previously.
h. Must have demonstrated ability and performance.

5.2.2 Duties

a. Reviews the credentials of all applicants.

b. Makes recommendations to the MEC and Board for appointments, reappointments, and delineation of Clinical Privileges for the Medical Staff and AHP.
c. Delineates Clinical Privileges for each category of the Medical Staff and AHP for approval by the MEC and Board.
d. Serves as investigative body:

    1. To assure that each Medical Staff Practitioner and AHP are acting within their delineated Clinical Privileges.
    2. May not discipline but reports to the MEC.
    3. Participates as indicated in Corrective Action of the Medical Staff Bylaws.

e. Investigates breach of ethics reported to the Committee and reports to MEC and Board.
f. Keeps in strict confidence all papers, reports and information obtained by virtue of membership on the committee.
g. Meets monthly or as often as necessary at a time determined by the Committee itself.
h. Maintains a permanent record of each meeting.

5.3 PERFORMANCE IMPROVEMENT COMMITTEE

a. ensures that when findings from the PI process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluation of a LIP's competence, in accordance with the standards on renewing or revising clinical privileges. See 2.4.3.
b. ensures that the findings, conclusions, recommendations, and actions taken to improve organizational performance are communicated to appropriate Medical Staff Practitioners.

5.3.1 Composition

a. Vice Chairman of Primary Care Department
b. Vice Chairman of Specialty Care Department
c. Pathologist
d. Physician appointed from each department
e. Immediate Past Chief of Staff (Chair)
f. PHO Medical Director
g. Quality Resources Director
h. Chief Nursing Officer
i. Pharmacy Director
j. Medical Information Director
k. Chief Operating Officer
l. Performance Improvement Manager

The CEO and current COS are ex-officio members.

5.3.2 Duties

a. To ensure the process measurement, assessment and improvement of Medical Staff Practitioners according to the hospital wide Performance Improvement plan as approved by the Medical Staff and Board include at least:

1. High risk operative invasive and non-invasive procedures.
2. Blood and blood components.
3. Medical assessment and treatment of patients.
4. Efficiency of Clinical Practice patterns.
5. Significant departure from established practice patterns.
6. Education of patients and families.
7. Coordination of Patient Care.
8. Medical Records review.
9. Pharmacy, therapeutics and medication use.
10. Peer review.
11. Autopsies.

b. Reports monthly to MEC. Reports quarterly to Board.
c. May not discipline but reports to the MEC.
d. Meets monthly or more often if necessary at a time determined by the committee itself.
e. Keeps permanent records of each meeting.

5.4 AD HOC COMMITTEES

The COS shall have the ability to appoint Ad hoc committees when appropriate to the operation of CRMC and the delivery of quality patient care.

5.5 ADDITIONAL COMMITTEES

5.5.1 Other standing committees may be formed as indicated by the COS with approval of the MEC and Board.

5.5.2 Appropriate policies and procedures shall be developed for these committees at that time.

5.6 Cardiovascular Controls Committee

The Cardiovascular Controls Committee shall be a sub-committee of the Specialty Care Department. It will report to the Medical Executive Committee through the Specialty Care Department.

5.6.1 Composition

The Committee shall be composed of all Active Staff Practitioners who hold credentials in invasive, interventional or surgical cardiovascular procedures at CRMC. The Chairman and Vice-Chairman of the Committee shall be elected by physician staff members of the

Committee. Administration shall be represented by one non-voting member approved by the Director of Quality Resources in conjunction with the Chief Operating Officer. Nursing Service shall be represented by non-voting members, as approved by the Chief Nursing Officer. Consulting physicians may serve as non-voting advisors to the Committee upon the request of the Committee and upon approval of the MEC.

5.6.2 Responsibilities and Duties

This committee shall provide recommendations to the Credentials Committee regarding threshold criteria for initial physician credentialing for invasive, interventional and surgical cardiovascular procedures at CRMC. The committee shall provide recommendations to the Credentials Committee regarding threshold criteria for re-credentialing of invasive, interventional and surgical cardiovascular procedures at CRMC. The committee shall provide physician specific clinical outcomes data to the Performance Improvement Committee with reference to procedures done at CRMC for quality improvement purposes. They shall review cost and utilization data, using benchmark data provided by the American Data Network and internal cost data, as it becomes available to ensure cost effective, quality health care at CRMC. Finally, the committee will address other business as deemed appropriate by the Committee.

5.6.3 Frequency

The committee meets at least quarterly or more frequently, as deemed necessary by the Chairman.

5.7 Mortality Committee

The Mortality Committee is responsible for reviewing all inpatient mortality cases, excluding those converted to hospice or comfort care status within twenty-four (24) hours of admission, identifying any potential process improvement opportunities, and analyzing preventable causes of death. Findings and recommendations should then be made to the Performance Improvement Committee.

5.7.1 Composition

The Committee shall be composed of the Director of Quality, an Emergency Room Physician, a Hospitalist, a General Surgeon, a Cardiologist, a resident physician, a clinical documentation integrity (“CDI”) specialist, and a member of the Coding Department.

5.7.2 Responsibilities and Duties

The Committee shall provide findings and recommendations to the Performance Improvement Committee regarding opportunities identified during review of mortality cases that occurred during hospitalization and

identified in this Section 5.7. If there is a question of an individual provider's care, the Committee will utilize the peer review process and forward the results of such peer review to the Performance Improvement Committee for further review and decision making.

5.7.3 Authority

The Committee will have the same authority as the Performance Improvement Committee to conduct investigation into mortality performance related issues.

5.7.4 Frequency of Meetings

The Committee meets at least once a month, or more frequently as determined by the Director of Quality.

SECTION 6: UTILIZATION

6.1 Utilization

Regulations regarding the utilization review and medical care evaluation procedures shall be in accordance with the conditions set forth by the Arkansas Foundation for Medical Care or other such QIO agency allowing for delegated status for CRMC.

There will be a Utilization Review (UR) Committee which operates via and reports regularly to the Performance Improvement (PI) Committee. The principal functions of the UR Committee will be to evaluate the care given to patients by CRHS and its Medical Staff with respect to a) the medical necessity of admission, b) the medical necessity of continued stay and c) the professional services provided, including drugs and biologicals, all as mandated by law. The composition and duties of the UR Committee will at all times comply with laws, rules and regulations that may from time to time be imposed by regulatory bodies/agencies with whom CRHS has operating relationships. Policies defining UR processes and functions will be developed by the UR Committee, updated and reviewed as needed (but at least yearly) and will be approved by the PI Committee, the MEC and the Board. The UR Committee will in fact operate as a part of the organized Medical Staff structure and will adhere to all Medical Staff Bylaws, Policies and Procedures and Rules and Regulations currently in effect.

6.2 Peer Review

6.2.1 Purpose

To ensure that the hospital, through the organized committees of its medical staff, assesses the performance of individuals granted clinical privileges and uses the results of such assessments to: (1) Improve the quality of care provided by individual physicians to patients of the hospital; (2) Monitor the performance of practitioners who have privileges; (3) Identify opportunities for performance improvement; and, (4) Monitor significant trends by analyzing aggregate data. All activities described in this Section and all reports, minutes, proceedings, records

and data generated thereby are absolutely privileged communications and not subject to discovery pursuant to Ark. Code Ann. §§16-45-105 and 20-9-503.

6.2.2 Definitions

6.2.2.1. Peer Review

Peer review is defined as the evaluation of an individual practitioner's professional performance and the identification of opportunities to improve care. Peer review differs from other quality improvement activities in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system. The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

6.2.2.2 Peer

Peer review of an individual practitioner's professional performance may be provided by any practitioner possessing similar credentials or who may be expected to have a reasonable level of competence in the subject matter under review.

6.2.3 General Procedure for Ongoing Peer Review

Peer review is conducted on an ongoing basis and reported to the PI committee for review. The process by which peer review takes place shall be as follows:

a. The Medical Information staff screen charts for peer review criteria during the coding process, and will notify staff from the Quality Resources Department if a chart meets peer review criteria. (Criteria are-updated and approved annually by the PI Committee and the Medical Executive Committee).

b. Charts that meet the peer review criteria are assigned to a physician reviewer by the Risk Manager or another member of the Quality Resources Department

c. Once assigned, a physician reviewer has two weeks to examine the case, document findings on the electronic Medical Staff Peer Review Form, and establish an overall Physician Care designation and a determination of potential harm related to physician care. The overall Physician Care designations are as follows:

- Care is Appropriate
- Issues Exist Regarding Care
- Care is Inappropriate or Deficient

- Unable to determine. Referral to Committee for review.

d. Along with the designations, the Physician Reviewer will include the issues identified as outlined on the Form.

e. If the Physician Reviewer selects any of the above other than “Care is Appropriate”, they will assign an actual or potential harm rating to the case as follows:

Actual Harm from Physician Care:

1. No actual patient harm from physician care
1. Actual minimal patient harm from physician care
2. Actual moderate patient harm from physician care
3. Actual severe patient harm from physician care

Potential Harm due to Physician Care:

1. No potential harm from physician care
1. Potential minimal harm from physician care
2. Potential moderate patient harm from physician care
3. Potential severe patient harm from physician care

f. If the Harm rating totals 1 or less, no further action is required. If the Harm rating totals 2 or greater, the review will be presented to the Performance Improvement Committee, which will forward to the Practitioner for a response if needed. All peer review forms are placed in the reviewed physician’s quality file.

g. If a response from the physician is required, the PI Committee will determine if the response will be received through discussion with a PI Committee Member, letter, or PI Committee appearance. Written responses must be received within two weeks of the reviewed physician's receipt of the findings to be considered. The reviewed physician’s response will be considered at the next regularly scheduled PI Committee meeting and a final recommendation will be made.

h. Review and follow-up is to be done in a timely fashion. Charts for which review or follow-up has been assigned for more than two weeks shall be counted as delinquent for the assigned physician until the review or follow up is complete.

i. Peer review information is then aggregated and considered at the credentials committee meeting at the time of reappointment.

