MARIANJOY REHABILITATION HOSPITAL & CLINICS, INC.

MEDICAL STAFF BYLAWS

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PREAMBLE

Marianjoy Rehabilitation Hospital & Clinics, Inc. ("Marianjoy") is a not-for-profit corporation organized under the laws of the State of Illinois, whose purpose is to serve as a physical rehabilitation organization providing patient care, education and research in rehabilitation medicine and care. These bylaws apply to Marianjoy's inpatient and outpatient hospital operations (the "Hospital"). Marianjoy is part of Northwestern Medicine.

Recognizing that Marianjoy shall not discriminate against any medical staff member, applicant for medical staff membership, employee, applicant for employment, director, officer, contractor, or any other person with whom it deals because of race, creed, color, sex, natural origin, handicap or any other illegal discriminatory basis; and recognizing that the best interests of the patient are protected by the concerted effort of the medical staff, the Administration, and the Board of Directors and the physicians practicing in the hospital hereby organize themselves for purposes of self governance in conformity with the Bylaws, and the Rules and Regulations, hereinafter stated.

For purposes of these Bylaws, and the Rules and Regulations, "Board of Directors" shall mean the Board of Directors of Marianjoy.

For purposes of these Bylaws, and the Rules and Regulations, "Administration" shall mean the Administration of Marianjoy.

For purposes of these Bylaws, "Caregiver Law" shall mean any state or federal felony or misdemeanor pursuant to which the individual is banned from access to patients pursuant to applicable law including under the Illinois Health Care Worker Background Check Act, found at 225 ILCS 46/1 et seq. and its related regulations.

For purposes of these Bylaws, and the Rules and Regulations, all words in the masculine gender shall be deemed to include the female gender, all singular words shall include the plural, and all plural words shall include the singular.

The medical staff bylaws, rules and regulations, policies and governing body bylaws and hospital policies are compatible with each other and are compliant with law and regulation.

The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

ARTICLE I - NAME

The name of the organization shall be the Medical Staff of Marianjoy Rehabilitation Hospital & Clinics, hereinafter referred to as the "Medical Staff."

The organized Medical Staff shall consist of physicians, dentists and podiatrists appointed by the Board of Directors and granted specific clinical privileges.

ARTICLE II - PURPOSE

The purpose of the Medical Staff shall be to:

1. Ensure that all patients receive appropriate care, consistent with Hospital resources;

2. Maintain overall responsibility for the professional services provided by individuals with clinical privileges as well as the responsibility of accounting therefore to the Board of Directors including but not limited to reviewing and evaluating the clinical activities of the Medical Staff to assure acceptable levels of performance;

3. Enforce the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others.

4. Provide a conflict management process for the resolution of problems of a medical-administrative nature and serve as a mechanism to facilitate effective communication among the Medical Staff, Administration and the Board of Directors;

5. Initiate, maintain, and enforce rules and regulations for governance and the operation of the Medical Staff;

6. Provide education for the Medical Staff and maintain its educational standards (the standards of continuing medical education shall be equal to those required for compliance with the State of Illinois medical licensure status, and such specialty boards and professional organizations as may impact upon the Medical Staff);

7. Create, maintain, monitor and be responsible for a uniform standard of quality of all health care rendered to patients in the organization; and

8. Share with Administration the responsibility for the accreditation status of the organization.

9. Self-governance of the organized medical staff includes the following:
    - Collaborating with the board in a well functioning relationship
    - Initiating, developing, and approving medical staff bylaws and rules and regulations and policies
    - Approving or disapproving amendments to the medical staff bylaws
    - Selecting and removing medical staff officers
    - Determining the mechanism for establishing and enforcing criteria and standards for medical staff membership
    - Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges
    - Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges
    - Engaging in performance improvement activities
    - Oversee the quality of care provided by all physicians and by other practitioners who are privileged through the medical staff process.

ARTICLE III - MEMBERSHIP

Article III, Section 1. BASIC QUALIFICATIONS.

The membership of the Medical Staff shall consist of physicians, dentists, and podiatrists who meet the following basic qualifications (the “Basic Qualifications”) :

- graduates of an ACGME (Accreditation Council for Graduate Medical Education), COCA (Commission on Osteopathic College Accreditation), APMA (American Podiatric Medical Association) or the ABGD (American Board of General Dentistry) accredited medical, osteopathic, dental or podiatric schools;

- have successfully completed an approved residency program;
- currently licensed to practice on an unrestricted basis in the State of Illinois;
- of demonstrated professional competency and acceptable moral character;
- adequately insured for medical malpractice as defined by the Marianjoy Board of Directors;
- have a record that is free from any state or federal felony conviction or any “Caregiver Law” conviction (defined herein), except as is otherwise permitted pursuant to the Pre-Application process set forth in these Bylaws; and
- any physician requesting to join the Medical Staff after October 12, 2005 must be board certified by the American Board of Medical Specialties, American Board of Osteopathic Medicine, American Board of General Dentistry or the American Board of Podiatric Surgery within three (3) years of successful completion of a residency program for Active, Associate, Consulting and Courtesy staff, however, the Board of Directors may make exceptions to the board certification requirement. In addition, physicians initially appointed to the Medical Staff, shall be required to maintain certification of such board status according to the timeframes for recertification as established by that specialty. Any such Medical Staff member who does not maintain his or her board certification shall have his or her Medical Staff status and clinical privileges immediately reviewed. The terms physician and doctor of medicine shall refer to graduates of both allopathic and osteopathic medical schools.
- In addition to professional competence, the needs of Marianjoy Rehabilitation Hospital for additional Practitioners in a given area of practice or specialty, the ability of Marianjoy to support with personnel, supplies and equipment, as well as the growth and development of the Medical Staff may be considered by Marianjoy in granting or denying an application for appointment.
- No applicant shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely by virtue of the fact that he is duly licensed to practice medicine, podiatry or dentistry in this or any other state, or that he is a member of any professional organization, or that he had in the past, or presently has, such privileges at another hospital or that he practices in the geographic area. For purposes herein, an individual meeting the above Basic Qualifications shall be defined as a “practitioner”.

Article III, Section 2. BASIC RESPONSIBILITIES.

Each member of the Medical Staff shall have a basic responsibility to:

1. Provide patients with quality care.

2. Abide by state and federal law and these Medical Staff bylaws and all other lawful standards, policies and rules of the Medical Staff, Marianjoy, as applicable.

3. Competently perform such Medical Staff duties and responsibilities as assigned.

4. Prepare and complete in a timely manner, as defined by policy, the medical and other required records for all patients treated in Marianjoy.

5. Abide by the ethical principles in his or her profession and the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the National Conference of Catholic Bishops, and interpreted by the local bishop.

6. Maintain appropriate continuous care and supervision of any patient admitted to the Hospital .

7. Maintain continuous insurance coverage in the amounts approved by the Marianjoy Board during tenure at the hospital and upon leaving or termination of privileges, which may require the purchase of “tail coverage”.

8. Pay medical staff dues as required by these Bylaws.

9. Practice in a manner consistent with the Mission, Vision, and Values of Marianjoy.

10. Notify the Hospital President, Chief of Staff, Vice President of Medical Affairs or the Medical Staff Office, within forty-eight (48) hours of, and provide such additional information as may be requested, regarding each of the following:

    (a) The revocation, limitation or suspension of his/her professional licensure or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license or the imposition of terms of probation or limitation in any state;

    (b) Cancellation of or failure to maintain professional liability insurance coverage in accordance with limits established by the Medical Staff;

    (c) Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation or the filing of charges by a Medicare peer review organization, the Department of Health and Human Services, IDPH, the Illinois Medical Examining Board or Dental Examining Board or Podiatric Examining Board or any law enforcement agency or health regulatory agency of the United States or the State of Illinois;

    (d) Receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital;

    (e) Being charged with any violation of any state or federal felony or any Caregiver Law or if the Practitioner becomes aware that he or she is the subject of any active investigation, involving his or her violation of any federal or state felony or violation of any Caregiver Law;

    (f) Being convicted of any state or federal felony or any Caregiver Law; or

    (g) Termination, suspension or restriction of staff membership or privileges, whether temporary or permanent, at any hospital or other health care facility.

    Failure to timely make notification of any of the items (a) through (g) above of this Section shall constitute an automatic withdrawal of a medical staff applicant's pending application. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic withdrawal shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and applicants whose applications are deemed to be automatically withdrawn pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

    For current members of the Medical Staff, failure to timely make the notifications of the items specified in (a) through (d) of this Section shall result in automatic suspension hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic suspension shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and members

whose medical staff membership and clinical privileges are deemed to be automatically suspended pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

For current members of the Medical Staff, failure to timely make the notifications with respect to items (e), (f) or (g) above of this Section shall result in automatic termination hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic termination shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and members whose medical staff membership and clinical privileges are deemed to be automatically terminated pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

ARTICLE IV – CATEGORIES OF THE MEDICAL STAFF

Article IV, Section 1. THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories:

A. Active Staff
B. Associate Staff
C. Consulting Staff
D. Courtesy Staff
E. Honorary Staff

Article IV, Section 2. THE ACTIVE STAFF

A. QUALIFICATIONS. Each Active Staff member shall, at a minimum:

1. meet the Basic Qualifications for Medical Staff membership set forth in Article III, Section 1 of
these Bylaws;
2. have served at least twelve (12) months as a member of the Provisional Staff pursuant to Article IV, Section 6 of these Bylaws, a Focused Professional Practice Evaluation will be conducted during the provisional period.
3. be employed by, or have an independent contract relationship with Marianjoy, Rehabilitation Medicine Clinic, Inc. d/b/a Marianjoy Medical Group (“MMG”), or Marianjoy, Inc. (“MI”), as determined by Administration;
4. have a minimum of fifty (50) or more inpatient contacts per year;
5. have recognized professional ability and have signified a willingness to accept such appointment; and

B. PREROGATIVES.

The Active Staff may:

1. admit patients to Marianjoy Rehabilitation Hospital
2. attend Medical Staff meetings
3. serve on Medical Staff Committees

4. vote
5. hold office

C. RESPONSIBILITIES.

1. admit and treat inpatients
2. complete history & physical on assigned admitted patients within 24 hours of admission. For H&P requirements and other documentation requirements, refer to Rules & Regulations 7.0 & 8.0
3. attend at least fifty percent (50%) of the Patient Care Review Committee/Quality Monitoring Committee and Quality of Care Committee meetings.
4. pay Active Staff membership dues, the amount of which shall be established by the Medical Staff in consultation with Administration;
5. participate in the care of unassigned patients;
6. be reasonably available to provide emergency care when requested.
6. attend at least 50% of the regular Medical Staff meetings during the previous year unless their absence has been excused by submitting a written request to the President of the Medical Staff.

Article IV, Section 3. THE ASSOCIATE STAFF

A. QUALIFICATIONS. Each Associate Staff member shall, at a minimum:

1. meet the Basic Qualifications for Medical Staff membership set forth in Article III, Section 1 of these Bylaws;
2. have served at least twelve (12) months as a member of the Provisional Staff pursuant to Article IV, Section 6 of these Bylaws, a Focused Professional Practice Evaluation will be conducted during the provisional period.
3. be employed by, or have an independent contract relationship with Marianjoy, MMG or MI, as determined by Administration;
4. have a minimum of twenty (20) patient contacts per year;
5. have recognized professional ability and have signified a willingness to accept such appointment;

B. PREROGATIVES. Associate Staff may:

1. admit patients to Marianjoy Rehabilitation Hospital.
2. have a minimum of twenty (20) patient contacts per year
3. attend one (1) regular Medical Staff meeting per year
3. serve on Medical Staff Committees, both without voting privileges or eligibility to hold office,

4. may be invited to become an Active Staff member provided that the Practitioner has been accepted according to the requirements set forth in these Bylaws, , and has attended at least one (1) of the regular Medical Staff meetings during the previous Medical Staff year.

C. RESPONSIBILITIES. All Associate Staff with admitting privileges at Marianjoy Rehabilitation Hospital are required to:

1. Complete history & physical on assigned admitted patients within 24 hours of admission. For H&P requirements and other documentation requirements, refer to Rules & Regulations 7.0 & 8.0.
2. attend at least one (1) Medical Staff meeting each year.
3. pay membership dues, the amount of which shall be established by the Medical Staff in consultation with Administration;
4. participate in the care of unassigned patients;
5. and be reasonably available to provide emergency care when requested.

Article IV, Section 4. THE CONSULTING STAFF

A. QUALIFICATIONS. Each Consulting Staff Practitioner shall

be a specialist who, at a minimum:

1. meets the Basic Qualifications for Medical Staff membership set forth in Article III, Section 1 of these Bylaws,
2. has served at least twelve (12) months as a member of the Provisional Staff pursuant to Article IV, Section 6 of these Bylaws, a Focused Professional Practice Evaluation will be conducted during the provisional period.
3. has a minimum of five (5) patient contacts per year or otherwise demonstrates a commitment to Marianjoy, as determined by the Board of Directors;
4. has recognized professional ability and has signified a willingness to accept such appointment.

B. **PREROGATIVES.** Consulting Staff may:

1. not admit patients to Marianjoy Rehabilitation Hospital.
2. attend meetings of the Medical Staff and Medical Staff Committees
3. may not vote or hold office.

A practitioner on the Consulting Staff who has attended at least fifty percent (50%) of the regular Medical Staff meetings during the previous year and who has at least fifty (50) patient contacts during the year may be invited, but not required, to become part of the Active Staff.

C. **RESPONSIBILITIES.** Consulting Staff are required to:

1. pay membership dues, the amount of which shall be established by the Medical Staff in consultation with Administration
2. be responsive to requests for, and reasonably available to respond to, requests for consultation when called; and
3. be reasonably available to provide emergency care when requested.

Article IV, Section 5. THE COURTESY STAFF

A. **QUALIFICATIONS**. Each Courtesy Staff Practitioner shall be a specialist who, at a minimum:

1. meets the Basic Qualifications for Medical Staff membership set forth in Article III, Section 1 of these Bylaws.
2. have served at least twelve (12) months as a member of the Provisional Staff pursuant to Article IV, Section 6 of these Bylaws, a Focused Professional Practice Evaluation will be conducted during the provisional period.
3. has a maximum of five (5) inpatient (hospital) contacts per year or otherwise demonstrates a commitment to Marianjoy, as determined by the Board of Directors;
4. has recognized professional ability and has signified a willingness to accept such appointment.

The courtesy staff member is not required to provide alternate coverage. If the courtesy staff member exceeds the five inpatient (hospital) contacts per year, the practitioner's status would automatically be transferred to the consulting staff status and he/she will need to provide for alternate coverage. The Practitioner will be informed and required to transfer to consulting staff status, unless otherwise agreed by the Medical Executive Committee.

B. **PREROGATIVES.** Courtesy Staff may:

1. may not admit patients to Marianjoy Rehabilitation Hospital
2. may attend meetings of the Medical Staff and Medical Staff Committees
3. may not vote
4. may not hold office.

C. **RESPONSIBILITIES**. Courtesy Staff are required to:

1. pay membership dues, the amount of which shall be established by the Medical Staff in consultation with Administration;

2. be responsive to requests for, and reasonably available to respond to, requests for consultation when called; and
3. be reasonably available to provide emergency care when requested.

D. **REAPPOINTMENT**. Reappointment shall consist of querying the National Practitioner Data Bank, verification of licensure in the State of Illinois, verification of professional liability insurance in accordance with these Bylaws, and verification of membership and privileges at the Practitioner's primary hospital. The above documents will be reviewed and approved, as appropriate, by the Credentials Committee, the Medical Executive Committee, and the Board of Directors, in the same manner as any other application for reappointment as defined in these Bylaws.

Article IV, Section 6. THE PROVISIONAL PERIOD

The purpose of the provisional period is to evaluate the quality of medical care that the practitioner delivers. New appointments for staff membership and clinical privileges shall be provisional for a period of one year. During the provisional period, a practitioner, with the exception of voting or holding office, shall meet the qualifications, exercise the prerogatives and be responsible for the category of the Medical Staff in which appointed.

At the conclusion of his/her provisional period, a practitioner's performance will be observed and evaluated by the Credentials Committee. If the provisional period concludes successfully, as determined by the Credentials Committee, Medical Executive Committee, and the Board of Directors, the Practitioner will be advanced to the staff category to which he/she applied. If the Practitioner's case load is inadequate for the Credentials Committee to make a determination, the Practitioner will be requested to submit a case load from his/her primary hospital and the department chair at his/her primary hospital will be queried to complete an evaluation on the Practitioner's past year's performance.