6.2.4 Peer Review for Specific Circumstances

Additional evaluation will be conducted when a sentinel event or "near miss" is identified during concurrent or retrospective review or when an unusual clinical pattern of care is identified during a quality review. Peer review in such circumstances may be prompted by the Director of Quality Resources, the Chief

of Staff, the credentials committee, the medical executive committee or the board of directors. When peer review is deemed warranted, the process outlined above will be utilized with the exception of the fact that all such reviews will be brought before the PI committee as directed above.

6.2.5 Peer Review for Patient Complaints

Peer review is conducted for patient complaints filed through the Quality Resources department regarding the performance or behavior of a Practitioner. The process by which physician complaints are reviewed shall be as follows:

a. The physician will be sent a copy of the complaint and given the option of providing a response.
b. Complaints related to quality of care concerns will be reviewed as outlined in 6.2.3 General Procedures for Ongoing Peer Review.
c. Complaints and physician responses to complaints will be reviewed by the PI Committee.
d. Peer review information regarding physician complaints is then aggregated and considered at the Credentials Committee meeting at the time of reappointment.

6.2.6 Participants in the Peer Review Process

The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities.

In the event of a conflict of interest or circumstances that would suggest a biased review, the chief of staff or other medical staff officer operating on behalf of the chief of staff will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

6.2.7 External Peer Review

No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the PI committee. External peer review will take place under the following circumstances if and only if deemed appropriate by the governing body, medical executive committee, credentials committee, or PI committee:

a. When dealing with the potential for a lawsuit.
b. When dealing with vague or conflicting recommendations from the internal review process described herein and conclusions from this review will directly impact a practitioner's appointment or privileges.
c. When no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are partners, associates, or direct competitors of the practitioner under review. External peer review will take place if this

potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or Board of Directors.
d. When a Practitioner requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
e. When the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring.

If an external peer review is deemed necessary for any of the reasons stated above, the Risk Manager will assist in locating an external peer reviewer with the appropriate credentials and provide the information to the body or person delegated by the body for such purposes, to approve the external peer review selection. Input from the reviewed physician may be requested, but is not required in the selection of the external peer reviewer.

6.2.8 Other Considerations

a. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and discoverability.
b. Provider-specific peer review results will be used in the credentialing and privileging process and, as appropriate, in the performance improvement activities.
c. Provider-specific peer review and other quality information concerning a practitioner will be maintained in a secure, locked file. Provider-specific peer review information consists of information related to quality and utilization review data; adverse events or near misses; sentinel events; and correspondence to the physician regarding 43commendation, comments regarding practice performance, or corrective action.
d. Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as medical staff leaders or hospital employees. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:

1. Medical staff officers
2. Medical staff department chairs (for members of their departments only)
3. Members of the Medical Executive Committee, Credentials Committee, and the Performance Improvement Committee
4. Director of Quality Resources, or designated staff working on his/her behalf
5. Risk Manager
6. Medical Staff Coordinator

7. Individuals with a legitimate purpose for access as determined by the hospital's administration, medical staff leadership or Board of Directors.

No copies of peer review documents will be created and distributed unless authorized by hospital management.

6.3 Focused Professional Practice Evaluation (FPPE)

6.3.1 Purpose

To ensure the organized medical staff monitors and evaluates privileged practitioners for all initially requested privileges, for requests for additional privileges or upon identification of performance issues. This process, defined as Focused Professional Practice Evaluation (FPPE), will provide the foundation for obtaining privilege-specific competency.

6.3.2 Medical Staff Oversight

FPPE shall be consistently implemented in accordance with the criteria and requirements defined. The Credentials Committee shall oversee the proctoring process and ensure compliance with this policy. The Credentials Committee accomplishes this oversight by reviewing the proctoring reports for all practitioners, as well as dealing with any issues in implementing this policy.

The Monitoring Team involved with Ongoing Professional Practice Evaluation (OPPE) will provide the Credentials Committee with data collected for providers to confirm current competence during the FPPE period.

6.3.3 Scope

For the purposes of this policy, FPPE shall apply to all Medical Staff and certain Allied Health Professionals (AHP). The specific AHP providers include Podiatrists, Dentist, Nurse Practitioners, Certified Registered Nurse Anesthetists, and Physician Assistants. These individuals subject to this policy are referred to as Practitioners.

6.3.4 Definitions

6.3.4.1 Focused professional practice evaluation (FPPE) - is a time limited evaluation of a practitioner's competence in performing a specific privilege. This process is implemented for all initially requested privileges or upon identification of performance issues.

6.3.4.2 Proctoring - is an objective evaluation of a practitioner's current clinical competence by an experienced professional, possessing similar

credentials as the practitioner to be proctored, referred to as the Practitioner.

6.3.4.3 Monitoring Team - the following departments shall be defined as the monitoring team: Quality Resources, Health Information, Information Systems, and the Medical Staff and Credentialing Office.

6.3.4.4 Focused Review Plan - The specific methods and extent of evaluation for a privileged practitioner.

6.3.4.5 Proctoring Report Form - Criteria based form used by the proctor to evaluate a practitioner's specific competence and to provide findings to the organized medical staff. Proctoring may be performed by an external source when it is determined that there is no internal professional or the internal professional has a conflict of interest in performing the necessary proctoring.

6.3.4.6 Prospective proctoring - Presentation of planned cases with planned treatment outlined.

6.3.4.7 Concurrent proctoring (Direct Observation) - Real-time observation of a procedure. May also be used for real-time observation of the patient's clinical history and review of treatment orders.

6.3.4.8 Retrospective Evaluation (Chart Review) - Review of case record after the case has been completed.

6.3.5 Method of Review

Proctoring shall be the monitoring method used for determining competency. Information for the FPPE monitoring process may be obtained from the following sources:

- Retrospective review
- Prospective review
- Concurrent review
- External review
- Monitoring clinical practice patterns (performance feedback report)

Criteria to be considered when determining the monitoring method include documentation, procedural and cognitive skills. At minimum, a retrospective review of five cases over the first six (6) months will be the standard for all new Practitioners or Practitioners currently on staff requesting new privileges. The cases shall be representative of the newly appointed Practitioner's scope of practice or for Practitioners currently on staff, the newly requested privilege. In the opinion of the Credentials Committee, a concurrent review may be necessary for reasons such as education, training, and experience, or based on the type of privilege requested. The FPPE period may be extended by the Credentials Committee if initial concerns are raised that require further evaluation or there is

insufficient activity during the initial period. The total FPPE period should not exceed two six-month cycles.

When a Practitioner has insufficient (minimal) clinical activity at CRMC or does not have the type of clinical activity required to be proctored, the Credentials Committee may request verification of clinical activity from another facility with which the Practitioner is affiliated.

6.3.6 Triggers for Focused Review

Triggers that indicate the need for performance monitoring are as follows:

- All initially requested privileges after April 30, 2012 including new privileges requested by currently privileged practitioners;
- Peer Review findings that identify performance issues
- Insufficient activity to evaluate professional competence on an ongoing basis.

6.3.7 Notification to Practitioner

Each Practitioner that is the subject of FPPE shall be notified that such action has been initiated as soon as is reasonably practical. Such notification shall be in writing and shall inform the Practitioners of his right to seek legal representation and engage an attorney to advise and assist the Practitioner concerning any phase of FPPE.

6.3.7 Proctor Qualifications - if proctoring is required, the following guidelines should be used:

- Proctors must be Practitioners with active Staff appointment, in good standing.
- The Proctor must have unrestricted privileges to concurrently observe any procedure performed by the Practitioner being proctored.
- Proctors will be mutually agreed upon between the Credentials Committee and the Practitioner being proctored. Any perceived conflicts-of-interest should be addressed and resolved in writing.
- Proctoring will be assigned to a qualified physician of the same practice specialty. The Proctor may be a part of the same practice group as the Practitioner being proctored, should there be a need for this option. Serving as Proctor is considered to be a responsibility of every Practitioner.

6.3.9 Responsibilities

6.3.9.1 The Credentials Committee will develop a focused review plan based on the applicants experience and available data. Written communication shall be sent to the proctor and the practitioner to be proctored outlining the plan. The plan shall include:

- Who the proctor will be
- The method of review
- The duration of review
- The volume to be reviewed

6.3.9.2 It shall be the responsibility of the practitioner to be proctored to make every attempt to schedule surgery/procedures in cooperation with the proctor's schedule when concurrent proctoring is required. The practitioner to be proctored shall notify the medical staff office of the schedule developed to allow monitoring and tracking of progress. Upon notification of the scheduled cases, the medical staff office will forward the proctoring report forms to the proctor.

6.3.9.3 The Health Information Director will initiate monitoring of the practitioner's activity when the focused review calls for evaluation of the patient records. Once the activity report is compiled the Health Information Director will provide the data to the Medical Staff Coordinator who will then notify the Proctor of its availability and issue proctoring report forms for completion.

6.3.9.4 The Proctor will report findings to the Department Chair for the duration of the focused review period. Proctors may concurrently observe the procedure being performed, observe medical management, or retrospectively review the completed medical record following discharge and will complete appropriate forms.

The Proctor is not a supervisor or consultant. The Proctor does not have control as to the care being delivered, but may, as a colleague, make real time recommendations to the Practitioner being proctored. The Proctor is an agent of the hospital and shall not receive compensation for this service. The Proctor or any Practitioner should render emergency medical care to the patient for medical complications arising from the care provided by the proctored Practitioner.

The Proctor shall document findings on the approved proctoring report forms and make recommendation based on the mechanism of review. To ensure confidentiality, the Proctor is required to submit report forms directly to the Medical Staff Office.

If at any time the Proctor has concerns about the Practitioner's competency to perform specific clinical privileges or care related to a specific patient, the Proctor will promptly report findings to the Department Chair. One of the following may be recommended:

a. The department chair will intervene and mediate the conflict if the Proctor and Practitioner disagree as to what constitutes appropriate care for the patient.
b. The Quality Director and PI Chair may be consulted to review the case for possible peer review.

c. Additional or revised proctoring requirements may be imposed upon the Practitioner until the Proctor can make an informed judgment and recommendation regarding the performance of the Practitioner being proctored.

6.3.9.5 The Department Chair will review the proctor's assessment and report to the Credentials Committee. Considering the findings, at the end of the review period the Credentials Committee will make its recommendation to MEC to grant the privileges requested if the practitioner has demonstrated competence.

If the issue(s) related to FPPE is unresolved, the Credentials Committee may extend the review for an additional period or refer the matter to MEC. Written notification of review determinations shall be forwarded to the proctored practitioner upon approval of the Board of Directors. If the review is extended, such action shall not constitute an adverse action and does not entitle the Practitioner to any hearing or other appeal rights. If the result of the FPPE is that the requested privileges are not granted, the Practitioner is entitled to a hearing under the Medical Staff Fair Hearing Plan.

6.3.10 Confidentiality
The activities of the Focused Professional Practice Evaluation are considered privileged and confidential. Documentation of the focused review reports shall be kept in the practitioners Quality file.

6.4 Ongoing Professional Practice Evaluation (OPPE)

6.4.1 The hospital utilizes an ongoing professional practice evaluation process that allows for the identification of professional practice trends that impact quality of care and patient safety. Information from the OPPE is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of reappointment to the medical staff.

6.4.2 The process for ongoing professional practice evaluation shall follow:

a. An ongoing professional practice evaluation (OPPE) report will be completed every six months on every Active staff credentialed practitioner and upon each provider's reappointment.
b. Quality Resources reviews quality data for each provider and conducts chart reviews
c. For providers who practice in outpatient clinic settings belonging to CRMC – quality metric data should be sent to the Quality Resources department to review and compile the aggregate data to present to Credentials
d. An OPPE summary report will be presented to the Credentials Committee for review. The report will be signed by the chair of the credentials committee after review of the OPPE data.

e. If a practice pattern presents a quality or safety issue, Credentials makes the determination on initiating a focused review process.

f. OPPE reports will be filed in the practitioner's confidential quality file.

6.5 Medical Staff Disclosure Policy

Policy for Disclosure of Unanticipated Outcomes and Adverse Events

6.5.1 Purpose

To provide a written Medical Staff Policy to assist Medical Staff, Nursing Staff and Ancillary Hospital personnel in the disclosure of potential adverse medical events during a patient’s treatment at Conway Regional Medical Center including hospitalization, surgical, medical or other procedures.

6.5.2 Definition

An adverse event is any untoward incident, therapeutic misadventure, iatrogenic injury, or other undesirable occurrence directly associated with care or services provided within the jurisdiction of Conway Regional Medical Center.

6.5.3 Policy

It is the policy of the Medical Staff of Conway Regional Medical Center and the Hospital to provide quality medical care to the patients and the communities they serve. There are, however, occasions in which patients are harmed rather than helped by the system. The Medical Staff at CRMC is committed to respecting the rights of patients and their families to be fully informed if such an event occurs. It is the right and responsibility of the Attending Physician to lead the process of disclosure with the assistance of the Quality and Risk Management departments, any reported incident will be investigated completely and candid disclosure to the patient and family will occur.

Patients and their representatives will be informed as soon as possible of any potential adverse event. The physician will lead the disclosure effort if at all possible. In the event that the physician is unable or unwilling to participate, he/she may designate a person to represent them in any discussions. They should realize there will be instances in which they do not consider the event significant and must understand that others involved may differ. Any and all communication regarding any such event must be documented either in the patient’s progress note or in separate communication. The physician and hospital representative(s) should all attempt to be present during any conversations with the family or patient.

Adverse event requiring consideration of disclosure include any occurrence that has resulted in or its expected to result in harm to the patient, require additional hospital stay, extra surgical procedure or extra testing that would otherwise not be required. Examples include the following: *Any Sentinel Event as defined in the Administrative Policy F7*

6.5.4 Procedure

a. Adverse events that may require disclosure should be immediately reported to the house supervisor on duty. The house supervisor will assist the physician in obtaining any additional information needed to determine if the situation warrants immediate notification of the Risk Manager, Director of Quality Resources, Chief of the Medical Staff, and/or Administrator on Call.
b. In the event the attending physician is involved, he/she may notify the Risk Manager or above medical staff or administrative officers directly if they deem it necessary.
c. The Attending Physician, Risk Manager and/or the Quality Director(or Designee) have the primary responsibility for determining that an adverse patient event may necessitate disclosure and initiate the process leading to disclosure.
d. The attending physician is encouraged to take the lead in making the disclosure. If the attending physician is uncomfortable or unwilling to make the disclosure, an alternate shall be jointly selected by the Attending Physician and Risk Manager or Quality Director.
e. During the initial disclosure the physician or designee will provide preliminary factual information to the extent known, express concern for the patient's welfare and reassure the patient and family that steps are being taken to investigate the occurrence, remedy the injury and prevent further harm. This discussion should ideally include both the physician and a hospital representative. Documentation should occur in the form of a progress note or supplemental dictation.
f. The Risk Manager along with the Attending physician will jointly oversee any investigation into the event. If needed the Chief Medical Officer or Chief of Staff will participate to the degree needed. If there is any disagreement among the parties to the significance of the event, these individuals will meet to discuss the issues.
g. Should the patient be incapable of comprehending the disclosure, the patient's family, guardian or power of attorney for healthcare should be informed. Appropriate documentation reflecting a guardianship or power of attorney for healthcare should be obtained prior to making any disclosure.
h. Discussions with the patient/family may be held following in-depth investigation of the event. The primary purpose of this communication is to provide a more complete description of the events that occurred and the nature of any system changes needed to address them. These discussions will be coordinated through the Quality Resources Department.

i. Information regarding any possible event shall not be communicated to the public, media representatives or legal counsel regarding any aspect of the event or the patient's outcome without approval and involvement of the Chief Medical Officer, Chief of the Medical Staff and the Chief Executive Officer of the Conway Regional Medical Center. This does not preclude any notification by the physician of his/her legal counsel deemed necessary of helpful.
j. This policy will be reviewed biannually and amended as recommended by the Medical Staff of Conway Regional Medical Center and shall be congruent with the Administrative Disclosure Policy of the Medical Center proper.

SECTION 7: IMPAIRED PRACTITIONERS, DISRUPTIVE CONDUCT AND SEXUAL HARASSMENT

7.1 IMPAIRED PRACTITIONERS

7.1.1 DEFINITION

An Impaired Practitioner is one who is unable to practice his profession with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs including alcohol, or otherwise impaired

7.1.2 HEALTH ASSISTANCE AND REHABILITATION

7.1.2.1 Purpose.

CRMC and the Medical Staff have identified the need to provide Practitioners with an opportunity for assistance in prevention of illness and impairment and for support during rehabilitation of illness or stress prior to those conditions causing actual impairment in the ability to provide Quality Patient Care. A process that provides such opportunity will serve to aid and nurture a Practitioner in retaining his ability to function at an appropriate professional level prior to and during periods of illness or stress that do not rise to the level of impairment required for disciplinary action and necessary for the protection of patients. By supporting Practitioners in the retention of professional skills and abilities, this process will enhance continuity of patient care, avoid unnecessary duplication of effort, bolster overall morale within the Medical Staff and adjoining communities, and promote a spirit of cooperation.

7.1.2.2 Education.

CRMC and Medical Staff will provide educational programs for the Medical Staff and other CRMC personnel pertaining to this Rule and the identification, recognition and prevention of conditions of individual Practitioner health that could lead to illness or impairment. Records of

such educational programs will be maintained. If no internal educational program is available, a referral to outside programs will be made.

7.1.2.3 Identification.

7.1.2.3.1 A Practitioner who believes himself to be in need of assistance or supportive rehabilitation in order to prevent illness or impairment or in order to retain the ability to function at an appropriate professional level is encouraged to immediately report to the Chief of Staff, the Chief Executive Officer or their designee his need for assistance and/or support.