If the provisional period does not end with a recommendation that the provisional period be removed, the practitioner's membership on the Medical Staff shall be terminated. The decision not to permit transfer out of provisional status shall be subject to the hearing procedures set forth in Article IX.

Article IV, Section 7. THE HONORARY STAFF

Honorary Staff shall consist of practitioners recognized for their longstanding service to Marianjoy, the medical staff and the community. A physician will be granted Honorary Staff if recommended by the Medical Executive Committee and approved by vote of both the Active Medical Staff and the Board of Directors. Honorary Staff members may not admit patients nor may they exercise clinical privileges. They may, however, attend Medical Staff meetings. Honorary Staff members may not vote or hold office and are not required to pay medical staff dues.

Article IV, Section 8. RESIDENTS

Residents are not members of the Medical Staff. Residents are not qualified to vote or hold office nor are they afforded any rights under these Bylaws including but not limited to the right to a hearing procedure, outlined in Article IX herein. Chief residents may however attend meetings of the Medical Staff, without vote, and serve in a non-voting capacity on Medical Staff committees. The duties and obligations, and the credentialing and governance of residents are provided for by contract with Marianjoy and the Marianjoy Resident Handbook, as it is amended from time to time.

Article IV, Section 9. TRANSFER OF MEDICAL STAFF CATEGORY

Any member may apply to the Medical Executive Committee for transfer from one category of the medical staff to another. A request for transfer to a different staff category shall be made in writing,

evidencing that the applicant meets the criteria for the different category for membership and submitted to the Credentials Committee. The Credentials Committee reserves the right to require an applicant to submit a new application for appointment if they determine the written evidence submitted by the applicant is incomplete or insufficient. If upon review of the submission of the applicant the Credentials Committee determines that the applicant is qualified for the proposed new category, the Credentials Committee will recommend approval of the transfer to the Medical Executive Committee. If after reviewing the recommendation of the Credentials Committee, the Medical Executive Committee approves of the request it shall make a recommendation for approval to the Board of Directors. If either the request is denied or not otherwise approved by any of the committees, they shall notify the applicant of the same. Failure to meet the qualifications for transfer or a voluntary withdrawal of a request for transfer, shall not entitle the applicant to any procedural rights under these Bylaws, and shall not be reported to the National Practitioner Data Bank. The Medical Executive Committee has the right to change a member's status category based on his/her patient activity.

Article IV, Section 10. LEAVE OF ABSENCE

A. **LEAVE STATUS.** At the discretion of the Medical Executive Committee, and upon approval by the Board of Directors, a Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive.

B. **TERMINATION OF LEAVE.** At least thirty (30) days prior to the expiration of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The Medical Staff member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation to the Board of Directors concerning the reinstatement of the medical staff member's privileges. Thereafter, the Board of Directors shall determine whether to reinstate the practitioner. A practitioner who is not reinstated shall be afforded the due process rights to a hearing as set forth in Article IX of these Bylaws.

C. **FAILURE TO REQUEST REINSTATEMENT.** Failure, without good cause, to request reinstatement from a leave of absence within one (1) year of the effective date of the leave of absence shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of medical staff membership and privileges. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Article IV, Section 11. EMPLOYED AND CONTRACTED PRACTITIONERS.

Any practitioner whose employment and/or other contractual engagement by Marianjoy, MMG and/or MI, requires membership on the medical staff shall not have his or her membership or clinical privileges hereunder terminated without the same due process as must be provided for any other member of the medical staff unless the practitioner's contract provides otherwise, in which case the terms of the contract shall supersede these Bylaws.

ARTICLE V – PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Article V, Section 1. APPLICATION FOR APPOINTMENT

A. PREAPPLICATION. A pre-application process is used with respect to requests for initial appointment to the Medical Staff provided that, any such pre-application process shall not afford the applicant any rights, prerogatives or responsibilities under these Bylaws.

An individual requesting an application for appointment shall initially receive a preapplication form which requests proof that the individual possesses the Basic Qualifications for appointment as specified in these Bylaws. The Vice President of Medical Affairs will review all preapplication forms, and may request additional information or require an interview to determine if the individual meets the qualifications for appointment described in these Bylaws, and are not disqualified from consideration on the basis of Hospital need and ability to accommodate as otherwise set forth in these Bylaws. Those individuals who meet the qualifications for appointment as enumerated in these Bylaws, and are not disqualified from consideration on the basis of Hospital need and ability to accommodate, shall receive an application for appointment. Individuals who fail to meet the threshold criteria for appointment shall not be given an application form and shall be notified that they are not eligible. Failure to meet the qualifications for application, or a voluntary withdrawal of a preapplication, shall not entitle the individual to any procedural rights under these Bylaws, and shall not be reported to the National Practitioner Data Bank.

Notwithstanding any other term or condition of these Bylaws, a prospective applicant shall <u>not</u> be eligible to receive an application for appointment or membership to the Medical Staff, nor shall an application be accepted from a prospective applicant, if, based on information from a pre-application questionnaire or any other source, it is determined that any of the following exist:

i. The prospective applicant does not meet the Basic Qualifications set forth in these Bylaws.

ii. The prospective applicant's medical staff membership and/or all privileges at any Northwestern Medicine Hospital have been terminated or suspended, whether on a temporary or permanent basis, (other than by voluntary resignation by the Practitioner unrelated to any investigation) or the prospective applicant is aware that he or she is the subject of a pending investigation involving the potential termination or suspension of his/ her medical staff membership and/or all privileges at any Northwestern Medicine Hospital.

iii. The prospective applicant currently has charges pending, or is aware that he or she is the subject of any active investigation, involving the prospective applicant's violation of any federal or state felony or violation of any Caregiver Law.

iv. The prospective applicant has been convicted of a violation of state or federal law as follows:

(a) *<u>Caregiver Law Convictions</u>*. If the prospective applicant was convicted of a Caregiver Law, then the prospective applicant is <u>not</u> eligible to receive an application, at any time, except as set forth in Subsection (b) below.

(b) *<u>Caregiver Law Convictions Where Rehabilitation Waiver Granted</u>*. If the prospective applicant was convicted of a Caregiver Law, and such conviction was entered <u>more than two (2) years</u> from the date of the prospective applicant's request for an application, then the prospective applicant is still not eligible to receive an application for membership to the Medical Staff, unless he or she is able to affirmatively demonstrate, to the satisfaction of the Pre-Application Background Review Committee ("PBR Committee") (defined below), in its sole discretion, that he or she has been deemed rehabilitated in accordance with applicable law and therefore not banned by state law from patient access, and the following requirements are also satisfied

1) The prospective applicant does not pose a threat to the health or safety of any individuals;

2) The conviction and the prospective applicant's conduct is not inconsistent with the Mission, Vision or Values of Northwestern Medicine; and

3) The conviction and the prospective applicant's conduct does not have the potential to cause any material injury to the reputation of the Medical Staff or the Hospital.

(c) *Other Felony Convictions Entered More than 2 Years from Date of Request*. If the prospective applicant was convicted of a state or federal felony other than a Caregiver Law conviction and such conviction was entered more than two (2) years from the date of the prospective applicant's request for an application, then the prospective applicant is still not eligible to receive an application for membership to the Medical Staff unless he or she is able to affirmatively demonstrate, to the satisfaction of the PBR Committee, in its sole discretion, that the following requirements are met:

1) The conviction and the prospective applicant's activities are not related to medical staff membership or privileges or patient care;

2) The prospective applicant does not pose a threat to the health or safety of any individuals;

3) The conviction and the prospective applicant's conduct is not inconsistent with the Mission, Vision or Values of Northwestern Medicine; and

4) The conviction and the prospective applicant's conduct does not have the potential to cause any material injury to the reputation of the Medical Staff or the Hospital.

B. APPLICATION. All applications for appointment to the medical staff shall be signed by the applicant, and submitted on the mandated State of Illinois Health Care Professional Credentialing & Business Data Gathering Form. Requested clinical privileges shall be delineated upon the basis of written and documented commensurate training, experience and competence.

Documents and information required for an application for membership on the Medical Staff and clinical privileges shall include evidence of the following:

1. Initial board certification by the American Board of Medical Specialties, American Board of Osteopathic Medicine, American Board of General Dentistry or the American Board of Podiatric Surgery within three (3) years of successful completion of training program for Active, Associate, Courtesy and Consulting Staff, however, the Board of Directors may make exceptions to the board certification requirement as recommended by the Credentials Committee and Medical Executive Committee.

   In addition, physicians initially appointed to the Medical Staff, shall be required to maintain certification of such board status according to the timeframes for recertification as established by that specialty. Any such Medical Staff member who does not maintain his or her board certification shall have his or her Medical Staff status and clinical privileges immediately reviewed.

2. Current, unrestricted licensure in the State of Illinois;

3. Current, unrestricted registration with the Federal Drug Enforcement Administration to prescribe controlled substances (if applicable to their profession);

4. Professional liability malpractice insurance in the amounts of $1,000,000 per event and $3,000,000 aggregate annually, or in such other amounts as may be determined by the Board from time to time after consultation with the insurance carrier, counsel, and Medical Executive Committee;

5. Compliance with the State of Illinois continuing medical education requirements;

6. Chronological education and employment history from medical school to present, with an explanation for gaps in time longer than three (3) months;

7. Names of at least three (3) professional peers who have had significant experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional training, skills, medical/clinical knowledge, practice-based learning and improvement, judgment, interpersonal and communication skills, professionalism and systems' based practice performance, health status, and character as they would affect performance at Marianjoy and, for applicants who have just completed training in an approved residency program, a letter from the program director of such program is required.

8. In accordance with applicable law, and the JC requirement that the applicant attests that "no health problems exist that could effect his or her practice," a statement from the applicant attests that he or she is able to practice medicine with reasonable skill and safety with or without reasonable accommodation and confirmation of the same from the department chief or chief of staff at another hospital at which the applicant holds privileges or the director of the applicant's training program;

9. For family practice, internal medicine and internal medicine specialties: arrange to have another member or members of the medical staff provide coverage for his/her practice in the event of an emergency, urgent situation, illness, vacation, or absence. The member(s) providing such coverage must possess skills and privileges similar to the member seeking coverage.

10. Demonstrated willingness to participate in the performance of Medical Staff responsibilities;

11. A report from the National Practitioner Data Bank;

12. Whether litigation/judgments/settlements/claims have been brought or entered against applicant, whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, voluntarily withdrawn, currently under investigation, or not renewed at any other hospital or institution, or his or her license to practice any profession in any jurisdiction, has been suspended, revoked, denied, relinquished, or subjected to probationary conditions or terminated, and if there are any currently pending challenges to professional licensure, certification or registration, DEA registration, and/or other similar credential or approval;

13. A current picture hospital identification card or a valid picture identification card issued by a state or federal agency with identity verified when applicant appears for his/her Credentials Committee interview:

14. Whether the applicant has been convicted of any state or federal felony or Caregiver Law; and

15. Any other information hereinafter required by state or federal law or otherwise deemed necessary and appropriate by the Medical Executive Committee.

When possible, the Illinois license, relevant training, and current competence will be primary source verified.

Applicants for appointment to the medical staff shall demonstrate in their application that they meet the qualifications for the category of the medical staff to which the practitioner is seeking appointment, as set forth in these Bylaws. Notwithstanding, with regard to practitioners applying for initial appointment as a provisional member of the medical staff only, these individuals shall not be required to demonstrate in their application that, in the year prior to their appointment, they met the minimum number of contacts required by their particular category of medical staff membership. These individuals will however be required to demonstrate that they satisfy such requirements upon consideration for their advancement from provisional staff to another category of medical staff membership.

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

1. comply with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, as amended, as interpreted by the local bishop, as well as the Wheaton Franciscan Services Corporate Ethics Standards;

2. if applicable, appear for an initial interview;

3. authorize the Credentials Committee or its agents to consult with members of other hospitals with which the applicant has ever been associated, and with any others who may have information bearing on his or her competence and character;

4. consent to the inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges he requests associated with medical staff membership;

5. consent to the completion of a criminal background check and confirm eligibility to participate in Medicare, Medicaid and other state and federal funded healthcare programs;

6. release from any liability all representatives of Marianjoy and the medical staff and all references contacted for acts performed in good faith and without willful or wanton misconduct concerning the applicant's competence, character and other qualifications for medical staff appointment and clinical privileges, including otherwise privileged or confidential information.

All initial application packets will include a copy of the Ethical and Religious Directives for Catholic Health Facilities, as well as a copy of Wheaton Franciscan Services Corporate Ethics Standards brochure, for the applicant's information in keeping with corporate guidelines.

The application packet shall include a statement that the applicant has received and read the Bylaws of Marianjoy and the Bylaws, Rules and Regulations of the Medical Staff and that he agrees to be bound by the terms thereof if he is granted membership and/or clinical privileges.

The provision of false or fraudulent information or the withholding of material information in the application shall be the basis for denial or termination of membership on the medical staff without hearing rights or appeal.

Each applicant and member of the medical staff shall provide corrections, updates, and modifications to his or her credentials data to ensure that all data remains current. Such corrections, updates, and modifications shall be provided within twenty four hours for state licensure revocation or limitation,

federal DEA registration revocation or limitation, Medicare or Medicaid sanctions, revocation/termination of hospital privileges, disciplinary proceedings or adverse actions taken at other hospitals relating to medical staff membership or clinical privileges, any lapse in professional liability coverage required by the hospital, or conviction of a felony. Any malpractice lawsuit, claim or judgment must be reported within thirty days**.** Corrections, updates, and modifications shall be provided within forty-five (45) days for any other change in information from the date the applicant or member knew of the change. All changes shall be reported on a form prescribed by the Board of Directors after development by and consultation with the Medical Executive Committee.

A reasonable application for initial appointment fee may be charged. The amount of the application fee shall be determined by the Medical Staff in consultation with Administration.

Article V, Section 2. APPOINTMENT PROCESS

Review and action with regard to all applications for appointment to the medical staff shall be performed, within a maximum of one hundred eighty (180) days after receipt by the Credentials Committee of an completed application for membership (except in extraordinary circumstances when this timeline cannot be satisfied, as determined by the Medical Executive Committee).

1. **ACTION BY THE CREDENTIALS AND MEDICAL EXECUTIVE COMMITTEES.** The Credentials Committee shall verify and review the application, verify at least two of the three references provided by the applicant, and conduct an interview with the applicant. Before recommending privileges, the organized medical staff also evaluates the following:
   a. challenges to any licensure or registration
   b. voluntary and involuntary relinquishment of any license or registration
   c. voluntary and involuntary termination of medical staff membership
   d. voluntary and involuntary limitation, reduction, or loss of clinical privileges
   e. any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
   f. documentation as to the applicant's health status
   g. relevant practitioner-specific data as compared to aggregate data, when available
   h. morbidity and mortality data, when available

   The Credentials Committee will also assess the applicant's competence in six core areas: (i) patient care; (ii) medical/clinical knowledge; (iii) patient-based learning and improvement; (iv) interpersonal and communication skills; (v) professionalism; and (vi) systems-based practice. A report shall be submitted to the chairman of the Medical Executive Committee. The Medical Executive Committee may, when it so elects, seek supplementary information about the character, professional competence, qualifications and standing of the practitioner.

   After receipt by the Credentials Committee of the completed application for membership, the Medical Executive Committee shall complete its review of the application. Based upon the information contained in the references given by the practitioner and from other sources available to and collected by the Credentials and Medical Executive Committees, the Medical Executive Committee shall determine whether the practitioner meets all the necessary qualifications for medical staff membership and the clinical privileges requested. The Medical Executive Committee shall be responsible for evaluating evidence of an unusual pattern ~~of~~ or an excessive number of professional liability actions resulting in final judgment against the applicant. The Medical Executive Committee shall transmit to the President and the Board of Directors its recommendation that: (i) the applicant be appointed to the Medical Staff; (ii) the applicant be denied for Medical Staff membership; or (iii) the application be deferred for further consideration. If the recommendation is for appointment, it shall also include the Medical Executive Committee's recommendation on the clinical privileges**,** requested by the applicant. A favorable recommendation is promptly forwarded to the Board.

When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it shall be followed up within forty-five (45) days with either a subsequent recommendation for provisional appointment with specified clinical privileges or for denial of medical staff membership.

When the recommendation of the Medical Executive Committee is adverse to the practitioner, the President or his/her designee shall promptly notify the practitioner verbally, followed by a written confirmation by certified mail, return receipt requested, of the adverse recommendation including an explanation of the reason for the decision, the practitioner's right to a fair hearing pursuant to these Bylaws and a summary of the practitioner's rights in the hearing. No such adverse recommendation shall be forwarded to the Board of Directors until after the practitioner has exercised or has been deemed to have waived his or her right to a hearing as provided in these Bylaws.