7.1.2.3.2 Practitioners and CRMC personnel who believe a Practitioner to be in need of assistance or supportive rehabilitation in order to prevent the Practitioner's illness or impairment or in order to retain or regain the Practitioner's ability to function at an appropriate professional level are encouraged to report such need for assistance and/or support to the affected Practitioner either orally or in writing. Such report shall encourage the Practitioner to make a report under **Rule 7.1.2.3.1**.

7.1.2.3.3 Should any practitioner attempt to perform any surgical procedure when, in the opinion of the Director of Surgical Services or OR Coordinator assigned to the Conway Regional Health System Medical Staff Rules and Regulations Policies and Procedures case, such practitioner's physical or mental capabilities are impaired, for any reason, then such Director or Coordinator shall immediately cancel such surgery and notify the Chief of Staff or Chief Executive Officer.

7.1.2.3.4 Reports made under **Rule 7.1.2.3.1** shall be evaluated for credibility through an informal interview with the Practitioner and other informal interviews as necessary.

7.1.2.3.5 Any actions taken by the Chief of Staff, Credentials Committee Chairman or their designee under this Rule shall be considered to be actions of the Credentials Committee. The Chief of Staff, the Chief Executive Officer or their designee shall make regular reports to the Credentials Committee of actions taken under this Rule.

7.1.2.4 Management.

7.1.2.4.1 In accordance with the needs of the Practitioner reported under **Rule 7.1.2.3**, the Chief of Staff, the Chief Executive Officer or their designee shall assist such Practitioner as follows:

7.1.2.4.1.1 with a referral to an independent Practitioner for assistance with prevention of illness or potential impairment;

7.1.2.4.1.2 with assistance in locating a suitable Practitioner for diagnosis and/or treatment of the conditions of illness or stress potentially leading to impairment;

7.1.2.4.1.3 with assistance in locating a suitable program for supportive rehabilitation under this Rule.

7.1.2.4.2 The Chief of Staff, the Chief Executive Officer or their designee may provide that any Staff Practitioner reported under **Rule 7.1.2.3**, and such Practitioner's patients, may be monitored as required by the Practitioner's potential illness or impairment until such time as the potential illness or impairment has been abated in a satisfactory manner. In determining the most appropriate method of Practitioner and patient monitoring, patient care interests shall be paramount.

7.1.2.4.3 While this Rule is designed to function outside the Medical Staff disciplinary process, any person working in CRMC or on its staff who has a reasonable belief that a Practitioner, who appears in CRMC with the intention of participating directly or indirectly in patient care, seems to be impaired shall immediately report such Practitioner as provided in **Rule 7.1.3**.

7.1.2.5 Confidentiality.

7.1.2.5.1 Actions taken under this Rule shall be confidential except as:

7.1.2.5.1.1 Provided by law;

7.1.2.5.1.2 Ethical obligation;

7.1.2.5.1.3 When a patient's safety is in immediate jeopardy; or

7.1.2.5.1.4 When necessary to reduce the likelihood of injury or damage to the

health or safety of any patient, employee or other person present in CRMC.

7.1.2.5.2 All requests for confidential information, outside the purview of the Medical Staff Rules and Regulations, concerning a Practitioner who has been reported under this Rule shall be referred to the Chief Executive Officer.

7.1.2.5.3 In order to effectively implement this Rule, all persons should avoid speculation, conclusion, gossip and any discussion of specific matters reported under this policy with anyone outside those described in this Rule.

7.1.3 IMMEDIATE ACTION.

Pursuant to the **Section 5.2** of the Medical Staff Bylaws, the Credentials Committee has the authority to summarily suspend the Clinical Privileges of a Practitioner whenever such action must be taken immediately to protect the life of any patient or to reduce the likelihood of injury or damage to the health or safety of any patient, employee or other person present in CRMC. Since instances may occur where convening the entire committee may be impractical, and in the interest of time and immediate action, the authority of the Credentials Committees to impose summary suspension (subject to subsequent ratification by the Credentials Committee) is delegated to any two of the following individuals: the Chief of Staff, the Chair of any Department, and the Chief Executive Officer.

In this regard, should any Practitioner appear in CRMC with the intention of participating directly or indirectly in patient care, and in the opinion of CRMC staff or a fellow Practitioner, the Practitioner appears at that time to be impaired in his capacity to render patient care then the following steps should be taken:

7.1.3.1 The Chief of Staff, or the appropriate Chair of a Department, should be notified and asked to come to CRMC, meet with the Practitioner immediately and assess the situation.

7.1.3.2 If in the Chief or Chair's opinion any question of impairment through drug or alcohol impairment exists, drug and urine samples should be immediately obtained under direct supervision of the Chief or Chair and subsequently evaluated for possible mood-altering substances. If a medical problem is believed to be present, the appropriate evaluation will be requested.

7.1.3.3 Practitioners are required to cooperate with the testing and evaluation described above. Failure to comply shall be grounds for summary suspension and for subsequent termination of Staff Appointment and Clinical Privileges.

7.1.3.4 Based on the Chief's or Chair's assessment of the situation, summary suspension pursuant to **Section 5.2** of the Medical Staff Bylaws may be appropriate.

7.1.4 REPORT & INVESTIGATION

If any individual working in CRMC or on its staff has a reasonable belief that a Practitioner is an Impaired Practitioner, the following steps should be taken:

7.1.4.1 A report, preferably in writing, should be given to the Chief of Staff or the Chief Executive Officer. The report shall include a description of the incident(s) that led to the belief that the Practitioner may be impaired. The report must be factual. The individual making the report does not need to be able to prove the impairment, but must state the facts leading to his belief. Ideally, the report shall include dates, times, the specific concerns/observations, witnesses to the possible impaired behavior and any other facts believed helpful to evaluators.

7.1.4.2 After discussing the incident(s) with the individual who filed the report, if any one of the persons named above who receives the report believes there is enough information to warrant an investigation, he shall so advise the Credentials Committee.

7.1.4.3 The Credentials Committee shall either investigate the matter itself or direct that an investigation be conducted and a report thereof be rendered by:

7.1.4.3.1 A standing committee of the Medical Staff; or

7.1.4.3.2 An outside consultant; or

7.1.4.3.3 Another individual or individuals appropriate under the circumstances.

7.1.4.4 As a part of its investigation, the Credentials Committee, in its sole discretion and without triggering any rights under **Article Six** of the Medical Staff Bylaws, may require the Practitioner to undergo a mental and/or physical health assessment by a Physician or at a facility selected by the Credentials Committee and under such circumstances (including direct reporting back to the Credentials Committee or its designee) as the Credentials Committee may establish. Failure or refusal of the affected

Practitioner to cooperate with the assessment may constitute grounds for denial of an application or reapplication or for corrective action. The results of such examination shall be reported to the Credentials Committee and shall at a minimum address:

7.1.4.4.1 Whether the Practitioner has the ability to continue to provide Quality Patient Care and to otherwise meet the qualifications and fulfill the responsibilities of Staff Appointment and the specific Clinical Privileges granted him;

7.1.4.4.2 Whether such ability is compromised by reason of illness, the use of alcohol, drugs, narcotics, chemicals or other substances, or as a result of any mental or physical condition; and

7.1.4.4.3 Whether there should be any restriction, limitation or consultation requirement placed upon the Practitioner's Staff Appointment or Clinical Privileges as a result of any such illness, use or condition.

7.1.4.5 If, after the investigation, it is found that sufficient evidence exists that the Practitioner is impaired, the Chairman of the Credentials Committee shall meet personally with the Practitioner or designate another appropriate individual to do so.

7.1.4.6 The Practitioner should be told that the results of an investigation indicate that he suffers from an impairment that affects his practice. The Practitioner should not be told who filed the report, but may be told of the general nature of the specific incidents contained in the report.

7.1.4.7 Depending upon the severity of the problem, and the nature of impairment, the Credentials Committee, subject to appropriate hearing and appellate review procedures, has the following options (which are not to be mutually exclusive):

7.1.4.7.1 Require the Practitioner to undertake a rehabilitation program as a condition of continued Staff Appointment and Clinical Privileges;

7.1.4.7.2 Impose appropriate restrictions on the Practitioner's practice;

7.1.4.7.3 Immediately suspend or restrict the Practitioner's privileges in the Medical Center until rehabilitation has been accomplished.

7.1.4.8 The original report and a description of the actions taken by the Credentials Committee should be included in the Practitioner's personnel file. If the investigation reveals not only that no action should be taken on the report but also that there is no merit to the report, the report should be destroyed unless a Federal or state statute or rule or regulation promulgated thereunder requires otherwise. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the Practitioner's personnel file and the Practitioner's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

7.1.4.9 Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy, the matter being confidential except to the extent that disclosure is required by Federal or state law, rule or regulation.

7.1.4.10 In the event of any apparent or actual conflict between this **Section Seven** and the Medical Staff Bylaws, the provisions of the Medical Staff Bylaws shall control.

7.1.5 REHABILITATION

If warranted, CRMC and Medical Staff leadership should assist an Impaired Practitioner in locating a suitable rehabilitation program. An Impaired Practitioner shall not be reinstated until it is established, to the Credentials Committees satisfaction, that the Practitioner has successfully completed a program in which the Credentials Committee has confidence.

7.1.6 REINSTATEMENT

Upon sufficient proof that a Practitioner who has been found to be suffering an impairment has successfully completed such a rehabilitation program, the Credentials Committee, in its discretion, should, but need not, consider that Practitioner for reinstatement to the Medical Staff.

7.1.6.1 In considering such a Practitioner for reinstatement, the Credentials Committee must consider patient care interests to be paramount.

7.1.6.2 The Credentials Committee should obtain at least a letter from the Physician director of the rehabilitation program where the Practitioner was treated. The Practitioner must authorize the release of this information. That letter shall state:

7.1.6.2.1 Whether the Practitioner is participating in the program;

7.1.6.2.2 Whether the Practitioner is in compliance with all of the terms of the program;

7.1.6.2.3 Whether the Practitioner attends support group meetings regularly (if appropriate);

7.1.6.2.4 To what extent the Practitioner's behavior and conduct are monitored;

7.1.6.2.5 Whether, in the opinion of those doctors, the Practitioner is rehabilitated;

7.1.6.2.6 Whether an after care program has been recommended to the Practitioner and, if so, a description of the after care program;

7.1.6.2.7 Whether, in his opinion, the Practitioner is capable of resuming medical practice and providing continuous, competent care to patients; and

7.1.6.2.8 Other information relevant to the Practitioner's present ability to render Quality Patient Care to his patients.

7.1.6.3 The Practitioner must inform CRMC of the name and address of his primary care Physician, and must authorize that Physician to provide CRMC with any information regarding his physical or mental condition and treatment. CRMC has the right to require an opinion from other Physician consultants of its choice.

7.1.6.4 From the primary care Physician, CRMC needs to know the precise nature of the Practitioner's condition, and the course of treatment as well as the answers to the questions posed above in **Rules 7.1.6.2.5** and **7.1.6.2.7**.

7.1.6.5 Assuming all of the information received indicates that the Practitioner is rehabilitated and capable of resuming care of patients, the Credentials Committee should take the following additional precautions when restoring Clinical Privileges:

7.1.6.5.1 The Practitioner should identify two Physician Practitioners who are willing to assume responsibility for the care of the Practitioner's patients in the event of his inability or unavailability to care for and treat his patients.

7.1.6.5.2 The Practitioner should be required to obtain periodic reports (at least quarterly) for CRMC from his primary Physician -- for a period of at least one year -- stating that the Practitioner is continuing treatment or therapy, as appropriate, and that his ability to treat and care for patients in CRMC is not impaired.

7.1.6.6 The Practitioner's exercise of Clinical Privileges in CRMC shall be monitored by the Chief of Staff or by a Practitioner appointed by the Chief of Staff. The nature of that monitoring shall be determined by the Chief of Staff after consultation with the Credentials Committee.

7.1.6.7 The Practitioner must agree to submit to alcohol or drug screening test (if relevant to the impairment) on terms prescribed by the Credentials Committee.

7.1.6.8 All requests for confidential information concerning a Practitioner who has been determined to be an Impaired Practitioner should be referred to the Chief Executive Officer.

7.2 DISRUPTIVE CONDUCT

7.2.1 BYLAW REQUIREMENT

The Medical Staff Bylaws require each Applicant and each Practitioner, at the time Staff Appointment and Clinical Privileges are granted and continuously thereafter, to demonstrate to the satisfaction of the Medical Staff and the Board, a willingness and capability based on current attitude and evidence of past performance:

7.2.1.1 To harmoniously work with and relate to other Practitioners, students, members of other health disciplines, CRMC administration and employees, visitors and the community in general, in the cooperative, professional manner that is essential for maintaining a hospital environment appropriate to Quality Patient Care;

7.2.1.2 To participate equitably in the discharge of Staff responsibilities;

7.2.1.3 To adhere strictly to all applicable ethical standards and principles; and

7.2.1.4 To avoid conduct which reflects adversely on the Applicant or Practitioner's professional fitness.

7.2.2 DISRUPTIVE CONDUCT PROHIBITED

Disruptive conduct is any activity that disrupts Practitioners, students, members of other health disciplines, CRMC administration and employees and the community in general from maintaining a hospital environment appropriate to Quality Patient Care. Disruptive conduct is prohibited.

7.2.3 EXAMPLES

Inappropriate disruptive conduct includes, but is not limited to:

7.2.3.1 Verbal or physical attacks leveled at other Practitioners, CRMC personnel, patients or others that are personal, irrelevant or go beyond the bounds of appropriate professional conduct;

7.2.3.2 Impertinent or inappropriate comments, notes, illustrations or other writings made in patient medical records or other documents;

7.2.3.3 Non-constructive criticism such as comments or criticism addressed in such a way as to intimidate, undermine confidence, belittle or imply stupidity or incompetence;

7.2.3.4 Refusal to accept Staff assignments or to participate in committee or optional clinical service affairs except on the Practitioner's terms or to do so in a disruptive manner;

7.2.3.5 Threats of violence or retribution, physical contact with others that is intimidating or threatening;

7.2.3.6 Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

7.2.4 DOCUMENTATION OF DISRUPTIVE CONDUCT

Practitioners, nurses and other hospital employees who observe behavior by a Practitioner which disrupts the smooth operation of CRMC, or jeopardizes patient care, should document the incident. The report should be submitted to the Chief Executive Officer or Chief of Staff. That documentation should include:

7.2.4.1 The date and time of the questionable behavior;

7.2.4.2 If the behavior affected or involved a patient in any way, the name of the patient;

7.2.4.3 The circumstances which precipitated the situation;

7.2.4.4 A description of the questionable behavior limited to factual, objective language as much as possible;

7.2.4.5 The consequences, if any, of the disruptive behavior as it relates to patient care or CRMC operations;

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

7.2.5 OPTIONAL INFORMAL DISCUSSION WITH PRACTITIONER.

In an informal attempt to deal with any reported incident, the Chief of Staff or the Chief Executive Officer, in lieu of, as an alternative to, or as a step preceding a formal request for corrective action under **Section 5.4** of the Medical Staff Bylaws may, in his sole discretion, discuss the matter informally with the Practitioner, emphasizing that the behavior is inappropriate and may subject the Practitioner to more formal action. If such informal discussion is held:

7.2.5.1 The initial approach should be collegial and designated to be helpful to the Practitioner.

7.2.5.2 It should be emphasized that if the behavior continues, more formal action will be taken to stop it.

7.2.5.3 The informal meeting should be documented.

7.2.5.4 A follow-up letter to the Practitioner should state that the Practitioner is required to behave professionally and cooperatively.

7.2.6 INITIATION OF FORMAL INVESTIGATION BY REQUEST FOR CORRECTIVE ACTION.

If the Chief of Staff or the Chief Executive Officer determines that a single incident or a pattern of disruptive conduct by a Practitioner may warrant corrective action, such person may initiate a formal investigation of the matter by the Staff Credentials Committee by making a Request for Corrective Action as described in **Section 5.4** of the Medical Staff Bylaws. Thereafter the procedures described in **Article Five** shall apply. Summary suspension pursuant to **Section 5.2** of the Staff Bylaws may also be appropriate.

7.3 SEXUAL HARASSMENT

7.3.1 SEXUAL HARASSMENT GENERALLY

Sexual harassment of any kind is unacceptable and will not be tolerated at CRMC. It is against the policies of CRMC for any Practitioner, male or female, to sexually or in any other way, harass another Practitioner, CRMC employee, patient or other person. Sexual or personal harassment is defined as:

7.3.1.1 Sexual advances including fondling, touching, patting, pinching or any other similar physical contact considered unacceptable by another individual;

7.3.1.2 Requests or demands for sexual favors, whether subtle or blatant, or whether in the form of pressure or request for any type of sexual favor accompanied by an implied or stated promise of preferential treatment or negative consequence concerning another person's employment status;

7.3.1.3 Verbal abuse or kidding that is sexually-oriented or personally directed and considered unacceptable by another individual, including comments about bodily appearance where such comments go beyond mere courtesy; "dirty jokes"; any other tasteless, sexually oriented comments, innuendos or actions that offend others; lewd pictures; or any type of conduct that tends to make employees of one gender "sex objects"; or

7.3.1.4 Engaging in any type of sexually-oriented or personally offensive conduct that would unreasonably interfere with another person's work performance.

7.3.2 CONDUCT NOT SEXUAL HARASSMENT

Normal, courteous, mutually respectful, pleasant, non-coercive interactions between men and women that are acceptable to both parties are not considered to be sexual or personal harassment.

7.3.3 REPORTS OF SEXUAL HARASSMENT

7.3.3.1 Complaints of sexual harassment regarding a practitioner, nurse or other hospital employee who observes or who has been the victim of sexual harassment must be made in writing. The complaints should include:

7.3.3.1.1 Date and time of the incident;

7.3.3.1.2 The name of the subject of the harassment;

7.3.3.1.3 A factual, objective description of the conduct;

7.3.3.1.4 The names of other individuals present when the incident occurred; and

7.3.3.1.5 Any action taken, including date, time, place, and name(s) of those intervening.

7.3.3.2 A report of sexual harassment regarding a CRMC employee will be processed in accordance with CRMC personnel policies.