2. ACTION BY THE BOARD OF DIRECTORS. The Board of Directors at its next meeting will act on a favorable recommendation of the Medical Executive Committee within ninety (90) days after receipt of such recommendation. If the Board of Directors' decision is favorable to the practitioner, the President shall promptly notify the practitioner and the medical staff.

If the Board of Directors' decision, following receipt of a favorable recommendation from the Medical Executive Committee, is adverse to the practitioner, the President shall promptly notify the practitioner of such adverse decision verbally, followed by a written confirmation by certified mail, return receipt requested, of the adverse decision, including an explanation of the reason for the decision, the practitioner's right to a fair hearing and a summary of the Practitioner's rights in the hearing. The President shall also send notice of the Board of Directors' decision to the President of the Medical Staff, the Chairman of the Medical Executive Committee, and the Vice President of Medical Affairs or his or her representative.

The Board of Directors shall notify those state agencies and government offices as required by law if the situation demands action, as set forth in Section 8 of Article IX.

Article V, Section 3. EXPEDITED CREDENTIALING PROCESS

A. An expedited credentialing process will be reserved for use only in situations where patient care needs may not be met due to an interruption in the regular approval process by the Board of Directors for appointments, reappointments and requests for new privileges, as requested by the President of Marianjoy, Inc. upon the recommendation of the Medical Staff President. Examples of such interruptions could be due to the sequencing of board meetings or the untimely cancellation of a scheduled meeting. The Board of Directors of Marianjoy Inc. has delegated its authority to the Executive Committee of the Marianjoy, Inc. Board to exercise all of its power between meetings of the board, per the Marianjoy, Inc. bylaws. Following a favorable recommendation from the Medical Executive Committee on an eligible, completed application as determined by the Credentials Committee, the Executive Committee of the Board may review and evaluate the qualifications and current competence of the practitioner who is applying for new, renewal, or modification of privileges and render a decision. To be eligible for this process, each application has to meet the criteria as stated in these bylaws for appointment, reappointment and new privileges.

1. ELIGIBILITY: To be eligible for the expedited process each application has to meet the following criteria:
   - The applicant promptly returns all requested information.
   - There are no negative or questionable recommendations.
   - There are no discrepancies in information received from the applicant or reference.
   - The applicant completed a normal education/training sequence.

- There are no reports of disciplinary actions or legal sanctions.
- There are no reports of malpractice cases within the past five years.
- The applicant has an unremarkable medical staff/employment history.
- The applicant submits a reasonable request for clinical privileges based on experience, training, and competence and is in compliance with applicable criteria.
- The applicant has never had third-party payer (e.g. Medicare, Medicaid, etc.) sanctions.
- The applicant has no state or federal felony convictions nor any convictions under any Caregiver Law.

2. INELIGIBILITY: An applicant is ineligible for the expedited process if at the time of the request, or if since the time of request, any of the following occur:
   - There is a current challenge or a previously successful challenge to licensure or registration.
   - The applicant has received an involuntary termination of medical staff membership at another organization.
   - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
   - It is determined that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

B. A favorable decision by the Executive Committee of the Board results in the membership and/or privileges requested being granted as of the date of the subcommittee's decision. The Executive Committee of the Board meets on an as needed basis, per the Marianjoy, Inc. bylaws.

C. If the Executive Committee of the Board's decision is adverse to the applicant, the matter shall be referred back to the Medical Executive Committee for further evaluation.

Article V, Section 4. FOCUSED PROFESSIONAL PRACTICE EVALUATION.

A. A period of focused professional practice evaluation shall be implemented:
   1. for all initially requested privileges; and
   2. in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.

B. Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient. The method, type and duration of the focused evaluation will be determined by the Credentials Committee for new privileges and by the Medical Executive Committee for concerns regarding the provision of safe, high quality patient care.

Article V, Section 5. ONGOING PROFESSIONAL PRACTICE EVALUATION.

A. A process of ongoing professional practice evaluation exists to continuously review medical staff members care and to identify professional practice trends that impact on quality of care and patient safety.

B. The criteria used in the ongoing professional practice evaluation may include such factors as:
   - The review of clinical procedures performed and their outcomes;
   - Patterns of pharmaceutical usage;
   - Requests for tests and procedures;
   - Length of stay patterns;

- Morbidity and mortality data;
- Practitioner's use of consultants; and
- Other relevant factors as determined by the medical staff.

C. The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, including consulting physicians, nursing, and administrative personnel which is provided on a profile that is reviewed by the Medical Executive Committee two (2) times a year.

D. Relevant information obtained from the ongoing professional practice evaluation shall be integrated into medical staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised or revoked.

Article V, Section 6. REAPPOINTMENT PROCESS

Reappointments to the medical staff shall occur at least every twenty-four (24) months from the time of initial appointment. The Credentials Committee shall be responsible for initially reviewing and verifying information obtained in the reappointment process. A written report of this review shall be submitted to the Chairman of the Medical Executive Committee.

Each recommendation concerning the reappointment of a medical staff member and clinical privileges to be granted upon reappointment shall be based upon:

1. Physicians initially appointed to the medical staff shall be required to maintain certification of such board status according to the timeframes for recertification as established by that specialty. Any such medical staff member who does not maintain his or her board certification shall have his or her medical staff status and clinical privileges immediately reviewed.
2. Evidence of current, unrestricted licensure in the State of Illinois;
3. Current, unrestricted registration with the Federal Drug Enforcement Administration to prescribe controlled substances;
4. A report from the National Practitioner Data Bank;
5. Eligibility to participate in the Medicare, Medicaid and other federally funded health programs;
6. An evaluation of the member's professional competence, skills, clinical judgment, performance, and conduct in the treatment of patients obtained by a letter of recommendation from the Department Chair or, if none, the Vice President of Medical Affairs (as applicable) of the primary hospital regarding the applicant's ability to perform privileges as requested;
7. Attendance at medical staff meetings and participation in medical staff affairs;
8. Compliance with Corporate and Medical Staff Bylaws;
9. Cooperation with medical staff and hospital associates based on information on the ongoing professional evaluation;
10. Evidence of professional liability insurance, as provided in the Bylaws, Rules and Regulations of the Medical Staff;
11. Compliance with the State of Illinois continuing medical education requirements;
12. In accordance with applicable law, and the Joint Commission requirement that the applicant state that no health problems exist that could effect his or her practice a statement from the applicant that he or she is able to practice medicine with reasonable skill and safety with or without reasonable accommodation and such statement shall be confirmed by a letter from the Department Director,or, if none, the Vice President of Medical Affairs;
13. Clinical technical skills, as indicated by results of performance improvement activities and monitors;
14. Information regarding litigation/judgments/settlements/claims brought or entered against applicant, whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, voluntarily withdrawn, currently under investigation, or not

renewed at any other hospital or institution, or his or her license to practice any profession in any jurisdiction, has been suspended, revoked, denied, relinquished, or subjected to probationary conditions or terminated, and if there are any currently pending challenges to professional licensure, certification or registration, DEA registration (if applicable to profession), and/or other similar credential or approval;

15. Review of Practitioner-specific data and aggregate data relevant to privileges.
16. Whether the Practitioner has been convicted of or charged with any violation of any state or federal felony or Caregiver Law; and
17. Any other evidence of current ability to perform privileges that may be requested or any other information hereinafter required by state or federal law.

It is the responsibility of the medical staff member to supply such information to the Medical Executive Committee that will assist in its task in a timely fashion. Failure of an applicant for reappointment to provide any requested information within thirty (30) days after receipt of written request by the Medical Executive Committee or Credentials Committee shall constitute abandonment of the application for reappointment. If the practitioner subsequently seeks medical staff membership, the practitioner shall be treated as an applicant for initial appointment to the medical staff.

The provision of false or fraudulent information or the withholding of material information in the reappointment process shall be the basis for denial of reappointment to the medical staff without hearing rights or appeal.

Any reappointments to the medical staff or change in clinical privileges must be approved by the Medical Executive Committee and the Board of Directors pursuant to the procedure for appointment to the medical staff set forth above.

A reasonable application for reappointment fee may be charged. The amount of such fee shall be determined by the Medical Staff in consultation with Administration.

Article V, Section 7. MAINTENANCE OF CREDENTIALING RECORDS

Records gathered and produced as a result of the appointment and reappointment process shall be retained by Marianjoy (or in the event of closure of Marianjoy, by Northwestern Medicine) for not less than ten (10) years after termination of a medical staff membership.

ARTICLE VI – ALLIED HEALTH PROFESSIONAL STAFF

Article VI, Section 1. ALLIED HEALTH PROFESSIONAL STATUS

"Allied Health Professionals" shall be divided into two (2) categories: Independent Allied Health Professionals are defined as Clinical Psychologists, Neuropsychologists and Optometrists and Dependent Allied Health Professionals defined as, Staff Therapist, Physician Assistants and Advanced Practice Nurses (Certified Nurse Practitioner, Certified Clinical Nurse Specialist). Independent Allied Health Professionals are those individuals, other than a Practitioner, who are licensed by the State of Illinois and duly qualified to provide independent patient care to patients without supervision or collaboration with a member of the medical staff. Dependent Allied Health Professionals are those individuals, other than a practitioner, who are permitted to provide services to patients under supervision of or collaboration with a practitioner member of the Medical Staff. Allied Health Professionals must satisfy the qualifications and granted clinical privileges according to these bylaws. Allied Health Professional's requests for privileges shall be reviewed an processed in accordance with the Pre-Application process set forth above in these Bylaws.

Article VI, Section 2. INDEPENDENT ALLIED HEALTH PROFESSIONALS ("IAHPs")

A. **QUALIFICATIONS FOR IAHP PRIVILEGES.** Only individuals, other than a physician, dentist or podiatrist, who are appropriately licensed, certified, or registered in the State of Illinois in the following categories of health professions, are eligible to be considered for IAHP privileges:

1. Individuals with doctorates in clinical, school or counseling psychology, or the equivalent; and

2. Individuals in such other categories of health care professions deemed eligible to apply for IAHP privileges by the Board of Directors.

B. **IAHP PRIVILEGING PROCESS.** Eligible individuals desiring IAHP clinical privileges at Marianjoy shall submit to the Credentials Committee and the Medical Executive Committee, prior to the time of providing services to patients, an application for clinical privileges, signed by the applicant and submitted on a form prescribed by the Board of Directors after development by and consultation with the Medical Executive Committee and/or Credentials Committee. In addition to the application, eligible individuals desiring IAHP clinical privileges shall submit to the Credentials Committee and the Medical Executive Committee, prior to the time of providing services to patients, evidence of all of the following:

1. Current, unrestricted licensure, certification, or registration by the appropriate agency or organization for his or her discipline in the State of Illinois and compliance with any applicable continuing medical education requirements;

2. Current competence (written verification of clinical judgment and technical skills) appropriate to perform services in his or her discipline;

3. Fulfillment of mandatory regulatory requirements, for example, those of the Occupational Safety and Health Administration;

4. Professional liability insurance coverage at a level acceptable to the Board of Directors;

5. Eligibility for participation in the Medicare, Medicaid and other federally funded health programs;

6. Chronological education and employment history from professional school to present, with an explanation for gaps in time longer than three (3) months;

7. A statement from the applicant that no medical condition, physical defect or emotional impairment exists which in any way impairs and/or limits the applicant's ability to provide services within the applicant's scope of practice with reasonable skill and safety;

8. When applicable, a report from the National Practitioner Data Bank;

9. Whether the applicant has been convicted of any state or federal felony or any Caregiver Law and whether any litigation/judgments/settlements/claims have been brought or entered against the applicant, whether the applicant's clinical privileges have ever been revoked, suspended, reduced, voluntarily withdrawn, currently under investigation, or not renewed at any other hospital or institution, whether his or her membership in local, state or national professional organizations, or his or her license, certification or registration (as applicable) to practice any profession in any jurisdiction, has been suspended,

revoked, denied, relinquished, or subjected to probationary conditions or terminated, and if there are any currently pending challenges to such professional licensure, certification or registration, and/or other similar credential or approval; and

10. Any other information hereinafter required by state or federal law or otherwise deemed necessary and appropriate by the Credentials Committee and/or the Medical Executive Committee.

When applicable, the Illinois license, registration or certification will be primary source verified and a criminal background check shall be performed. Individuals who are eligible for IAHP privileges may upon submission of the information set forth above, be approved by the Board of Directors (upon recommendation of the Medical Executive Committee) for IAHP privileges for appropriate activities in a manner consistent with Article VII, Section 1.B. Privileges in the IAHP category shall be extended to only professionally competent individuals who continually meet the qualifications, standards and requirements set forth in these Bylaws, in the policies of Marianjoy, or in the policies or procedures of the department in which they are approved to practice. No individual may provide services to patients in Marianjoy unless he/she has been so privileged.

No individual shall be entitled to privileges merely by virtue of the fact of professional licensure, certification, membership in any professional organization, or past or present privileges at this or any other hospital.

By applying for appointment to the Allied Health Professional Staff, each IAHP agrees to:

1. Comply with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, as amended, as interpreted by the local bishop, as well as the Wheaton Franciscan Services Corporate Ethics Standards;

2. Appear for interviews in regard to the application;

3. Authorize the Credentials Committee or its agents to consult with members of other hospitals with which the applicant has ever been associated, and with any others who may have information bearing on his or her competence and character;

4. Consent to the inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges requested;

5. Consent to the completion of a criminal background check and confirm eligibility to participate in Medicare, Medicaid and other state and federal funded healthcare programs;

6. Release from any liability all representatives of Marianjoy and the medical staff and all references contacted for acts performed in good faith and without willful or wanton misconduct concerning the applicant's competence, character and other qualifications for clinical privileges, including otherwise privileged or confidential information.

When the Credentials Committee, Medical Executive Committee or Board of Directors has reason to question the physical and/or mental health status of an IAHP, with or without reasonable accommodation, relative to the IAHP's clinical privileges, in accordance with applicable law, the IAHP may be required to submit to an evaluation of physical and/or mental health status by a physician or physicians designated by the Medical Executive Committee and

acceptable to the IAHP and thereafter, as necessary, a "plan of action," as a prerequisite to the exercise of previously granted clinical privileges, or to further consideration of his or her application for initial or renewal of clinical privileges.

The provision of false or fraudulent information or the withholding of material information in the application for IAHP clinical privileges shall be the basis for denial or termination of clinical privileges without hearing rights or appeal.

Each applicant for IAHP clinical privileges shall provide corrections, updates, and modifications to his or her data submitted with an initial or renewal application for such clinical privileges to ensure that all such data remains current. Such corrections, updates and modifications shall be provided within twenty four hours for State licensure revocation or limitation, federal DEA registration revocation or limitation (if applicable), Medicare or Medicaid sanctions, revocation/termination of hospital privileges, disciplinary proceedings or adverse actions taken at other hospitals relating to clinical privileges, any lapse in professional liability coverage required by the hospital, or conviction of a felony. Any malpractice lawsuit, claim or judgment must be reported within thirty days. Corrections, updates and modifications shall be provided within forty-five days for any other change in information from the date the applicant knew of the change. All changes shall be reported in the manner directed by the Board of Directors after consultation with the Medical Executive Committee.

C. LIMITATIONS ON IAHP PRIVILEGES. Each IAHP shall be entitled to exercise only those clinical privileges that are within his or her scope of practice, as permitted by his or her licensure, certification or registration, and that are granted to the IAHP by the Board of Directors. If required by law, regulation or applicable third party payor(s), each IAHP shall render services under the supervision or collaboration, as may be required by such law, regulation or applicable third party payor(s), of a physician member of the Medical Staff. Written results of peer review activities related to an IAHP shall be entered into the quality file maintained by the Medical Staff Office.

The Medical Staff Office will maintain a written description of the privileges granted to an IAHP and IAHPs shall have their functions monitored by the director of the department to which an IAHP is assigned. An IAHP shall not admit or discharge patients to or from Marianjoy. IAHPs are not members of the medical staff and shall not vote in medical staff matters, hold medical staff office or participate in privileges or responsibilities of medical staff membership.

Each IAHP with clinical privileges shall participate in appropriate educational activities of the medical staff, and shall complete the necessary continuing education required to maintain his or her license or certification. In addition, each IAHP with clinical privileges shall be required to continuously conduct himself/herself in accordance with any code of ethics which has been adopted by his or her particular professional organization.

D. IAHP PROCEDURAL RIGHTS. An IAHP shall have the due process rights set forth in these Bylaws that are applicable to all Allied Health Practitioners.

E. DURATION AND RENEWAL OF IAHP PRIVILEGES. Clinical privileges granted to an IAHP shall remain in effect for a period of two (2) years, unless a reason for a review of privileges occurs prior to that time. Privileges may be renewed for subsequent two (2) year periods upon approval by the Board of Directors (upon the recommendation of the Medical Executive Committee) pursuant to a process substantially similar to that undertaken for initial granting of clinical privileges to an IAHP in the manner discussed herein.

Article VI, Section 3. DEPENDENT ALLIED HEALTH PROFESSIONALS ("DAHPs")

A. **QUALIFICATIONS FOR DAHP PRIVILEGES.** Only individuals, other than a practitioner, who are appropriately licensed, certified, or registered in the State of Illinois in the following categories of health professions and who are not employed by or under contract with Marianjoy are eligible to be considered for DAHP privileges:

1. Any individual who functions under the supervision of a duly licensed physician with relevant clinical privileges at Marianjoy; and

2. Any licensed individual in such other category of health care professions deemed eligible for DAHP by the Board of Directors.

B. **DAHP PRIVILEGING PROCESS.** Eligible individuals desiring DAHP clinical privileges at Marianjoy shall submit to the Credentials Committee and the Medical Executive Committee, prior to the time of providing services to patients, an application for DAHP clinical privileges, signed by the applicant and submitted on a form prescribed by the Board of Directors after development by and consultation with the Medical Executive Committee and/or Credentials Committee. In addition to the application, individuals desiring DAHP clinical privileges shall submit to the Credentials Committee and the Medical Executive Committee, prior to the time of providing services to patients, evidence of all of the following:

1. Current, unrestricted licensure, certification, or registration by the appropriate agency or organization for his or her discipline in the State of Illinois and compliance with any applicable continuing medical education requirements;

2. Current competence and scope of practice (written verification of clinical judgment and technical skills) appropriate to perform his or her assigned responsibilities;

3. Ability to perform job responsibilities;

4. Fulfillment of mandatory regulatory requirements, for example, those of the Occupational Safety and Health Administration;

5. Professional liability insurance coverage at a level acceptable to the Board of Directors;

6. Eligibility for participation in the Medicare, Medicaid and other federally funded health programs;

7. Chronological education and employment history from college to present, with no gaps in time left unaccounted for;

8. A statement from the applicant that no medical condition, physical defect or emotional impairment exists which in any way impairs and/or limits the applicant's ability to provide services within the applicant's scope of practice with reasonable skill and safety;

9. When applicable**,** a report from the National Practitioner Data Bank;

10. Whether an applicant has been convicted of any state or federal felony or any Caregiver Law and whether any litigation/judgments/settlements/claims have been brought or entered against the applicant, whether the applicant's clinical privileges have ever been revoked, suspended, reduced, voluntarily withdrawn, currently under investigation, or not renewed at any other hospital or institution, whether his or her membership in local, state or national professional organizations, or his or her license, certification or registration

(as applicable to practice in any profession in any jurisdiction, has been suspended, revoked, denied, relinquished, or subjected to probationary conditions or terminated, and if there are any currently pending challenges to such professional licensure, certification or registration, and/or other similar credential or approval; and

11. Any other information hereinafter required by state or federal law or otherwise deemed necessary and appropriate by the Credentials Committee and/or the Medical Executive Committee.

As applicable, the Illinois license, registration or certification will be primary source verified and a criminal background check shall be performed. The results will be reviewed with the application. Individuals who are eligible for DAHP privileges may, upon submission of the information set forth above, be approved by the Board of Directors (upon recommendation of the Medical Executive Committee) for DAHP privileges for appropriate activities in a manner consistent with Article VII, Section 1.B. Privileges in the DAHP category shall be extended to only professionally competent individuals who continually meet the qualifications, standards and requirements set forth in these Bylaws, in the policies of Marianjoy, or in the policies or procedures of the department in which they are approved to practice. No individual may provide services to patients in Marianjoy unless he or she has been so privileged.

No individual shall be entitled to privileges merely by virtue of the fact of professional licensure, certification, membership in any professional organization, or past or present privileges at this or any other hospital.

By applying for appointment to the Allied Health Professional Staff, each DAHP agrees to:

1. Comply with the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, as amended, as interpreted by the local bishop, as well as the Wheaton Franciscan Services Corporate Ethics Standards;

2. Appear for interviews in regard to the application;

3. Authorize the Credentials Committee or its agents to consult with members of all other hospitals with which the applicant has ever been associated, and with any others who may have information bearing on his or her competence and character;

4. Consent to the inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges requested;

5. Consent to the completion of a health care worker or other criminal background check and confirm eligibility to participate in Medicare, Medicaid and other state and federal funded healthcare programs;

6. Release from any liability all representatives of Marianjoy and the Medical Staff and all references contacted for acts performed in good faith and without willful or wanton misconduct concerning the applicant's competence, character and other qualifications for clinical privileges, including otherwise privileged or confidential information.

When the Credentials Committee, Medical Executive Committee or Board of Directors has reason to question the physical and/or mental health status of a DAHP, with or without reasonable accommodation, relative to the DAHP's clinical privileges, in accordance with applicable law, the DAHP may be required to submit to an evaluation of physical and/or mental health status by a

physician or physicians designated by the Medical Executive Committee and acceptable to the DAHP and thereafter, as necessary, a "plan of action," as a prerequisite to the exercise of previously granted clinical privileges, or to further consideration of his or her application for initial or renewal of clinical privileges.

The provision of false or fraudulent information or the withholding of material information in the application for DAHP clinical privileges shall be the basis for denial or termination of clinical privileges without hearing rights or appeal.

Each applicant for DAHP clinical privileges shall provide corrections, updates, and modifications to his or her data submitted with an initial or renewal application for such clinical privileges to ensure that all such data remains current. Such corrections, updates and modifications shall be provided within twenty four hours for State licensure revocation or limitation, federal DEA registration revocation or limitation (if applicable), Medicare or Medicaid sanctions, revocation/termination of hospital privileges, disciplinary proceedings or adverse actions taken at other hospitals relating to clinical privileges, any lapse in professional liability coverage required by the hospital, or conviction of a felony. Any malpractice lawsuit, claim or judgment must be reported within thirty days. Corrections, updates and modifications shall be provided within forty-five days for any other change in information from the date the applicant knew of the change. All changes shall be reported in the manner directed by the Board of Directors after consultation with the Medical Executive Committee.

C. **LIMITATIONS ON DAHP PRIVILEGES.** Each DAHP shall be entitled to exercise only those clinical privileges that are within his or her scope of practice, as permitted by his or her licensure, certification or registration, and that are granted to the DAHP by the Board of Directors. If required by law, regulation or applicable third party payor(s), each DAHP shall render services under the supervision or collaboration, as may be required by such law, regulation or applicable third party payor(s), of a physician member of the Medical Staff. Written results of peer review activities related to a DAHP shall be entered into the quality file maintained by the Medical Staff Office. The activities of DAHPs shall not interfere with the patient care furnished by employees of Marianjoy.

The Medical Staff Office will maintain a written description of the privileges granted to a DAHP and DAHPs shall have their functions monitored by a supervising or collaborating, as applicable, physician member of the Medical Staff. A DAHP shall not admit or discharge patients to or from Marianjoy. DAHPs are not members of the Medical Staff and shall not vote in Medical Staff matters, hold Medical Staff office or participate in privileges or responsibilities of Medical Staff membership.

Each DAHP with clinical privileges shall participate in appropriate educational activities of the Medical Staff, and shall complete the necessary continuing education required to maintain his or her license or certification. In addition, each DAHP with clinical privileges shall be required to continuously conduct himself in accordance with any code of ethics which has been adopted by his or her particular professional organization.

D. **DAHP PROCEDURAL RIGHTS.** A DAHP shall have the due process rights set forth in these Bylaws that are applicable to all Allied Health Practitioners.

E. **DURATION AND RENEWAL OF DAHP PRIVILEGES.** Clinical privileges granted to a DAHP, Section 2 shall remain in effect for a period of two (2) years, unless a reason for a review of privileges occurs prior to that time. Privileges may be renewed for subsequent two (2) year periods upon approval by the Board of Directors (upon the recommendation of the Medical Executive Committee) pursuant to a process substantially similar to that undertaken for initial granting of clinical privileges to a DAHP that is discussed herein.

Article VI, Section 3. NOTIFICATION REQUIREMENTS OF ALLIED HEALTH PROFESSIONALS ("AHPs")

All AHPs shall be responsible to notify the Hospital President, Chief of Staff, Vice President of Medical Affairs or the Medical Staff Officer within forty-eight (48) hours of, and provide such additional information as may be requested, regarding each of the following:

(i) The revocation, limitation, or suspension of his/her professional licensure or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license or the imposition of terms of probation or limitation in any state;

(ii) Cancellation of or failure to maintain professional liability insurance coverage in accordance with requirements established by the Board of Directors;

(iii) Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction, or the commencement of a formal investigation of the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services, IDPH, the Illinois Department of Regulation and Licensing, or any law enforcement agency or health regulatory agency of the United States or the State of Illinois.

(iv) Receipt of notice of the filing of any suit against the Allied Health Professional alleging professional liability in connection with the treatment of any patient in or at the Hospital.

(v) As applicable, termination of employment or other engagement by a Member of the Hospital's Medical Staff.

(vi) Being charged with any violation of any state or federal felony or any Caregiver Law or if the Allied Health Professional becomes aware that he or she is the subject of any active investigation, involving his or her violation of any federal or state felony or violation of any Caregiver Law;

(vii) Being convicted of any state or federal felony or any Caregiver Law.

(viii) Termination, suspension or restriction of staff membership or privileges, whether temporary or permanent, at any hospital or other health care facility, including without limitation any Northwestern Medicine Hospital.

Failure to timely make notification of any of the items (i) through (viii) above of this Section shall constitute an automatic withdrawal of an Allied Health Professional Applicant's pending application. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic withdrawal shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Allied Health Professional Applicants whose applications are deemed to be automatically withdrawn pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

For Allied Health Professionals with privileges, failure to timely make the notifications of the items specified in (i) through (iv) of this Section shall result in automatic suspension hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic suspension shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Allied Health Professional whose privileges are deemed to be automatically suspended pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

For Allied Health Professionals with privileges, failure to timely make the notifications of the items specified in (v) through (viii) above of this Section shall result in automatic termination hereunder. Notwithstanding any other term or conditions set forth in these Bylaws, any such automatic termination shall not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Allied Health Professional whose privileges are deemed to be automatically terminated pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

ARTICLE VII – CLINICAL PRIVILEGES

Article VII, Section 1. GRANTING OF CLINICAL PRIVILEGES

Every practitioner practicing at Marianjoy by virtue of medical staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Board of Directors as specified in these bylaws. All such privileges must be in keeping with the hospital's available resources. Routine admitting privileges are limited to only those Active ~~Staff~~ and Associate Staff members employed as Marianjoy Medical Group physicians.

1. **APPLICATION FOR CLINICAL PRIVILEGES.** Every initial application for medical staff appointment must contain a written request for the clinical privileges desired by the applicant. The evaluation of the request shall be based upon the applicant's education, training, experience, demonstrated competence, peer recommendations and all other relevant information, and shall follow the procedure for appointment to the medical staff set forth in these Bylaws. The ~~r~~equired peer recommendation includes written information regarding the practitioner's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. The evaluation of a request shall further be based on whether sufficient space, equipment, staffing, and financial resources are available to support the requested privileges. The Credentials Committee is responsible for the criteria utilized for granting, restricting and/or removing privileges. The applicant shall have the burden of establishing and maintaining qualifications and competency in the clinical privileges he or she requests.

   At least once in every twenty-four (24) months in connection with the reappointment process, or more often if needed or requested, re-determination of clinical privileges and the increase or curtailment of same shall be based upon the review of care provided and/or review of which document the evaluation of the member's participation in the delivery of medical care including, but not limited to, records of the medical staff, quality of care indicators, results of process improvement activities and monitors, information contained in patient records, and documentation of compliance with these Bylaws and applicable policies, procedures or standards issued or adopted by Marianjoy.

   When a Medical Staff member seeks a revision of his or her clinical privileges, the member shall submit a request to the Credentials Committee. Expansion of existing privileges shall be based

upon further evidence of training, experience, and demonstrated competence and judgment (including without limitation a query to the National Practitioner Data Bank) as requested by the Credentials Committee. Any changes in medical staff privileges must be subsequently approved by the Medical Executive Committee and Board of Directors. A Focused Professional Practice Evaluation must be conducted for each new privilege by a method determined by the Credentials Committee.

Denial of a request for clinical privileges recommended by the Medical Executive Committee or taken by the Board of Directors shall be subject to the hearing procedures set forth in these Bylaws.

2. **ALLIED HEALTH PROFESSIONALS.** Every Allied Health Professional requesting clinical privileges must submit an application for the clinical privileges desired by the applicant. The evaluation of the request shall be based upon the applicant's education, training, experience, demonstrated competence, references and all other relevant information, including an appraisal by the service in which such privileges are sought. Privileges for patient care activity will be granted to allied health professionals, who meet the qualifications set forth in Article VI, after adequate review by the Credentials Committee, review and approval by the Medical Executive Committee and approval by the Board of Directors. The Credentials Committee is responsible for establishing the criteria utilized for granting, restricting and/or removing allied health professional privileges. An applicant for allied health professional staff shall have the burden of establishing and maintaining the qualifications and competency in the clinical privileges he or she requests. An allied health professional's scope of practice is discipline specific as described in Article VI of the Bylaws.

Renewal of clinical privileges granted to allied health professionals shall be conducted in the manner described in these Bylaws.

Article VII, Section 2. TEMPORARY PRIVILEGES

A. GRANTING OF TEMPORARY PRIVILEGES

The Medical Staff allows for temporary privileges to be granted only for the two circumstances:

1. **AWAITING REVIEW AND APPROVAL**

Temporary privileges may be granted to a new applicant with a complete application that raises no concerns and is awaiting review and approval of the Medical Executive Committee and the Board of Directors. These privileges may be granted upon verification of the following:

- current licensure;
- relevant training or experience;
- current competence;
- ability to perform the privileges requested;
- query and evaluation of the NPDB;
- a complete application;
- no current or previously successful challenge to licensure or registration
- no subjection to involuntary termination of medical staff membership at another organization
- no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges;
- criminal background check; and
- other information deemed necessary by the hospital may also be required.

The President and CEO or his or her designee may, upon the basis of written information available, which may reasonably be relied upon as to the competence and character of the applicant, and with the written concurrence of both the Vice President of Medical Affairs (or his or her representative) and the Chairman of the Medical Executive Committee (or his or her representative), grant temporary admitting and/or clinical privileges to the applicant. In exercising such privileges, the applicant shall act under the supervision of the Vice President of Medical Affairs or his or her representative. In the event that the Credentials Committee or the Medical Executive Committee does not recommend the granting of medical staff membership to the applicant, the practitioner's temporary privileges shall be immediately terminated. Temporary privileges may be granted only for a temporary period, the duration of which, unless otherwise specified by the President and CEO or his or her designee, shall automatically terminate after one hundred twenty days (120) days.

2. **IMPORTANT PATIENT CARE, TREATMENT, AND SERVICE NEED FOR A SPECIFIC PATIENT.** Temporary privileges for patient care, treatment and service need may be granted by the President and CEO**,** upon the recommendation of the Vice President of Medical Affairs and the Medical Staff President or their designee, to a practitioner who is not an applicant for medical staff membership, but upon the same conditions set forth in this Section A, provided that there shall first be obtained a completed "Temporary Privileges Application Form" application for temporary privileges along with the practitioner's signed acknowledgement that he has received and read Section A. of Article VII; he agrees to be bound by the terms thereof in all matters relating to his or her temporary clinical privileges; that his or her license is current and in effect, and that he has adequate professional liability insurance as determined by the Board of Directors in conference with the Medical Executive Committee and as appears in the Bylaws, Rules and Regulations of the Medical Staff. The applicant's current licensure, NPDB, and clinical competence must also be verified. If the practitioner is on staff at an area hospital where criminal background checks are performed, then a background check is not required. "In good standing status" must be verified with this hospital. However, if they are not on staff at an area hospital, then a criminal background check is required in order to grant temporary privileges. Upon discharge of the patient, the practitioner's temporary privileges shall automatically terminate.