7.3.3.3 A report of sexual harassment regarding a Practitioner that is filed by a CRMC employee should be submitted to the employee's supervisor, who shall forward it to the Chief Executive Officer. The report may be submitted directly to the Chief Executive Officer if the report concerns conduct by the supervisor or conduct that the employee believes is condoned by the supervisor.

7.3.3.4 A report of sexual harassment regarding a Practitioner that is filed by another Practitioner should be submitted directly to the Chief Executive Officer.

7.3.3.5 The Chief Executive Officer should immediately notify the Chief of Staff of the report.

7.3.4 MEETING WITH INDIVIDUAL WHO FILED REPORT

The Chief Executive Officer should interview the individual who filed the report, and when possible, others who were present when the incident occurred.

7.3.5 MEETING WITH THE PRACTITIONER

7.3.5.1 If, after interviewing the individual who filed the report and others who were present, the Chief Executive Officer determines that the report of sexual harassment is credible, the Chief Executive Officer should schedule a meeting with the Practitioner involved. At that meeting, the Practitioner should be advised of the nature of the complaint(s). The Chief Executive Officer may protect the identity of a complainant if, in the Chief Executive Officer's judgment, that is necessary and appropriate to do so.

7.3.5.2 The Practitioner should be given an opportunity to respond to the allegations.

7.3.5.3 If, at the conclusion of this meeting, it is believed that the alleged misconduct did, in fact, occur:

7.3.5.3.1 The Practitioner must be informed that the conduct is inappropriate will not be tolerated by CRMC;

7.3.5.3.2 It must be made clear that the offending behavior must cease and, if appropriate, an apology must be offered to the individuals involved; and

7.3.5.3.3 Further incidents of a similar nature will result in formal Medical Staff disciplinary action.

7.3.5.3.4 The meeting shall be documented.

7.3.6 INITIATION OF FORMAL INVESTIGATION BY REQUEST FOR CORRECTIVE ACTION

Without regard to whether the actions described in **Rules 7.3.3, 7.3.4**, and **7.3.5** above have been taken, if the Chief of Staff or the Chief Executive Officer determines that a single incident or a pattern of disruptive sexual harassment conduct by a Practitioner may warrant corrective action, such person may initiate a formal investigation of the matter by the Medical Staff Credentials Committee by making a Request for Corrective Action as described in **Section 5.4** of the Medical Staff Bylaws. Thereafter the procedures described in **Article Five** of the Medical Staff Bylaws shall apply. Summary suspension pursuant to **Section 5.2** of the Medical Staff Bylaws may be appropriate.

SECTION 8: PHYSICIANS' RIGHTS

8.1 Each Physician on the Medical Staff has the right to an audience with the MEC . In the event a Practitioner is unable to resolve a difficulty working with his/her respective Department Chairman, that Physician may, upon presentation of a written notice meet with the MEC to discuss this issue.

8.2 Any Practitioner has the right to initiate a recall election of a Medical Staff officer and/or Department Chairman. A petition for such recall must be presented, signed by at least 5 Active Staff Practitioners. Upon presentation of such valid petition, the MEC will schedule a special general staff meeting for the purposes of discussing the issue and (if appropriate) entertain a non-confidence vote.

8.3 Any Practitioner may call a Medical Staff meeting, upon presentation of a petition signed by 5 Active Staff Practitioners. The MEC will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

8.4 Any Practitioner may raise a challenge to any rule or policy established by the MEC. In the event a rule, regulation, or policy is felt to be inappropriate, any Physician may submit a petition signed by 5 Active Staff Practitioners. When such petition has been received by the MEC, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

8.5 Any section/sub-specialty group may request a Department meeting when a majority of the members/sub-specialists believe that the department has not acted in an appropriate manner.

8.6 This section is common to Sections 1 through 5 above. This section does not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges, or any other matter relating to individual "credentialing" actions. The Fair Hearing Plan provides recourse in these matters.

SECTION 9: ALLIED HEALTH PROFESSIONALS

9.1 Dependent Health Professionals (AHP-I)

9.1.1 Categories

a. Advanced Nurse Practitioner, Registered Nurse Practitioner, Certified Physician's Assistant
b. Registered Nurse
c. Certified Registered Nurse Anesthetist
d. Licensed Practical Nurse
e. Surgical Scrub Technician or Assistant, certified
f. Surgical Scrub Technician, not certified

9.1.2 Qualifications

a. Employee of the hospital or employee of a Medical Staff Practitioner.
b. Assumption by that Medical Staff Practitioner of the responsibility for all of the employee's actions with agreement to indemnify CRMC for all the employee's acts or omissions.
c. Demonstration of adequate education, training, licensure, certification, or experience to perform the requested Clinical Privileges.
d. Unlicensed Surgical Scrub Technicians must complete the required CRMC Surgical Services Training Program as described in the OR Policies & Procedures.

9.1.3 Clinical Activities

Written delineation of Clinical Activities for performance shall be developed by the Credentials Committee with approval of the MEC and Board.

9.1.4 Prerogatives

a. Shall not be appointed to the Medical Staff or have any rights of appointment.
b. Shall be evaluated by the Performance Improvement Committee.

9.1.5 Responsibilities

a. Provide specifically designated patient care services according to delineated Clinical Activities under the supervision of the sponsoring Medical Staff Practitioner.
b. Abide by the Bylaws, Policies & Procedures and Rules and Regulations of the Medical Staff and CRMC.
c. Prepare and complete accurate and timely medical and other records in accordance with delineated Clinical Activities.

9.1.6 Application and duration of Clinical Activities

a. Application for appointment and delineation of Clinical Activities shall be processed in accordance with the same procedure set for the Medical Staff.
b. Six (6) month provisional period at initial appointment shall also apply.
c. Duration of appointment and Clinical Activities shall be no longer than 24 months.

9.1.7 Denial, termination, or suspension of appointment and Clinical Activities.

a. Occurs when the appointment of the Medical Staff Practitioner is terminated whether such termination is voluntary or involuntary.
b. Occurs when AHP ceases to be the employee of the sponsoring Medical Staff Practitioner.
c. Occurs when the license or certification, if applicable, expires, is revoked or suspended.

9.1.8 Corrective Action

Applicants and appointees in AHP-I are entitled only to the procedural rights in Section 6.15 of the Fair Hearing Procedure.

9.2 Consulting Health Professionals (AHP-II)

9.2.1 Categories

a. Clinical Psychologist
b. Podiatrist
c. Certified Prosthetist, Certified Orthotists

9.2.2 Qualifications

a. Shall not be an employee of a Medical Staff Practitioner.
b. Shall show evidence of adequate education, training, licensure or certification to perform the requested Clinical Activities.

9.2.3 Delineation of Activities

.Written delineation of Clinical Activities for performance shall be developed by the Credentials Committee with approval of the MEC and Board.

9.2.4 Prerogatives

a. Shall not be appointed to the Medical Staff or have any rights of appointment.
b. Shall be evaluated by the Performance Improvement Committee.

9.2.5 Responsibilities

a. Provide specifically designated patient care services according to delineated Clinical Activities under the supervision of the sponsoring Medical Staff Practitioner.
b. Abide by the Bylaws, Policies and Procedures and Rules and Regulations of the Medical Staff and CRMC.
c. Prepare and complete accurate and timely medical and other records in accordance with delineated Clinical Activities.

9.2.6 Application and duration of Clinical Activities

a. Application for appointment and delineation of Clinical Activities shall be processed in accordance with the same procedure set for the Medical Staff.
b. Six (6) month provisional period at initial appointment shall also apply.
c. Duration of appointment and Clinical Activities shall be no longer than 24 months.

9.2.7 Denial, termination or suspension of appointment or Clinical Activities.

Occurs when the license or certification expires, is revoked or suspended.

9.2.8 Corrective Action

Applicants and appointees in AHP-II are entitled only to the procedural rights in Section 6.15 of the Fair Hearing Procedure.

9.3 CRMC Employed or Contracted Dependent Health Professionals (AHP III)

9.3.1 Categories

a. Dependent AHP required by law to be credentialed by the Medical Staff
b. Dependent AHP employed or contracted by CRMC and not working under a job description.

9.3.2 Qualifications

a. Not an employee of a Medical Staff Practitioner.
b. Employee of CRMC or employee of a contracted service of CRMC.
c. Have sponsoring Physician who is a Medical Staff Practitioner.
d. Show evidence of adequate education, training, licensure, certification, or experience to perform the requested Clinical Privileges.

9.3.3 Delineation of Clinical Privileges

Written delineation of Clinical Privileges shall be developed by the Credentials Committee with the approval of the MEC and Board.

9.3.4 Prerogatives

a. Shall not be appointed to the Medical Staff or have any rights of appointment.
b. Shall be evaluated by the Human Resources Department of CRMC or Medical Staff Office.

9.3.5 Responsibilities

a. Provide specifically designated patient care services according to delineated Clinical Privileges under the supervision of the sponsoring Medical Staff Practitioner.
b. Abide by the Bylaws, Policies and Procedures and Rules and Regulations of the Medical Staff and CRMC.
c. Prepare and complete accurate and timely medical and other records in accordance with delineated Clinical Privileges.

9.3.6 Application and Duration of Clinical Privileges

a. Documents necessary for credentialing are copy of current contract, copy of current malpractice insurance with appropriate limits, copy of job description, copy of performance evaluation, current ability to perform statement, current TB skin test, proof of education and current competency and copy of professional license as applicable.