   Temporary privileges shall be restricted to the treatment of not more than a total of four (4) patients in one year by any practitioner, after which such practitioner shall be required to apply for membership on the medical staff before he is allowed to attend additional patients.

3. Temporary privileges shall be restricted to the treatment of not more than a total of four (4) patients in one year by any practitioner. A separate application must be completed for each patient, after which such practitioner shall be required to apply for membership on the medical staff before he is allowed to attend additional patients.

4. **LOCUM TENENS.** Upon the recommendation of the Medical Staff President, the President and CEO may permit a physician serving as a locum tenens for a member of the medical staff to attend patients for a period not to exceed sixty (60) days, providing he has applied for membership on the medical staff and all his or her credentials have been approved and confirmed by the Vice President of Medical Affairs or his or her designee. Evidence of liability insurance must be provided in the manner prescribed for all members of the Medical Staff.

B. TERMINATION OF TEMPORARY PRIVILEGES. Special requirements of supervision and reporting may be imposed by the Vice President of Medical Affairs or his or her representative on

any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the President and CEO upon any failure by the practitioner to comply with such special conditions.

When it is determined that the best interests of patient(s) would be compromised by continued treatment by the practitioner, termination of temporary privileges may be imposed by any person entitled to impose a summary suspension pursuant to Article VIII of these Bylaws, and the same shall be immediately effective.

A practitioner shall not be entitled to the hearing procedures set forth in Article IX of the Bylaws because a request for temporary privileges is refused or because all or a portion of the practitioner's temporary privileges are terminated or suspended. Notwithstanding the foregoing, a practitioner whose temporary privileges granted under Subsection A.1. of this section are terminated as a result of a negative recommendation of the Medical Executive Committee concerning his or her medical staff membership application is entitled to the hearing procedures of Article IX as a result of the adverse recommendation of the Medical Executive Committee on initial appointment to the Medical Staff.

The Vice President of Medical Affairs or his or her representative shall assign alternate coverage by a member of the active staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

Article VII, Section 3. EMERGENCY AND DISASTER PRIVILEGES

A. **EMERGENCY PRIVILEGES.** In the case of an emergency, any member of the medical staff, to the degree permitted by his or her license and regardless of medical staff status or lack of it, shall be permitted to use all facilities of the organization necessary to attend a patient experiencing an emergency as defined below, including calling for any consultation necessary or desirable. When an emergency situation no longer exists, such medical staff member must request temporary privileges necessary to continue to treat the patient. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff. For purposes of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient in the absence of treatment or in which the life of the patient is in immediate danger and any significant delay in administering treatment would add to that danger.

B. **DISASTER PRIVILEGES.** During a disaster, defined as a situation wherein Marianjoy Hospital implements either its External or Internal Disaster Plan or Marianjoy is unable to handle immediate patient needs, and in the best interest of patient care, the President and CEO or his or her designee may, at his or her discretion, grant disaster privileges on a case-by-case basis to non-members and volunteer practitioners upon presentation of any of the following:

1. A valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport);

   AND

2. A current hospital picture identification card that clearly identifies professional designation;

   OR

3. A current license to practice;

   OR

4. Primary source verification of the license;

   OR

5. Identification indicating that the individual is a member of a disaster medical assistance team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.

OR

6. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)

OR

7. Identification by current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

The "Disaster Incident Commander," defined as the President and CEO or his or her designee, the Vice President of Medical Affairs, or the Vice President of Nursing Services and Inpatient Operations or their designee(s) shall have the overall responsibility for assignment of duties to any volunteer practitioner(s) granted disaster privileges. As soon as possible, additional information will be gathered from the volunteer practitioner(s) on a "Disaster Privileges" form. When possible, all persons granted disaster privileges will be identified by a "Volunteer Practitioner: Disaster Privileges Granted" ID badge.

The Vice President of Medical Affairs or his designee will:

1. assign physicians and residents to assess patient in the triage area;
2. assign the medical staff to assess existing inpatients for possible discharge;
3. and oversee the practice of the volunteer licensed independent practitioners.

When Marianjoy deems a disaster situation to no longer exist or to be under control:

1. The disaster privileges shall expire;
2. The practitioner(s) granted disaster privileges must request medical staff membership and the clinical privileges necessary to continue to treat patients at Marianjoy. In the event such privileges are denied or the practitioner does not desire such privileges, the patient under the practitioner's care shall be assigned to an appropriate medical staff member; and
3. After the fact/retrospective credentialing for temporary privileges will occur as soon as is feasible to cover the time period of the disaster.

   Within 72 hours of the time that the volunteer practitioner presents him/herself to the organization, primary source verification of licensure will be conducted. If for some reason, this cannot be completed within 72 hours, it is expected to be completed as soon as possible and provide documentation on the "Disaster Privilege" form of the reason why it could not be performed within the required timeframe; the evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.

In regard to granting disaster privileges, the "designee" of the President of the Medical Staff shall include: Vice President of Nursing and Inpatient Services or designee, any Marianjoy Administrator or Vice President, Medical Staff or any past President of the Medical Staff or the physician on duty at the time of the disaster.

ARTICLE VIII – CORRECTIVE ACTION

Article VIII, Section 1. PROCEDURE

Corrective action against a medical staff member may be initiated whenever the activities or professional conduct of the medical staff member are believed to be: (i) detrimental to patient safety or to the efficient delivery of quality patient care; (ii) reasonably probable of being disruptive to the operation of the organization ; (iii) reasonably probable of being in violation of the Medical Staff Bylaws, Rules and Regulations, Marianjoy's Code of Ethics, or other policies that are applicable to member through his or her participation in the organization; or (iv) reflective of physical or mental impairment which may interfere with the member's ability to function competently relative to the practitioner's clinical privileges, with or without reasonable accommodation.

Before any corrective action is taken against a member of the medical staff, an effort shall be made, if reasonable under the circumstances, to deal with the specific activities or conduct that may constitute the grounds for a corrective action. This effort shall be informal and collegial in nature.

Requests for corrective action may be initiated by an officer of the medical staff, by the chairman of any standing committee of the medical staff, by the President and CEO or by any member of the Board of Directors. Such requests will be in writing to the Chairperson of the Medical Executive Committee and be supported by reference to the specific activities or conduct which constitute the grounds for the request. Prior to consideration by the Medical Executive Committee, the President of the Medical Staff shall notify the affected medical staff member and the Chairman of the Board of Directors. If the President of the Medical Staff is the affected medical staff member, then the Vice President of Medical Affairs shall assume the duties required of the President of the Medical Staff under this Section.

Corrective action that may be taken by the Medical Executive Committee includes, but is not limited to, the following: a warning; a letter of reprimand; probation; requirement for consultation; reduction, suspension or revocation/termination of clinical privileges; or suspension or revocation/termination of Medical Staff membership.

Prior to making a decision and after review of the request for corrective action, the President of the Medical Staff shall appoint an ad hoc committee to investigate the matter. The ad hoc committee shall, within sixty (60) days, report the results of the investigation and recommendations in writing to the Medical Executive Committee which shall then make its decision within thirty (30) days. Prior to the investigation, the member of the medical staff against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc committee. Before such an interview, the member shall be informed of the nature of the charges against him and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.

Whenever corrective action is requested, the affected member shall be notified in writing by the President of the Medical Staff of the request for corrective action and shall be provided with the reason for the contemplated action.

Except as otherwise provided in these Bylaws, whenever the action or recommendation by the Medical Executive Committee will or could result in a reduction, suspension or revocation/termination of clinical privileges for more than fourteen (14) days, or suspension or revocation of Medical Staff membership, the member shall be entitled to the procedural rights provided in Article IX of the Bylaws.

ARTICLE VIII, Section 2. PRECAUTIONARY SUSPENSION

At any time during an investigation, the Medical Executive Committee, with the concurrence of: the Vice President of Medical Affairs, the President of the Hospital or his or her designee, or the Chairman of the

Board, shall have the authority to suspend all or any portion of the clinical privileges of the Medical Staff member being investigated. Such precautionary suspension shall be deemed an interim precautionary suspension and does not constitute a Corrective Action. It shall not imply any final finding of responsibility for the situation that caused the suspension. The precautionary suspension shall be imposed for up to 14 (fourteen) days and shall become effective immediately upon imposition, remaining in effect without appeal during the course of the investigation only. If such a precautionary suspension is placed in effect, the investigation must be completed within fourteen (14) days of the suspension. The Vice President of Medical Affairs or his or her designee shall promptly give special notice of the suspension to the Medical Staff member.

Article VIII, Section 3. SUMMARY SUSPENSION

Whenever in the best interest of patient care, action must be taken immediately, all or any portion of the clinical privileges of a member may be summarily suspended by the President and CEO after consultation with the President of the Medical Staff and/or Vice President of Medical Affairs. Such summary suspension shall become effective immediately upon imposition.

A member whose clinical privileges have been summarily suspended for longer than 14 days may request a fair hearing to conduct a review of the summary suspension. This hearing shall be conducted not less than thirty (30) days after the member's request for a hearing unless the member requests an earlier hearing. The fair hearing shall be conducted pursuant to the requirements as stated in these Bylaws.

Article VIII, Section 4. AUTOMATIC TERMINATION

The following shall result in automatic termination of a Medical Staff member's membership and clinical privileges:

1. Conviction of the practitioner of any state or federal felony or conviction of any Caregiver Law. There will be no review, fair hearing, or appeal of the termination based on such conviction.

2. The practitioner's medical staff membership at any other hospital in the practice area have been terminated (other than voluntary resignation by the practitioner unrelated to any investigation). There will be no review, fair hearing, or appeal of the termination based on the foregoing.

3. Failure to timely make the notifications required by Article III, Section 2.10(e)-(g) above of these Bylaws. There will be no review, fair hearing, or appeal of the termination based on the foregoing

4. In the event that a practitioner has been decertified, debarred or excluded from participation in the Medicare or Medicaid program. There will be no review, fair hearing, or appeal of the termination based on the foregoing

Immediately upon the imposition of an automatic termination, the practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such termination. The wishes of the patient(s) shall be considered in the selection of such alternate practitioner(s). The terminated practitioner shall confer with the alternate practitioner to the extent necessary to safeguard the patient(s). If the practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the Chief of Staff, Vice President of Medical Affairs or responsible Department Chief shall have the authority to provide for alternative medical coverage for patients of the terminated practitioner.

Notwithstanding any other term or condition of these Bylaws, automatic termination for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

Article VIII, Section 5. AUTOMATIC SUSPENSION.

The following shall result in automatic suspension of a Medical Staff member's membership and clinical privileges:

A. Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, or imposing probation or limitation of practice, shall automatically suspend all of the practitioner's Hospital privileges. Such shall occur whether the action of the Medical Examiners Board is unilateral or agreed to by the practitioner. In such an event, the Medical Executive Committee shall promptly review the matter and submit a recommendation to the Board of Directors regarding the practitioner's Medical Staff status and clinical privileges. The Medical Executive Committee shall, if concurred in by the Hospital President be authorized to lift or modify any such automatic suspension pending final determination by the Board of Directors. In the event that such limitation imposes only a requirement to obtain additional continuing medical education and no other restrictions or practice limitations, the Chief of Staff may, if concurred by the Hospital President, lift such automatic suspension pending review by the Medical Executive Committee.

B. An automatic suspension shall be imposed, after a warning of delinquency, upon a practitioner for failure to complete medical records in accordance with the time limits set forth in the current Medical Staff Rules and Regulations, except as otherwise set forth in the Rules and Regulations. Such suspension shall take the form of withdrawal of the practitioner's admitting privileges and shall be effective until requirements for medical record completion, as stated in the Rules and Regulations are met. Such suspension of privileges shall not affect the status or privileges of the practitioner as regards patients who are at the time of the automatic suspension in the Hospital under the care of the practitioner

C. An automatic suspension shall be imposed, after a warning of delinquency, upon a practitioner for failure to pay Medical Staff dues and/or assessments within sixty (60) days of billing, except as otherwise set forth in the Rules and Regulations. Such suspension shall take the form of withdrawal of the Practitioner's admitting privileges and shall be effective until the delinquent dues or assessments are paid. Such suspension of privileges shall not affect the status or privileges of the practitioner as regards patients who are at the time of the automatic suspension in the Hospital under the care of the Practitioner.

D. A practitioner whose DEA number is revoked or restricted or voluntarily surrendered shall automatically be divested of the right to prescribe medications controlled by such number.

E. An automatic suspension of all privileges shall be imposed by the Hospital President after discussion with the Chief of Staff, for misconduct that does not directly involve clinical issues but is in violation of Hospital policy. Such misconduct can consist of, but is not limited to: sexual harassment or abuse of others; drug, alcohol or other addiction; criminal, fraudulent or other improper conduct.

F. An automatic suspension shall be imposed upon a practitioner's failure without good cause to supply information or documentation requested by any of the following: the Hospital President or his or her designee, the Credentials Committee, the Medical Executive Committee or the Board. Such suspension shall be imposed only if: (1) the request was in writing, (2) the request was related to evaluation of the Practitioner's current qualifications for membership or clinical privileges, (3) the Practitioner failed to either comply with such request or to satisfactorily explain his or her inability to comply, and (4) the Practitioner was notified in

writing that failure to supply the request information within 15 days from receipt of such notice would result in automatic suspension. Any automatic suspension imposed pursuant to this paragraph may be a suspension of any portion or all of the Practitioner's privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.

G. An automatic suspension shall be imposed upon a Practitioner's failure to maintain professional liability insurance coverage in accordance with limits established by the Medical Staff.

H. An automatic suspension shall be imposed upon a practitioner's failure to timely make the notifications required by Article III, Section 2.10(a)-(d) above of these Bylaws.

Immediately upon the imposition of an automatic suspension, the practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of such alternate practitioner(s). The suspended practitioner shall confer with the alternate practitioner to the extent necessary to safeguard the patient(s). If the practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the Chief of Staff, Vice President of Medical Affairs or responsible Department Chief shall have the authority to provide for alternative medical coverage for patients of the suspended practitioner.

Notwithstanding any other term or condition of these Bylaws, automatic suspension for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

Article VIII, Section 6. ALLIED HEALTH PROFESSIONALS

A. <u>Automatic Suspension or Termination of Allied Health Professional Privileges</u>

1. Automatic Termination. An allied health professional's clinical privileges shall automatically terminate upon any of the following events:

(a) As applicable, termination of employment or other engagement by a Member of the Hospital's Medical Staff.

(b) Conviction of any state or federal felony or conviction of any Caregiver Law;

(c) The allied health professional's termination of all of their clinical privileges at any other Wheaton Hospital (other than voluntary resignation by the allied health professional unrelated to any investigation);

(d) The allied health professional's decertification, debarment or exclusion from participation in any state or federal health care program; or

(e) The allied health professional's failure to timely make the notifications required by Article VI, Section 3(v)-(viii) above of these Bylaws.

Notwithstanding any other term or condition of these Bylaws, automatic termination in the event of any of the above shall be administrative in nature and shall not entitle the allied health professional to any of the hearing or appellate review rights otherwise set forth below.

2. Automatic Suspension. An allied health professional's clinical privileges shall be automatically suspended upon any of the following events:

(a) loss or restriction of licensure or certification to practice in the State of Illinois;

(b) failure to maintain professional liability insurance in amounts established by the Hospital applicable to allied health professionals;

(c) The existence of any of the following as they relate to patient abuse, neglect, misappropriation of patient property or similar offenses shall result in automatic suspension or termination of an allied health professional's clinical privileges to the extent required by any Caregiver Law: (a) pending criminal charges; or (b) pending investigation;

(d) An automatic suspension shall be imposed upon an allied health professional's failure without good cause to supply information or documentation requested by any of the following: the Hospital President or his or her designee, the Credentials Committee, the Medical Executive Committee or the Board. Such suspension shall be imposed only if: (1) the request was in writing, (2) the request was related to evaluation of the allied health professional's current qualifications for membership or clinical privileges, (3) the allied health professional failed to either comply with such request or to satisfactorily explain his or her inability to comply, and (4) the allied health professional was notified in writing that failure to supply the request information within 15 days from receipt of such notice would result in automatic suspension; or

(e) The allied health professional's failure to timely make the notifications required by Article VI, Section 3(i)-(iv) above of these Bylaws. Notwithstanding any other term or condition of these Bylaws, automatic suspension in the event of any of the above shall be administrative in nature and shall not entitle the Allied Health Professional to any of the hearing or appellate review rights otherwise set forth below.