   The Medical Staff Coordinator will assemble the Credential file for Allied Health-III professionals and verify professional licenses as appropriate. All information in folder will be updated bi-annually every 24 months. Allied Health-III professionals will be reported to the Board every 24 months for approval.

   If the AHP-III practitioner leaves employment of the contracted service, privileges at CRMC will be terminated.

b. Six (6) month provisional period at initial appointment shall also apply.
c. Duration of appointment and Clinical Privileges shall be no longer than 24 months.

9.3.7 Denial, termination or suspension of appointment or Clinical Privileges

Occurs when the license or certification expires, is revoked or suspended.

9.3.8 Corrective Action

Applicants and appointees in AHP III are entitled only to the procedural rights of Section 6.15 of the Fair Hearing Procedure.

9.4 Observation

RNP, RN, LPN, and Medical Students may, at the request and under the supervision of a Medical Staff Practitioner, be given permission for observation on patient rounds, surgery and other procedures.

9.5 Additional Classes of Professionals

Additional classes of professionals may be established in any classification or category upon recommendations by the Credentials committee with approval of the MEC and Board.

SECTION 10: MEDICAL RECORDS

10.1 Completed Records. Completion of medical records will be in compliance with Federal and State regulations. The responsibility for preparation and completion of the medical record rests solely with the Physician/Practitioner providing care to the patient, and no record shall be considered complete until dated, time and authenticated by the Physician's/Practitioner's signature. Such signature shall be considered Physician's/Practitioner's acknowledgement that the record is complete. All entries are written or, in the case of dictation, transcribed and inserted in the medical record, and all clinical entries in the patient's medical record shall be current, complete, accurate, legible, pertinent, accurately timed, dated and authenticated. Medical Records may only be amended upon showing of just cause by the Physician/Practitioner.

10.2 Medical Record Contents. The attending physician shall be responsible for the preparation of the complete and legible medical record for each patient he admits to CRMC. The content of the record shall be pertinent and current. The following items constitute those for which the physician is primarily responsible:

a. Admitting diagnosis

b. Medical history – history of present illness, review of systems, past medical history, family history and social history.
c. Physical examination – provisional diagnosis, assessment, plan, including statement of conclusions and impressions drawn from the physical examination.
d. Special reports such as consultations, anesthesia reports, operative reports, pathology reports.
e. Diagnostic and therapeutic orders
f. Evidence of appropriate informed consents
g. Reports of procedures, tests, and results
h. Progress notes, including response to care and reassessments, when necessary.
i. Every medication ordered for, prescribed for, or dispenses to any patient and the dosage of and, if any, adverse reaction to the medication.
j. Summary list of diagnosis, procedures, ICD-9 CM.
k. Autopsy report when autopsy performed.
l. Appropriate documentation of use of restraints, when applicable.
m. Authentication by date, time and signature of the attending Physician/Practitioner.

10.3 History and Physical. Unless specified otherwise by written order, the physician admitting a patient will be considered the attending physician and will be responsible for the history and physical and completion of the medical record.

A completed history and physical examination is required to be recorded in the medical record within twenty-four (24) hours after an admission of a patient to the hospital and pre-operatively on all non-emergent invasive procedure cases. History and physical examinations may be completed up to thirty (30) days prior to admission if the physician updates the examination at the time of admission and before surgical procedures. This update must document any changes in the patient's status and confirm the continued necessity for care or the planned procedure.

These reports shall include all pertinent history and physical findings resulting from an assessment of all body systems. In addition:

a. Newborn physical exams shall be completed and documented within twenty-four (24) hours of birth and at time of discharge and/or transfer.
b. A dental history by the consulting dentist or oral surgeon will be required on all dental patients.
c. An oral surgeon who admits a patient may complete an admission history and physical and assess the medical risks of the procedure if credentialed to do so.
d. Podiatrists and dentists shall complete a consultative report of their history and findings, operative note and a summary of diagnoses and procedures on outpatients.
e. Pre-operative History and Physicals in a dictated or written short form must be on the patient's chart before non-emergent surgery/procedure begins. Pre-operative H&Ps written on the progress note is acceptable,

however, a notation in the progress notes that the H&P has been dictated is not acceptable.

The Physician will be responsible for the final completion of the medical record on inpatients and/or countersign the summary of diagnoses and procedures.

Any Practitioner who admits a patient from his office and who provides signed, dated and time orders and an admission or observation note indicating that the patient has been examined by the admitting Practitioner shall be considered to have met the requirements of Rule 10.4.

10.4 Outpatient Procedures. All outpatient surgical procedures or invasive diagnostic procedures performed under general, regional, or spinal anesthesia or moderate sedation will have a History and Physical completed prior to the procedure by the staff physician doing the procedure. A short form History and Physical may be done where appropriate.

Outpatient procedures defined as minimally invasive, requiring less than moderate sedation, will require a targeted exam and pre-procedure note pertinent to the procedure being done. An assessment will be done by the physician performing the procedure that may include a review of the history of the current condition requiring the diagnostic procedure, the patient's recent history of cardiac and respiratory illness, current medications, allergies and any pertinent lab work prior to the procedure being done.

A preoperative diagnosis is recorded before surgery by the licensed independent practitioner responsible for the patient.

A detailed report of the procedure will be dictated or handwritten by the physician doing an outpatient surgical procedure or an invasive or noninvasive diagnostic procedure immediately following the procedure and must be signed within seventy-two (72) hours of the time of the procedure.

When the history and physical examination (or an update note as required by Rule 10.4) has not been written or transcribed and placed in the patient's chart before an operation or high-risk procedure, the operation or procedure shall be canceled, unless, in an emergency situation, the Physician documents an abbreviated physical examination and states in writing in the progress notes why such delay would be detrimental to the patient.

10.5 Progress Notes. Progress notes shall be recorded which give a pertinent clinical report of the patient's course in CRMC and should reflect any change in condition and results of treatment. Whenever possible, each of the patient's clinical problems should be identified in the progress notes and correlated with specific orders as well as the results of tests and treatment. Progress notes shall be written on all patients admitted to CRMC every twenty-four (24) hours, except the inpatient behavioral health unit where progress notes by the attending psychiatrist are required a minimum of five (5) days per week. On short stay patients not requiring a discharge summary, a brief discharge note should be entered on the progress notes at time of

discharge in lieu of a discharge summary stating the final impression, the treatment upon discharge and follow-up plan. Death notes should be written on all patients who die in CRMC stating the probable cause of death, contributing factors, treatment immediately prior to death, whether or not resuscitation was attempted and whether autopsy was requested and/or performed. Documentation regarding donation of organs or tissue shall be in accordance with organ and tissue donation policies.

10.6 Operative Progress Note. An Operative Progress Note must be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. The Postoperative documentation should include at least any unusual events or postoperative complications, including blood transfusion reactions, and the management of those events. Immediately is defined as "Before the patient transfers to the next level of care."

The minimum required elements include: the name of the primary surgeon and assistants, procedures performed and description of each procedure findings, any estimated blood loss, any specimens removed, and the post-operative diagnosis.

Operative reports shall be dictated within twenty-four (24) hours following surgery and should be signed by the surgeon within seventy-two (72) hours of the procedure. Physicians with incomplete reports twenty four (24) hours following the day of the surgery will be unable to schedule subsequent elective procedures until such operative reports are dictated.

Operative reports shall include a preoperative and postoperative diagnosis and listing of procedures performed. The report shall contain a description of the findings, the technical procedures used, the specimens removed and the name of the primary surgeon and any assistants.

10.7 Anesthesia Records. Anesthesia records shall include a pre-anesthetic evaluation and documentation of all pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood components. A specific consent for anesthesia shall be obtained from the patient or next of kin and documented prior to the surgery/procedure to be performed, except in cases of emergency. Such anesthesia consents from the patient or next of kin shall be obtained by the anesthesia Practitioner and documented appropriately and shall include the disclosures communicated to the patient. The anesthesiologist will countersign the pre-anesthetic evaluation, anesthesia record and post anesthesia discharge when completed by a CRNA. Post anesthetic recovery room discharge is by criteria (see PACU P&P) and signed by an anesthesiologist and is documented on the anesthetic record.

10.8 Dental and Podiatric Records. A patient admitted for oral surgery, dental or podiatric care is a dual responsibility of the dentist, oral surgeon, or podiatrist and a physician Practitioner with active staff appointment, as follows:

a. Dentist's, Oral Surgeon's, or Podiatrist's responsibilities

1. A detailed dental/podiatric history justifying hospital admission.
2. A detailed description on the examination of the operative area and a preoperative diagnosis and planned procedure.
3. A complete operative report describing the findings and the techniques used. In cases involving extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including (at the request of the surgeon) teeth and fragments, shall be sent to CRMC pathologist for examination.
4. Progress notes as are pertinent to the type of surgery performed.
5. Clinical resume (summary).
6. Oral surgeons may do history & physical examinations.

b. Physician's responsibilities:

1. Medical history pertinent to the patient's general health.
2. An appropriate pre-operative physical examination to determine the patient's condition prior to anesthesia and surgery.
3. Supervision of the patient's general health status while hospitalized.
4. Discharge of the patient

10.9 Obstetrical Records. The current obstetrical record shall include a complete prenatal record. Such prenatal record may be a legible copy of the attending physician's office record transmitted to CRMC before admission, but an interval admission note to include pertinent additions to the history and physical examination must be recorded prior to delivery. In the event a Cesarean section or postpartum surgical procedure is performed a complete history and physical examination will be required prior to surgery.