B. Allied Health Professional Corrective Action.

Corrective action against an allied health professional may be initiated whenever the activities or professional conduct of the allied health professional are believed to be any of the following:

1. detrimental to patient safety or to the efficient delivery of quality patient care;
2. reasonably probable of being disruptive to the operation of the organization;
3. reasonably probable of being in violation of the or Medical Staff Bylaws, Rules and Regulations, or other policies that are applicable to the individual through his or her participation; or
4. reflective of physical or mental impairment which may interfere with his or her ability to function competently as an Allied Health Professional.

Requests for corrective action may be initiated by any member of the medical staff, the Vice President of Medical Affairs, the President or by any member of the Board of Directors. Such requests will be in writing and be supported by reference to the specific activities or conduct which constitute the grounds for the request and shall be submitted to the chair of the Medical Executive Committee.

Prior to consideration by the Medical Executive Committee, the President of the Medical Staff shall notify the affected allied health professional and the Chairman of the Board of Directors.

Corrective action includes, but is not limited to, the following:

1. a warning;
2. a letter of reprimand;
3. probation;
4. reduction,
5. suspension or revocation/termination of clinical privileges;
6. or suspension or revocation/termination of allied health professional status.

Prior to making a decision and after review of the request for corrective action, the Medical Executive Committee shall investigate the matter. The allied health professional shall be afforded a personal interview with a representative from the Medical Executive Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.

Whenever corrective action is requested, the affected individual shall be notified in writing by the Medical Executive Committee of the request for corrective action and shall be provided with the reason for the contemplated action. Once the Medical Executive Committee has made a final recommendation, whether adverse or favorable, the matter shall be forwarded to the Vice President of Medical Affairs for consideration.

Whenever the action by the Vice President of Medical Affairs could result in a reduction, suspension or revocation/termination of clinical privileges, or suspension or revocation/termination of allied health professional status, the allied health professional shall be entitled to the procedural rights provided in these Bylaws.

Article VIII, Section 7. PHYSICIAN HEALTH PROGRAMS

If the Medical Executive Committee determines that a request for corrective action is based upon conduct that is reflective of physical or mental impairment which may interfere with the member’s ability to function competently relative to the practitioner’s clinical privileges, it may consider alternatives to corrective action under these bylaws, including, but not limited to, such things as designing a process to provide education about physician health; prevention of physical, psychiatric or emotional illness; and confidential diagnosis, treatment and rehabilitation. The process may stress assistance and rehabilitation instead of discipline. Any such process must be consistent with protection of the health and safety of patients. If at any time during any such process, the Medical Executive Committee determines that a member is unable to safely perform his or her duties or is not benefiting from such process, the Medical Executive Committee may revoke the member’s participation in the process and begin corrective action immediately. Any time spent involved with any such process by the Medical Executive Committee shall suspend the time required to act by the Medical Executive Committee or any other person under these Bylaws. Each member, by participating in any such process, irrevocably agrees to the suspension of any time requirements under these bylaws.

When there is reason to question the physical and/or mental health status of a practitioner, with or without reasonable accommodation, relative to the practitioner’s clinical privileges, in accordance with applicable law, the practitioner may be required to submit to an evaluation of physical and/or mental health status as defined in the Medical Staff Practitioner Health Policy.

ARTICLE IX – HEARING PROCEDURE

Article IX, Section 1. RIGHT TO HEARING AND APPELLATE REVIEW

A member of the medical staff or applicant thereto shall be entitled to a fair hearing and appellate review in the following circumstances:

1. Adverse recommendation of the Medical Executive Committee on initial appointment or reappointment to the medical staff;

2. Adverse recommendation of the Medical Executive Committee with respect to clinical privileges requested on initial appointment or reappointment to the medical staff;
3. Adverse decision of the Board of Directors (following a favorable decision by the Medical Executive Committee) on initial appointment or reappointment to the medical staff;
4. Adverse decision of the Board of Directors (following a favorable decision by the Medical Executive Committee) with respect to clinical privileges requested on initial appointment or reappointment to the medical staff;
5. Termination of medical staff membership at the unsuccessful conclusion of the provisional staff period; based on data reported on the Ongoing Professional Practice Evaluation;
6. Upon the reduction or suspension of clinical privileges for more than fourteen (14) days;
7. Upon the imposition of a summary suspension that lasts more than 14 days; or
8. Upon a decision by the Board of Directors not to allow continued membership when a member fails to obtain board certification within three (3) years of successful completion of a training program or fails to obtain board recertification as required under these Bylaws.

All hearings and appellate reviews shall be in accordance with procedural safeguards set forth in this Article to assure that the affected member is afforded all rights to which he is entitled.

An affected medical staff member shall be provided a minimum of sixty (60) days prior notice of the effect on his or her medical staff membership or privileges for changes resulting from the organization electing to exercise its option to enter into an exclusive contract. Affected medical staff members must request a hearing within fourteen (14) days after notification of the exclusive contract.

Article IX, Section 2. REQUEST FOR HEARING

The President and CEO and the Vice President of Medical Affairs shall be responsible for giving prompt written notice by certified mail, return receipt requested, explaining the reasons for an adverse action to any affected practitioner who is entitled to a hearing. The notice must notify the affected practitioner of his or her right to a fair hearing and the affected practitioner's rights at such a hearing. The practitioner shall be advised that failure to request a hearing in writing by certified mail within thirty (30) days of the date of the notice forfeits the right to a hearing and appeal. In such case, the recommendation of the Medical Executive Committee or the Board of Directors, as applicable, shall be final and remain effective against the practitioner.

Article IX, Section 3. NOTICE OF HEARING

Within ten (10) days after receipt of a request for a fair hearing, the Medical Executive Committee shall appoint an ad hoc committee of the medical staff and direct it to schedule and arrange for such a hearing. The ad hoc hearing committee shall, through the President and/or the Vice President of Medical Affairs, notify the practitioner by certified mail, return receipt requested, of the time, place and date so scheduled, which date shall not be less than thirty (30) but not more than sixty (60) days after the date of the notice to the practitioner of the proposed action. The notice of hearing shall state concisely the basis for the adverse action, and shall supply relevant documentation. A list of the witnesses, if any, who are expected to testify on behalf of the body recommending the adverse action must also be included with the notice of hearing. The affected practitioner shall submit a list of witnesses, if any, expected to testify on his or her behalf in his or her written hearing request.

Article IX, Section 4. COMPOSITION OF HEARING COMMITTEE

The ad hoc hearing committee shall be composed of not less than five (5) members of the active medical staff appointed by the President of the Medical Staff in consultation with the Vice President of Medical Affairs, and one of the members appointed shall be designated as chairman. No medical staff member who has actively participated in the consideration of the adverse action or the investigation shall be appointed except in unusual circumstances when consented to by the affected member of the medical staff. No member of the ad hoc hearing committee may be in direct economic competition with the affected member.

Article IX, Section 5. CONDUCT OF HEARING

There shall be at least a majority of the members of the ad hoc hearing committee present when the hearing takes place, and only those present may vote. The meeting shall be closed. No outside media representatives are allowed at any meeting.

Personal presence of the affected practitioner for whom the hearing is being held is required, and failure without good cause to appear shall constitute a waiver of his or her rights to a hearing and appellate review. Postponement of the hearing shall be only for good cause, and at the sole discretion of a majority of the ad hoc hearing committee. The affected practitioner shall have the right to representation by counsel or other person of the affected practitioner's choice. The body recommending the adverse action shall also have the right to representation by counsel.

The affected practitioner shall be entitled to inspect and copy (at his or her own expense) all documentary materials, records and other information which is in the possession or control of the ad hoc hearing committee and which is relevant to the subject of the hearing or necessary to the presentation of the practitioner.

The affected practitioner and body recommending the adverse action shall have the right to call and examine witnesses, introduce written evidence, cross-examine any witness on any matter relevant to the issues of the hearing, challenge any witness, and rebut any evidence. If the practitioner does not testify on his or her own behalf, he may be called and examined as if under cross examination. The body recommending the adverse action shall appoint one of its members as a designated representative to present the facts in support of the adverse action by appropriate evidence and to examine witnesses.

The hearing need not be conducted strictly according to any civil or criminal rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence in civil or criminal actions. The practitioner for whom the hearing is held and the body recommending the adverse action, shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or fact and such memoranda shall become a part of the hearing record.

A verbatim record of the hearing, which may be a sound recording of the proceedings, shall be available to the affected Practitioner, together with copies of all documentary evidence introduced. Any costs of such transcription and duplication shall be borne by the practitioner.

The burden of proof at the hearing rests on the affected practitioner. The affected practitioner shall be responsible for supporting his or her challenge to the adverse action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn therefrom are arbitrary, unreasonable, or capricious.

Upon the conclusion of the hearing, the affected practitioner and the body recommending the adverse action have the right to submit a written statement to the ad hoc hearing committee. Not more than twenty (20) days after the conclusion of the hearing, the ad hoc hearing committee shall submit a written

report and recommendations, based on the hearing record, to the Medical Executive Committee (or Board of Directors, if that body recommended the adverse action). The affected practitioner shall have the right to receive a copy of the written recommendations, including a statement of the basis for the recommendations. Not less than ten (10) days after receipt of the ad hoc committee report, the Medical Executive Committee (or Board of Directors, as the case may be) shall transmit its decision and the ad hoc committee report and recommendations to the Board of Directors and to the affected practitioner.

Article IX, Section 6. APPEALS TO THE BOARD OF DIRECTORS

The affected practitioner may request within ten (10) days after receipt of notice of an adverse decision, an appellate review by the Board of Directors. The request must occur by written notice to the Board of Directors through the President, delivered by certified mail, return receipt requested. If such appellate review is not timely requested, the affected practitioner shall be deemed to waive the rights to such review and to have accepted the adverse decision, and the same shall become effective immediately as provided in Section 2 of this Article.

The Board of Directors shall schedule a date for appellate review, which date shall not be more than thirty (30) days after the receipt of the practitioner's request for such review. The Board of Directors shall notify the practitioner of the time and place of the review through the President by certified mail, return receipt requested.

The affected practitioner shall have access to the reports and records of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse decision against him. The practitioner may submit a written statement in his or her own behalf on those factual and procedural matters with which he disagrees, and the reasons for such disagreement shall be specified. Such statement shall be submitted to the Board of Directors through the President by certified mail, return receipt requested, at least five (5) days prior to the date of the designated appellate review. In addition, the Medical Executive Committee (or Board of Directors, as the case may be), may submit a written statement in support of its decision and the ad hoc committee report.

The Board of Directors shall review the records created in the proceedings, and shall consider the written statement submitted by the affected practitioner and the Medical Executive Committee (or the Board of Directors) for the purpose of determining whether the practitioner satisfied his/her burden to prove, by clear and convincing evidence, the grounds for the adverse decision lack any factual basis or that such basis or the conclusions drawn therefrom are arbitrary, unreasonable, or capricious. If the affected practitioner has requested an opportunity to personally appear before the Board of Directors, he shall be permitted to do so and shall answer questions put to him by any member of the Board of Directors. If the practitioner appears before the Board of Directors, the body recommending the adverse action shall appoint one of its members as a designated representative to present its position to the Board of Directors.

Article IX, Section 7. FINAL DECISION BY THE BOARD OF DIRECTORS

The Board of Directors shall make its final decision in the matter within thirty (30) days after the conclusion of the appellate review, and shall send notice thereof and an explanation of the final decision, by certified mail, return receipt requested, through the President and CEO to the Medical Executive Committee, and to the affected member. The decision of the Board of Directors shall be immediately final. Such decision shall not be subject to further hearing or appellate review.

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter that shall have been the subject of action by the Medical Executive Committee or by the Board of Directors or both.

Article IX, Section 8. REPORTING OF ADVERSE DECISIONS

The Board of Directors shall be required to report to the Illinois Department of Professional Regulation: (i) any professional review action that adversely affects the clinical privileges of a medical staff member for a period of longer than thirty (30) days; or (ii) acceptance of the surrender of clinical privileges of a physician while the physician is under investigation by the Board of Directors relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding. Reports to the National Practitioner Data Bank shall occur as deemed appropriate by the medical staff in consultation with Administration in accordance with applicable law.

Article IX, Section 9. ALLIED HEALTH PROFESSIONALS

If the Medical Executive Committee makes an adverse recommendation with respect to any allied health professional who has membership and clinical privileges on the Allied Health Professional Staff**,** then before the adverse recommendation is sent to the Board of Directors, the process outlined below shall be followed.

The allied health professional shall be afforded a personal interview with a representative from the Medical Executive Committee. During this interview, the Medical Executive Committee representative shall share with the allied health professional all of the bases upon which the adverse recommendation is founded. Within thirty (30) days after such meeting, the allied health professional may submit a written response to the issues identified by the Medical Executive Committee representative during the interview. Failure to submit a response constitutes a waiver of any further rights under this Section.

If the allied health professional submits a statement of response, the Medical Executive Committee shall invite the allied health professional to its next regularly scheduled meeting. At this meeting, the allied health professional may, during such time as is allotted by the Medical Executive Committee, present any information he deems relevant. After consideration of the allied health professional's response, the Medical Executive Committee may choose to affirm its initial adverse recommendation, reverse its initial adverse recommendation and forward a favorable recommendation to the Board of Directors, or table the matter for purposes of further discussion with the allied health professional and/or other investigation.

If the Medical Executive Committee's recommendation remains adverse after consideration of the allied health professional's response, it shall send its entire record, including a copy of the allied health professional's written response, to the Board of Directors, which shall sit as an appellate review body as it makes its decision regarding the matter.

Once the Medical Executive Committee has made a final recommendation, whether adverse or favorable, the matter shall be forwarded to the Board of Directors for its consideration. The decision of the Board of Directors shall be final.

ARTICLE X – ORGANIZATION OF THE MEDICAL STAFF

Article X, Section 1. OFFICERS OF THE MEDICAL STAFF AND TENURE OF OFFICE

The officers of the Medical Staff are:

1. President
2. Vice President
3. Secretary/Treasurer.

Officer terms shall be two (2) years unless or until his or her successor is elected. No Practitioner may serve more than two (2) consecutive two year terms as President.

A. ELECTIONS. On odd years and prior to the annual meeting of the Medical Staff, the Nominating Committee will nominate from among the active staff a slate of officers to serve for two (2) years. No more than two (2) practitioners shall be nominated for each office. Election of officers shall take place at the Spring Annual Meeting of the Medical Staff. Nominations shall be accepted from the floor and write-in candidates shall be permitted. The list of officers elected by the medical staff shall be presented to the Board of Directors, at its next meeting following the medical staff meeting, for approval. If approved by the Board of Directors, the terms of the officers elected shall begin on July 1st.

B. QUALIFICATIONS AND DUTIES OF OFFICERS

1. **PRESIDENT.** The President of the Medical Staff must be a physician who is a member of the active staff. He shall also serve as chairman of the Medical Executive Committee and an ex officio member of the Board of Directors. He shall call all quarterly, special and annual medical staff meetings. He shall be an ex-officio member of all committees and shall have general supervision over all the professional work of the institution. Except for the Pre-application Background Review Committee, the President, with input from the Vice President of Medical Affairs, shall appoint all standing medical staff committees.

2. **VICE PRESIDENT.** The Vice President must be a member of the active staff and in the absence of the president shall assume all the duties and have all the authority of the president. He shall also be expected to perform such duties of supervision as may be assigned to him by the President of the Medical Staff or the Vice President of Medical Affairs.

3. **SECRETARY/TREASURER.** The Secretary/Treasurer shall be a member of the active staff. The following duties are to be undertaken by the Secretary/Treasurer:
   a. Give proper notice of all medical staff meetings on order of the appropriate authority.
   b. Supervise the preparation of accurate and complete minutes for all medical staff and standing committee meetings.
   c. Perform such other duties as ordinarily pertain to this office.

C. VACANCIES. In the event of a vacancy in the office of the President, the Vice President shall automatically assume the office of the Presidency for the unexpired portion of the term. In the event of a vacancy in the office of the Vice President or Secretary/Treasurer, the Board of Directors, after consultation with the Medical Executive Committee, shall make an interim appointment among members of the active staff. The newly appointed officer shall hold office for the unexpired portion of the term of the replaced officer.

D. REMOVAL OF OFFICERS. The medical staff may remove from office any officer by a petition signed by 25% of the active staff members and a subsequent two-thirds affirmative vote by ballot of the active staff. Automatic removal shall be for failure to conduct those responsibilities assigned within these bylaws; failure to comply with policies and procedure of the medial staff; conduct or statements damaging to the hospital, its goals, or its programs; or an automatic or summary suspension of clinical privileges that lasts for more than 30 days. The hospital board will determine the existence of such failures after it consults with the Medical Executive Committee and approve the removal of said officer.

Article X, Section 2. VICE PRESIDENT OF MEDICAL AFFAIRS

The Vice President of Medical Affairs is appointed by the President and CEO and is responsible for medical quality oversight within the organization, reporting to the President and CEO. The Vice President of Medical Affairs shall have at least the following roles and responsibilities:

1. Be board certified in Physical Medicine & Rehabilitation.
2. Have at least ten years of clinical experience.
3. Liaison person, along with the President of the Medical Staff, between the Medical Staff and the Board of Directors.
4. Serve on the Medical Executive Committee and such other medical staff committees as set forth in these Bylaws.
5. Interpret and apply Medical Staff Bylaws and Rules and Regulations in consultation with the President of the Medical Staff.
6. Perform the role of Designated Institutional Official for the postgraduate medical education program.
7. Work with the program medical directors to coordinate professional services.
8. Provide liaison in conjunction with the chair of Physical Medicine and Rehabilitation of the Chicago Medical School, Rosalind Franklin University of Medicine and Science, between affiliated universities and medical schools in the educational and research programs.
9. Oversee continued assessment and improvement of quality of care treatment and services.
10. Supervise with the program medical directors and be ultimately responsible for medical administration.
11. Provide continuing surveillance of the professional performance of all individuals with delineated clinical privileges.
12. Recommend criteria for clinical privileges.
13. Assess and recommend to Administration off-site sources for needed patient care services not provided by the organization.
14. Develop and implement policies and procedures that guide and support the provision of services.
15. Recommend a sufficient number of qualified and competent persons to provide care or service.
16. Determine the qualifications and competence of department or service personnel who are not licensed independent Practitioners and provide patient care.
17. Recommend space or other resources needed by the medical staff.
18. Provide for orientation and continuing education of the medical staff.
19. Oversee the clinically-related activities of the medical staff.
20. Recommend clinical privileges for each member of the medical staff in conjunction with the credentials committee.
21. Integrate the various services into the primary functions of Marianjoy.
22. Provide leadership for quality control programs and provide organizational leadership for performance improvement.

Article X, Section 3. MEDICAL STAFF COMMITTEES

The standing committees of the medical staff shall be as set forth these Bylaws. Additional ad hoc committees may be created as determined necessary by the Board of Directors and the Medical Staff. Except for the Pre-application Background Review Committee, committee members may be removed by the majority vote of the other members of the committee or the majority vote of the Board of Directors. As feasible, a meeting record of the medical staff committees shall be made available at the next meeting of the Medical Executive Committee.

A. MEDICAL EXECUTIVE COMMITTEE ("MEC Committee")

1. **MEC COMMITTEE - MEMBERSHIP AND TENURE.** The Medical Executive Committee shall consist of the President of the Medical Staff, who shall serve as

chairman of this committee, Vice President of the Medical Staff, Secretary/Treasurer of the Medical Staff, the immediate Past President of the Medical Staff, the President and CEO or his or her designee, the Vice President of Medical Affairs and a member-at-large. The member-at-large is to be appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs. The member-at-large shall serve on the committee for two (2) years unless or until his or her successor is appointed. All members of the Medical Staff or other licensed independent practitioners of any discipline or specialty are eligible for membership on the committee.

2. **MEC COMMITTEE - MEETINGS AND QUORUM.** The Medical Executive Committee shall meet as needed but not less than quarterly. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present with the majority of voting members being fully licensed physicians actively practicing in the hospital. The presence of a majority of this committee's members shall constitute a quorum.

3. **MEC COMMITTEE – RESPONSIBILITIES.** The Medical Executive Committee shall have the authority and the responsibility to:

   a. Act on behalf of the full Medical Staff between medical staff meetings and in accordance with delegated authority to ensure full compliance with the Medical Staff Bylaws, Rules and Regulations, maintain objective surveillance of the medical care being delivered throughout the organization.
   b. Approve and submit to the Board of Directors rules and regulations appropriate to the provision of high quality medical care.
   c. Cooperate in providing for and implementing educational programs.
   d. Receive recommendations from the Credentials Committee on appointments, removals/termination, privileges, and change of status for consideration and recommendation to the Board of Directors. The Medical Executive Committee shall have the authority to approve appointment and reappointment applications received from the Credentials Committee and report its action to the medical staff at the quarterly meetings. The Medical Executive Committee shall request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.
   e. Receive information from and coordinate the activities and policies of the committees of the medical staff, departments, and other assigned activity groups and of the medical staff as a whole, and make recommendations to the Board of Directors, as appropriate.
   f. Maintain a permanent record of proceedings and actions of the Medical Executive Committee and report on such to the medical staff as a whole at the quarterly meeting.
   g. Call special meetings for purpose of corrective actions and fair hearings.
   h. Review and approve all contracts by which Marianjoy acquires patient services from outside services.
   i. Annually review the timeliness and quality of services provided by allied health professionals.
   j. Organize the medical staff's organizational performance improvement activities and establish a mechanism to conduct, evaluate and revise such activities.
   k. Make medical staff recommendations directly to the Board of Directors for its approval of the medical staff structure and the credentialing and privileging process.
   l. Design a peer review plan for medical staff members. The peer review plan is designed to improve the clinical skills of members by having a medical staff

member's "peers" evaluate his or her clinical competence. A "peer" shall be a practitioner with the same or similar clinical privileges.

m. Investigate any report of less than acceptable conduct by a medical staff member, review problem cases that may be referred by any member of the medical staff or any committee thereof.

B. CREDENTIALS COMMITTEE

1. CREDENTIALS COMMITTEE - MEMBERSHIP AND TENURE. The Credentials Committee shall consist of three (3) active staff members of the medical staff appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs. In the event a member resigns before the expiration of his or her term, a replacement for the unexpired term only shall be appointed by the President of the Medical Staff. The chairman of the Credentials Committee shall be appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs of Marianjoy. Members of the Credentials Committee shall serve terms of two (2) years unless or until their successor is elected or appointed.

2. CREDENTIALS COMMITTEE - MEETINGS AND QUORUM. This committee shall meet as needed, with a minimum of two meetings per year. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present. For purpose of this committee, attendance by at least two-thirds (2/3) of active staff members serving on the committee, provided that at least two (2) committee members are present, shall constitute a quorum.

3. CREDENTIALS COMMITTEE – RESPONSIBILITIES. The Credentials Committee shall have the authority and the responsibility to:

a. Implement criteria and procedures for initial medical staff appointment, orientation, and reappointment as outlined in Article V of these Bylaws.

b. Consistent with the policies established by the Medical Executive Committee, review at least biannually all information available regarding clinical competence of medical staff members, and as a result of such review, make appropriate recommendations to the Medical Executive Committee.

c. Maintain a profile folder of each medical staff member identifying his or her initial appointment, credentials, reappointment credentials, privileges and personal educational and professional data as necessary to have a ready reference file.

C. BYLAWS COMMITTEE

1. BYLAWS COMMITTEE - MEMBERSHIP AND TENURE. The Bylaws Committee shall consist of the Vice President of Medical Affairs, who serves as chairman, and two (2) members of the medical staff, appointed by the President in collaboration with the Vice President of Medical Affairs. Members of the Bylaws Committee shall serve terms of two (2) years unless or until their successors are elected or appointed.

2. BYLAWS COMMITTEE - MEETINGS AND QUORUM. This committee shall meet as needed, with a minimum of at least one meeting per year, and shall report to the Medical Executive Committee. The Committee may meet any time at the request of the President of the Medical Staff, Vice President of Medical Affairs, or President of the Board of Directors. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present. For purpose of this committee, attendance by at least two-thirds (2/3) of active staff members

serving on the committee, provided that at least two (2) committee members are present, shall constitute a quorum.

3. **BYLAWS COMMITTEE – RESPONSIBILITIES.** The Bylaws Committee shall have the authority and the responsibility to:

   a. Review and revise these Bylaws to comply with federal and state law, accreditation requirements, and the practices of the medical staff.
   b. Write new bylaws for newly developed medical staff entities as they are formed.

D. NOMINATING COMMITTEE

1. **NOMINATING COMMITTEE - MEMBERSHIP AND TENURE.** The Nominating Committee shall consist of the Vice President of Medical Affairs, the Past President who serves as the Chairman and one active staff member appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs. Members of the Nominating Committee shall serve terms of two (2) years unless or until their successors are elected or appointed.

2. **NOMINATING COMMITTEE - MEETINGS AND QUORUM.** This committee shall meet as needed, with a minimum of one meeting every other year. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present. For purpose of this committee, attendance by three committee members shall constitute a quorum.

3. **NOMINATING COMMITTEE – RESPONSIBILITIES.** The purpose and responsibility of the Nominating Committee shall be to nominate individuals for each medical staff office when needed and to present a complete listing of all medical staff officers to the medical staff biannually.

E. CONTINUING MEDICAL EDUCATION COMMITTEE ("CME COMMITTEE")

1. **CME COMMITTEE - MEMBERSHIP AND TENURE.** The Continuing Medical Education Committee shall consist of the Vice President of Medical Affairs or his or her designee, the Director of Quality, and an attending physician appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs. The chairman of this committee shall be appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs. A resident, selected by the residency program director, may also serve on this committee, without vote. Members of the Continuing Medical Education Committee shall serve for a term of two (2) years, except for the resident, who will serve for one (1) year, unless or until their successors are elected or appointed.

2. **CME COMMITTEE - MEETINGS AND QUORUM.** This committee shall meet as needed, with a minimum of two meetings per year. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present.

3. **CME COMMITTEE - PURPOSE AND RESPONSIBILITIES.** The purpose of the Continuing Medical Education Committee shall be to support a commitment to the highest professional standards of physiatric practice through provision, access, and promotion of excellence in quality continuing medical education activities that maintain, develop, or improve knowledge, skills, and professional performance and relationships necessary to provide services for patients, the community, the public, or the profession.

The responsibilities of the Continuing Medical Education Committee shall be to:

a. Assure that all continuing medical education ("CME") activities are consistent with the CME Mission statement.
b. Review, evaluate, and oversee so that all CME activities, in-house or external, adhere to Illinois State Medical Society ("ISMS") accreditation standards developed for intrastate sponsors of CME in order to maintain the status of ISMS accreditation.
c. At least annually, assess the learning needs of the constituency for CME program planning and development.
d. Support, advise, and assist with available resources in CME program development to encourage and foster effective delivery of educational experiences.
e. Assure that each individual CME activity and the CME program as a whole are appropriately evaluated and reported in a timely fashion, and the results are used toward improving and developing more effective programs.
f. Keep abreast of state-of-the-art CME program delivery methods to assist in creating innovative and effective learning experiences.
g. Assure documentation of planning, implementation, and evaluation of all CME activities.
h. Maintain liaison with the Continuing Education Committee, the Board of Directors, and the Medical Executive Committee.
i. Develop and update policies and procedures related to CME.
j. Report and communicate all recommendations and matters concerning CME to the Medical Executive Committee.
k. Ensure that management procedures, educational quality, and other necessary resources are available and effectively used to fulfill its continuing medical education mission.
l. Other duties as requested by the Vice President of Medical Affairs.

F. PATIENT CARE REVIEW COMMITTEE/QUALITY MONITORING COMMITTEE ("PC/QM COMMITTEE")

1. **PC/QM COMMITTEE - MEMBERSHIP AND TENURE.** The Vice President of Medical Affairs or his or her designated physician shall serve as chair. All active staff physicians with inpatient bed services at Marianjoy shall be members of this committee.

2. **PC/QM COMMITTEE - MEETINGS AND QUORUM.** The committee shall meet as needed but not less than quarterly. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present. For purpose of this committee, attendance by at least twenty-five percent (25%) of the active staff members serving on the committee, provided that at least two (2) committee members are present, shall constitute a quorum.

3. **PC/QM COMMITTEE – RESPONSIBILITIES.** The responsibilities of this committee shall be**:**

a. To conduct peer review in accordance with the Medical Staff Peer Review Plan.
b. Once every quarter, the committee will function as the Quality Monitoring Committee. At this time, it will review reports from the Patient Care Review Committee and the Pharmacy and Therapeutics Committee. It will oversee all medical staff concurrent monitors as established by the Medical Executive

Committee; monitor trends and recommend quality improvement initiatives and medical staff education as warranted.

G. **PHARMACY AND THERAPEUTICS COMMITTEE ("P&T COMMITTEE")**

1. **P&T COMMITTEE - MEMBERSHIP AND TENURE.** This committee shall consist of one attending physician appointed by the President in collaboration with the Vice President of Medical Affairs, the Director of Infection Control, the Vice President of Nursing Services and Inpatient Operations**;** one nutritional support representative appointed by the President in collaboration with the Vice President of Medical Affairs, and the Pharmacy Manager. The chair of this committee shall be a physician appointed by the President in collaboration with the Vice President of Medical Affairs, and the secretary must be the Pharmacy Manager. Members shall serve for two (2) year terms or until their successor is appointed, and they may be reappointed.

2. **P&T COMMITTEE - MEETINGS AND QUORUM.** This committee shall meet quarterly. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which quorum is present. For purpose of this committee, attendance by at least twenty-five percent (25%) of active staff members serving on the committee, provided that at least two (2) committee members (one physician and one person from pharmacy management) are present, shall constitute a quorum.

3. **P&T COMMITTEE - RESPONSIBILITIES AND PURPOSE.** The purpose of this committee shall be to draft policies and procedures regarding the selection, storage, handling, distribution, and safe administration of drugs; review and revise pharmacy department policies and procedures as appropriate; and review all reports of medication errors and make recommendations for corrective action.

   The responsibilities of this committee shall be to:

   a. Review, recommend, and approve emergency medications, associated policies and procedures, and contents of crash carts.
   b. Maintain an ongoing drug formulary designed to meet the unique needs of a comprehensive physical rehabilitation center and address concerns presented by the medical staff, nursing, or other staff to facilitate coordination of pharmaceutical services.
   c. Prepare data for and review drug utilization programs and report the results to the Quality Steering Committee quarterly.
   d. Conduct ongoing reviews of adverse drug reactions, trend, and take corrective action if necessary.

H. **QUALITY OF CARE COMMITTEE**

1. **QUALITY OF CARE COMMITTEE - MEMBERSHIP AND TENURE.** The chairman of the committee shall be appointed by the President of the Medical Staff in collaboration with the Vice President of Medical Affairs. All attending physicians with inpatient bed services and residents shall be members of this committee.

2. **QUALITY OF CARE COMMITTEE - MEETINGS AND QUORUM.** The committee shall meet as needed but not less than quarterly. Minutes of the meetings shall be sent to the Medical Executive Committee. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present. For purpose of this committee, attendance by at least twenty-five percent (25%) of active staff members serving on the committee, provided that at least two (2) committee members are present, shall constitute a quorum.

3. QUALITY OF CARE COMMITTEE – RESPONSIBILITIES.

The responsibilities of this committee shall be:

a. Discuss issues and direct concerns arising from Patient Care Review and Quality Monitoring Committee with active education to provide remedial actions.
b. Presentation of an antibiotic review by Pharmacy a minimum of twice a year.
c. Receive periodic reports related to infection control at a minimum of twice a year.
d. Presentation of the required annual safety review for residents and physicians.
e. Discussion of new policies.

I. GRADUATE MEDICAL EDUCATION COMMITTEE ("GME COMMITTEE")

1. GME COMMITTEE - MEMBERSHIP AND TENURE: The GME Committee shall consist of the Designated Institutional Official (DIO), Residency Program Director, who serves as Chairperson, the Associate Program Director, Vice President of Medical Affairs, Residency Program Coordinator, chief resident(s), one resident nominated by his or her peers, one member of the medical staff appointed by the Vice President of Medical Affairs in collaboration with the Residency Program Director. Members (not including the President/CEO, Vice President of Medical Affairs, Residency Program Director, Associate Residency Program Director, Residency Program Coordinator), of the GME Committee shall serve terms of one year unless or until their successors are elected or appointed.

2. GME COMMITTEE - MEETINGS AND QUORUM: This committee shall meet as needed, with a minimum of four (4) meetings per year. Any action by this committee shall require the affirmative vote of a majority of committee members present at a meeting at which a quorum is present. For purpose of this committee, attendance by at least 25% of members serving on the committee, provided that at least two (2) committee members (Residency Program Director and a resident physician) are present, shall constitute a quorum.