10.10 Emergency Care Documentation. An appropriate medical record shall be kept for every patient receiving care in the emergency department of CRMC. Such record shall include adequate patient identification, information relating to the time and means of arrival and by whom transported, time of physician notification and arrival if applicable, pertinent history of the injury or illness, to include any treatment received by the patient prior to the arrival at CRMC, description of significant clinical, laboratory and radiological findings, diagnosis, treatment given, condition of the patient upon discharge or transfer and final disposition of the patient, including any instructions give the patient and/or his family relative to the necessary follow-up care, and signed and dated discharge order.

10.11 Signature Requirement. All entries into the medical record must be legible, complete, accurately dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. Each patient's medical record shall be signed by the responsible practitioner who shall be responsible for clinical accuracy. Rubber stamps are not acceptable for use unless the person responsible for authentication has a disability which would prevent them from making a written or electronic signature.

In this instance, the person using the rubber stamp will file a written statement with the Director of Medical Information Management stating that he/she is the only person who has access to the stamp and is the only one who will use it.

10.12 Final Diagnosis. The final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the physician at the time the patient is discharged unless certain diagnostic reports are not available.

10.13 Discharge Summary. Patients shall be discharged only on a written order of the attending Physician/Practitioner. A discharge summary shall be written or dictated on all patients hospitalized over two (2) days except for normal obstetrical deliveries or normal newborn infants.

A final summary note should be made on normal obstetrical and newborn patients as well as other short stay cases hospitalized under forty-eight (48) hours. Instructions at discharge to include the level of activity, diet, medications and follow-up plan should be included in all discharge summaries. A discharge or death summary will be required on all cases resulting in death. When an Autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three days, and the complete autopsy findings should be made part of the record within ninety (90) days.

10.14 Permanent File. Unless so ordered by the Health Information Management Department, a medical record shall not be permanently filed until it is completed by the responsible practitioner and/or his designee in the event of illness or other extraordinary circumstances.

10.15 Time Requirements. Physicians are responsible for ensuring that their patient's medical record is completed in a timely fashion. Medical record delinquency is defined as follows:

a. An inpatient record not completed within fifteen (15) days following discharge of the patient. (Note: A final progress note may be utilized for completion of the final diagnosis and procedures to be transferred to the face sheet (attestation record) upon discharge.)
b. A chart without a history and physical that is dated thirty (30) days prior to or within twenty-four (24) hours after admission.
c. A chart on a surgical patient without an operative report dictated within twenty-four (24) hours of surgery.
d. A written note of pertinent aspects of a surgical procedures and the patient’s condition is not entered into the chart immediately following surgery.
e. An OB delivered chart without a prenatal record (unless the patient is unassigned.)
f. Incomplete emergency and outpatient records not completed within fifteen (15) days of service.
g. A chart that has been identified as requiring clarification for the purposes of core measure compliancy not completed within 30 days of initial notification from the quality office (Note: Charts where action cannot be taken would not be considered delinquent).
h. Progress Notes have not been recorded as required.

10.16 Delinquent Records. Notification to Practitioners regarding delinquent charts:

a. The Health Information Management Department will post a list every other Friday of the month at 4:30 p.m. on the bulletin boards in the doctors' medical record lounge, physician's lounge, surgery dressing room, emergency department and dictating rooms on the nursing units.

b. Each Practitioner will be given until 1:00 pm on the following Wednesday to complete his charts or be subject to corrective action as prescribed in the Medical Staff Rules and Regulations.

10.17 Other Considerations:

a. All medical records referred by committee/department meeting for study purposes must require response prior to the committee/department meeting for which they are being reviewed or otherwise be considered a delinquent medical record.

b. If a physician is on vacation or otherwise unavailable to complete records, he must notify the Director of Health Information Management Department or his designee and make arrangements to complete charts before he leaves. If this is absolutely not possible, all charts must be completed within forty-eight (48) hours of his return.

10.18 Penalties. The following penalties shall be levied against Practitioners who continue to have delinquent medical records following 1:00 PM on the Wednesday following a posting:

a. Patients already scheduled can be seen by the physician automatically suspended for delinquent medical records as a matter of courtesy and commitment to patient care for those patients already scheduled that day, but the offending physician will not be able to schedule any other patients until the delinquent records are brought current. Further, the physician's office will be notified at 4:00 pm that day to ask their office to reschedule patients for the following day and any other subsequent patients until the physician's medical records are brought current. The physician may continue to care for all inpatients but may not admit patients, evaluate and treat patients in the Emergency room, schedule any new elective surgeries or schedule any additional ancillary services for outpatient care during the suspended period.

b. The number of times a physician's name appears on the delinquent list will be reflected in his physician statistical information file which will be reviewed at the time of credentialing and reappointment.

c. In the event a physician's privileges are automatically suspended three times in a six (6) month period for delinquent medical records, a $500 fine shall be imposed. Privileges will be reinstated after payment of $500 and completion of medical records.

d. For those specialties who do not admit patients, written warnings will be issued up to three times in a six-month period at which time clinical privileges will be automatically suspended until a $500 fine is paid and the delinquent medical records are complete.

e. Whenever it is necessary to automatically suspend privileges and impose a fine, it will be the responsibility of the Director Health Information

Management Department or her designee to notify the COS who will notify the delinquent physician, the CEO, Admitting Office, Emergency Room and Chairman of the Department involved. Medical Records Staff will prepare the written notifications.

f. By law, the National Practitioners Data Bank must be notified of any physician Practitioner whose privileges are suspended more than thirty (30) days. – not or automatic suspensions.

g. These policies and procedures shall apply to all Practitioners with active and consulting staff appointment. Violations by the consulting staff who do not admit patients will be reported to the Credentials Committee.

10.19 Active Staff Requirement. The Patient History and Physical, conclusions and assessment of risks is performed by a Practitioner with Active Staff appointment prior to any diagnostic or therapeutic procedure.

10.20 No Unlicensed Personnel. No unlicensed personnel is allowed to make entries into the medical record unless those entries are cosigned by an appropriately licensed personnel.

10.21 Continuing Care. For those patients receiving continuing outpatient services, the following shall be documented at each outpatient visit.

a. Known diagnosis
b. Known or observed conditions
c. Prior procedures
d. Drug allergies
e. Medications

SECTION 11: FINANCIAL MANAGEMENT

11.1 Dues and Fees

11.1.1 Any dues, fine or other money collected as the result of a policy include in this document shall be placed in an account at Bank of America in Conway, Arkansas.

11.1.2 Expenditures from the account will be approved as follows:

- Amounts of $500 or less may be approved by the COS or COS-E
- Amounts of $501 to $2500 or less may be approved by the MEC by a positive vote of a simple majority of the members.
- Amounts greater than $2500 will be approved by a vote of the entire Active Medical Staff of CRMC following the same procedure for a mail ballot to approve an amendment to the Bylaws, as outlined in the Bylaws section of this document.

11.1.3 Requests for checks will be made by the Medical Staff Coordinator to the Chief Financial Officer of CRMC by providing a check request and

attaching documentation of approval of the COS, COS-E, the MEC or the Active Medical Staff (whichever is appropriate).

11.1.4 The checking account will be reconciled monthly by the CRMC Accounting Department.

11.1.5 A report of the balance and expenditures of the account will be reported to the MEC at least quarterly as an agenda item at the MEC meeting.

11.1.6 Persons authorized to sign checks will be the Chief Executive Officer (CEO), the Chief Operating Officer (COO) and the Chief Financial Officer (CFO) of Conway Regional Medical Center. Each check will require 2 (two) signatures. Signatures must be original. Copied and/or stamped signatures are not acceptable.

SECTION 12: AMENDMENT OF RULES AND REGULATIONS

The Rules and Regulations may be amended at the request of the MEC, or a department or committee to the MEC after affirmative vote of the MEC; the amendment becomes effective after approval from the Board.

ADOPTED by the Medical Staff on this **21st** day of **January, 1997**.

APPROVED by the Board of Directors on this **27th** day of **January, 1997.**

Revised:

October 27, 1997
January 26, 1998
July 27, 1998
August 24, 1998
February 22, 1999
May 24, 1999
January 24, 2000
March 27, 2000
April 24, 2000
August 21, 2000
July 22, 2002
August 26, 2002
August 25, 2003
December 22, 2003
May 3, 2004
November 22, 2004
July 25, 2005
October 24, 2005
November 27, 2006
December 22, 2006
February 26, 2007
April 23, 2007

June 25, 2007
June 29, 2009
September 2, 2009
November 2, 2009
March 30, 2010
August 31, 2010
January 31, 2011
April 30, 2011
July 31, 2011
November 30, 2011
February 28, 2012
April 30, 2012
August 31, 2012
December 3, 2012
September 30, 2013
October 31, 2013
February 24, 2014
September 29, 2014
December 19, 2014
September 28, 2015
October 26, 2015
December 7, 2015
March 28, 2016
March 27, 2017
February 25, 2019
June 28, 2021
September 27, 2021
July 25, 2022
August 31, 2022
October 19, 2023
July 28, 2025
February 24, 2026