3. GME COMMITTEE – RESPONSIBILITIES:

The responsibilities of the committee include the following:

a. Establish and implement policies that affect the residency program regarding the quality of education and the work environment for the residents in the program.
b. Establish and maintain liaison with appropriate personnel of other institutions where residents participate in rotations.
c. Regular review of all Accreditation Council of Graduate Medical Education ("ACGME') letters of accreditation and the monitoring of action plans for the correction of areas of non-compliance.
d. Regular internal review to assess compliance with the Institutional Requirements and the Program Requirements of the ACGME Residency Review Committee ("RRC").
e. Assure the establishment and implementation of formal written criteria and processes for the selection, evaluation, promotion, and dismissal of residents in compliance with the Institutional and Programs Requirements of the ACGME RRC.
f. Ensure an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation.

g. Recommend the appropriate funding for resident positions, including benefits and support services.

h. Monitor the program to ensure the establishment of an appropriate work environment and the duty hours of residents.

i. Ensure that the residency program provides a curriculum and an evaluation system to ensure that residents demonstrate competency in patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice at the level expected of a new Practitioner.

j. Communicate with the medical staff and Board of Directors about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, residents participating in Marianjoy's residency programs.

Article X, Section 4. MEDICAL STAFF MEETINGS

A. MEETINGS OF THE MEDICAL STAFF

1. **ANNUAL MEETING.** The annual meeting of the medical staff shall be held in the Spring of each year. At this meeting, the officers shall make or cause to be presented such reports as may be desirable and necessary. Election of officers shall also occur at this meeting. Future continuing medical education programs will be outlined and a progress report of ongoing research shall be made.

2. **REGULAR MEETINGS.** Regular meetings of the medical staff as a whole shall be held quarterly. Robert Rules of Order will be followed at all meetings. The annual meeting shall substitute for one regular meeting in the Spring.

3. **SPECIAL MEETINGS.** Special meetings of the medical staff may be called at any time by a written notice indicating date, time, place and topic, by the President of the Medical Staff, at the written request of a majority of the Board of Directors, a majority of the Medical Executive Committee, or a quorum of the active staff. No business shall be transacted at a special meeting except that stated in the written request and notice calling the meeting. Sufficient notice of any special meeting shall be a notice mailed ten (10) working days prior to the time set for the meeting.

B. QUORUM. Attendance by twenty-five percent (25%) of Active Staff members, but not fewer than five (5) such members, shall constitute a quorum for all medical staff meetings.

C. MANNER OF ACTION. Except as provided otherwise, the action of a majority of the active staff present and voting at a meeting at which a quorum is present shall be the action of the medical staff.

D. ATTENDANCE AT MEETINGS. Members of the consulting and courtesy staff shall not be required to attend meetings, but they are encouraged to attend and participate in these meetings unless unavoidably prevented from so doing. Absence of a medical staff member from a meeting at which a case he has attended is scheduled for discussion shall not be grounds for a postponement of such discussion unless specifically requested by said medical staff member for good cause. Active staff with committee assignments are expected to attend at least fifty percent (50%) of assigned committee meetings in order to maintain committee membership.

E. **MEETING MINUTES.** Minutes of all meetings shall be prepared by the Secretary of the Medical Staff and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, and made available to the medical staff. A permanent file of the minutes of each meeting shall be maintained by the Secretary of the Medical Staff.

G. **MEDICAL STAFF YEAR.** The medical staff year shall begin on July 1st and end on June 30th.

ARTICLE XI – IMMUNITY FROM LIABILITY

The following shall be express conditions to any Medical Staff or Allied Health Professional application for, or exercise of, clinical privileges within the organization:

1. That any act, communication, report, recommendation, or disclosure with respect to any such Practitioner, performed or made in good faith and without willful or wanton misconduct and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other situation, shall be privileged to the fullest extent permitted by law.

2. That such privilege shall extend to the Vice President of Medical Affairs, Vice President of Medical Affairs, members of the Medical Staff, the Board of Directors, Marianjoy Practitioners, President and his or her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Board of Directors or of the medical staff.

3. That there shall, to the fullest extent permitted by law, be immunity from civil liability arising from any act, communication, report, recommendation or disclosure addressed by this Article XI, even where the information involved would otherwise ordinarily be deemed privileged.

4. That the immunity granted hereby shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to:

    a. Applications (and pre-application) for appointment or clinical privileges:

    b. Periodic reappraisal for appointments, reappointments or clinical privileges;

    c. Corrective action, including summary suspension;

    d. Hearing and appellate reviews;

    e. Medical care evaluations;

    f. Utilization reviews; and

    g. Other service or committee activities related to quality patient care and interprofessional conduct.

5. That the acts, communications, reports, recommendations and disclosures referred to in this Article XI may relate to a practitioner’s professional qualifications, clinical competency,

character, mental or emotional stability, physical condition, or any other matter that might, directly or indirectly, have an effect on patient care and/or the reputation of Marianjoy.

6. That in furtherance of the foregoing, each practitioner shall, upon request, execute releases in accordance with the tenor and import of this Article XI in favor of the individuals and organizations specified above subject to such requirements, including those of good faith and absence of willful or wanton misconduct, as may be applicable under law.

ARTICLE XII – RULES AND REGULATIONS AND POLICIES

The Medical Executive Committee is delegated authority over amendments for rules and regulations and policies. If the Medical Executive Committee proposes to adopt a rule or regulation or an amendment thereto, it communicates the proposal in writing to the medical staff for comment. Such rules and regulations shall be a part of these Bylaws and may be adopted or amended following review of comments at any regular meeting of the Medical Executive Committee at which a quorum is present, by a majority vote of the active staff members present on the Medical Executive Committee. However, no rules and regulations shall become effective until approved by the Board of Directors. If the voting members of the organized medical staff propose to adopt a rule or regulation or policy or an amendment thereto, they first communicate the proposal to the Medical Executive Committee before presenting to the Board of Directors. When the Medical Executive Committee adopts a policy or an amendment thereto, it communicates this to the medical staff.

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these Bylaws and may be adopted or amended at any regular meeting of the Medical Executive Committee at which a quorum is present, by a majority vote of the active staff members present on the Medical Executive Committee. However, no rules and regulations shall become effective until approved by the Board of Directors.

ARTICLE XIII – CONFLICT MANAGEMENT

In the event of conflict between the Medical Executive Committee and the medical staff (as represented by written petition signed by a majority of the voting members of the medical staff) regarding a proposed or adopted rule or policy, or other issue of significance to the medical staff, the President of the medical staff shall convene a meeting with the petitioner’s representatives.

The foregoing petition shall include a designation of up to three members of the voting medical staff who shall serve as the petitioner’s representatives. The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee’s and the petitioners’ representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the medical staff, the leadership responsibilities of the medical executive committee and the safety and quality of patient care in the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee’s representatives at the meeting and a majority vote of the petitioners’ representatives. Unresolved differences shall be submitted to the Board of Directors by the President of the medical staff for its consideration in making its final decision with respect to the proposed rule, policy or issue.

Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

ARTICLE XIV - AMENDMENTS

Amendments to these Bylaws shall be presented for discussion at any regular or special medical staff meeting, following notice of at least twenty (20) working days to the active staff. An amendment shall require for adoption a majority vote of the active members who are eligible to vote. The amendments may be voted upon by polling the medical staff via mail, e-mail and/or fax. Results will be presented at the next Medical Executive Committee meeting. Physicians not responding within fourteen (14) days of the poll will be considered a negative vote for the proposed amendment. Amendments so made shall be effective when approved by the Board of Directors. After ratification by the Board of Directors, a copy of the approved and signed amendment will be distributed to the medical staff.

Where urgent action is required to comply with law or regulation, the medical executive committee is authorized to provisionally adopt a rule and forward it to the Board of Directors for approval and immediate implementation. If the medical staff did not receive prior notice of the proposed rule, the medical staff shall be notified of the provisionally adopted and approved rule. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and medical executive committee is implemented. If necessary, a revised amendment is then submitted to the Board of Directors for action.

ARTICLE XV – REVIEW OF BYLAWS

These Bylaws shall be reviewed every two years and revised as appropriate.

ARTICLE XVI - ADOPTION

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any medical staff meeting of the active staff and shall replace any and all previous Bylaws. They shall become effective when approved by the Marianjoy Board of Directors and, when adopted and approved, shall be equally binding by the Board of Directors and the Medical Staff.

____________________	____________________
President of the Medical Staff	Date
____________________	____________________
Secretary of the Medical Staff	Date
____________________	____________________
Chair, Board of Directors	Date
____________________	____________________
President	Date

Board Approved: 03/26/91
Board Approved: 04/06/93
Board Approved: 05/24/95
Board Approved: 04/01/96
Board Approved: 07/29/96
Board Approved: 04/28/97
Board Approved: 04/27/98
Board Approved: 06/05/01
Board Approved: 08/05/03
Board Approved: 06/15/05
Board Approved: 08/09/06
Board Approval: 08/08/07
Board Approval: 03/03/11

Board Approved: 07/28/92
Board Approved: 04/26/94
Board Approved: 10/16/95
Board Approved: 06/03/96
Board Approved: 09/30/96
Board Approved: 06/30/97
Board Approved: 05/24/99
Board Approved: 04/09/03
Board Approved: 02/11/04
Board Approved: 10/12/05
Board Approval: 12/13/06
Board Approval: 06/18/09
Board Approval: 08/12/13
Board Approval: 10/19/15
Board Approval: 10/25/17

MARIANJOY REHABILITATION HOSPITAL & CLINICS, INC.

MEDICAL STAFF RULES AND REGULATIONS

Medical Staff Rules and Regulations
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1.0 INTRODUCTION

1.1 These rules and regulations ("Rules and Regulations") govern the Medical Staff and the Medical Staff committees of Marianjoy, Inc. ("Marianjoy"). The Rules and Regulations are promulgated by the Marianjoy Medical Staff, with the concurrence of the Board of Directors. They are designed to assist the members of the Medical Staff in the provision of optimal care for all patients of Marianjoy Rehabilitation Hospital.

1.2 These Rules and Regulations apply to all members of the Medical Staff directly, and, as indicated herein or as appropriate, to all those employed or directed by the Medical Staff in those matters that impact upon patient care activities.

1.3 These Rules and Regulations are separate and distinct from, and are not in any way affected by, any other rules and regulations of other institutions at which members of the Medical Staff may practice.

1.4 The Medical Executive Committee is delegated authority over amendments for rules & regulations and policies. If the Medical Executive Committee proposes to adopt a rule or regulation or an amendment thereto, it communicates the proposal in writing to the medical staff for comment. Such rules and regulations shall be a part of these bylaws and may be adopted or amended following review of comments at any regular meeting of the Medical Executive Committee at which a quorum is present by a majority vote of the active staff members present on the Medical Executive Committee. However, no rules and regulations shall become effective until approved by the Board of Directors. If the voting members of the organized medical staff propose to adopt a rule, regulation or policy, or an amendment thereto, they first communicate the proposal to the Medical Executive Committee. When the Medical Executive Committee adopts a policy or an amendment thereto, it communicates this to the medical staff.

1.5 For purposes of the Rules and Regulations, the terms used throughout this document shall have the following meanings:

1.5.1 "Medical Staff" shall mean the Medical Staff of Marianjoy.

1.5.2 "Board of Directors" shall mean the Board of Directors of Marianjoy.

1.5.3 All words in the masculine gender shall be deemed to include the female gender, all singular words shall include the plural, and all plural words shall include the singular.

1.5.4 Throughout the document, the term "inpatient" refers to acute inpatients and RehabLink Subacute Unit patients, unless otherwise stated.

1.5.5 "RehabLink Subacute Unit" shall mean the subacute unit located on the Marianjoy campus.

2.0 GENERAL CONDUCT OF CARE

2.1 All physicians providing care or treatment of patients as part of their medical staff responsibilities must agree to maintain availability for continuous care of patients that they serve.

2.2 Physicians must arrange for coverage for themselves when they are on vacation or ill. The covering physician must be a member of the medical staff and hold privileges in the same specialty.

When the care of a patient is transferred to another physician for weekend or time off coverage, the procedures in the Patient Hand Off Policy must be followed.

2.3 Rehabilitation is a team activity, under the direction of physicians. Allied Health Professional Staff, as defined in the Medical Staff Bylaws, under the direction of physicians are subject to these Rules and Regulations. When such Allied Health Professional Staff are not employees of Marianjoy, the Medical Executive Committee has the responsibility for review and discipline of these Allied Health Professionals.

2.4 The Medical Staff and Allied Health Professionals are expected to maintain an appropriate level of continuing education to keep them current with new developments in their fields and in the general field of rehabilitation, as well as the specific developments in their sub-specialty or program. As the State of Illinois requires continuing medical education credit for licensure, the issuance of a state license will be sufficient to indicate compliance with continuing education requirements. However, the Credentialing Committee reserves the right to audit the continuing education documentation of any members of the Medical Staff.

2.5 All Active Staff are expected to participate in teaching programs for students and residents as reasonably requested by Administration. Active medical staff members are expected to supervise residents in their patient care responsibilities and adhere to the standards for supervision as delineated in the medical staff policy on Supervision of Residents, including daily review of the patient's care with the resident and countersigning History and Physicals within 48 hours. This policy also allows residents to write orders but specifies when orders are to be reviewed by the supervising medical staff member. The attending physician has responsibility for the actions and inactions of the resident physician in patient care activities.

2.6 Do Not Resuscitate ("DNR").

2.6.1 Marianjoy. The Medical Staff must adhere to the Marianjoy policy on DNR. This policy, mutually established by the Code Blue Committee, Medical Staff, and Administration of Marianjoy, will be updated, reviewed and approved by all on a biannual basis, or more frequently, as indicated.

2.6.2 Outpatient Services. The policy on medical emergencies in outpatient settings of Marianjoy requires that 911 be called in the event of a medical emergency and resuscitative efforts attempted. However, Medical Staff will honor a patient's legally authorized DNR/POLST (Illinois Department of Public Health Physician's Orders for Life Sustaining Treatment) form if it has been provided and will present such form to the medical emergency services personnel.

2.7 Emergency Situations.

2.7.1 Marianjoy. In the event of a patient medical emergency the attending physician, resident, or resident on call shall attend to the needs of the patient and then, as early as possible, inform either the patient's referring physician or personal physician, as deemed appropriate. To the extent possible, patients will be referred to their referring hospital unless the nature of the emergency is such that the travel would be life threatening. When the travel would be life threatening,

the patient will be transported to the closest institution at the discretion of the emergency transfer team.

2.7.2 Comprehensive Outpatient Services. In the event of a patient medical emergency the Rapid Response Team will be paged using the overhead page system. The team will assess the patient and make the decision if "911" should be called. In the event of a life threatening emergency a "Code Blue" will be paged.

2.8 The Medical Staff should attempt to secure autopsies in all cases in which a death has occurred and the circumstances concerning the death are suspicious, obscure, mysterious, or otherwise unexplained and in the opinion of the attending physician or the coroner, the cause of death cannot be established definitely except by autopsy. The medical staff should communicate the need for the same to the patient's legal representative. Autopsies that qualify as coroner's cases need to be requested through the coroner's office. It shall be the responsibility of the coroner to cause an autopsy to be performed, as well as to secure consent to the autopsy to the extent required by law. Should the case not qualify as a coroner's case and an autopsy is requested by the family or recommended by the physician, it is the responsibility of the physician to refer the patient's legal representative to an appropriate resource for the autopsy.

3.0 ADMISSION AND DISCHARGE

3.1 A pre-admission screening (PAS) is required for every patient considered for an admission to an inpatient rehabilitation facility (IRF). The assigned physiatrist or designee physiatrist must review the PAS completed by the nurse liaison and document the justification of a rehabilitation admission within 48 hours of the patient admission for patients which are required by payor source to have this documentation. The PAS must be electronically signed by the physician who documented the justification.

3.2 The attending physician must document the post admission evaluation (PAE) within 24 hours of the patient's admission for patients which are required by payor source to have this documentation. The PAE must identify any relevant changes since the PAS and must include a documented history and physical examination as well as review of the patient's prior and current medical and functional conditions and comorbidities.

3.3 Questions or concerns regarding the admission of patients who may pose a danger to staff or other patients shall be referred to the Vice President of Medical Affairs of Marianjoy or the President and CEO of Marianjoy or his or her designee.

3.4 The individualized plan of care must be completed and signed by the attending physician or designated covering attendant by the fourth day of admission for patients which are required by payor source to have this documentation.

3.5 An initial Patient Care Conference (PCC) will be held within seven (7) days of the patient's admission on physician scheduled staffing days.

3.6 Patients shall be discharged only on the authorization, written or verbal, of the attending physician. If a patient wishes to the leave against medical advice, the patient or legal representative of the patient shall sign a written release indicating that the patient has left Marianjoy against medical advice and a full narrative of the incident shall be recorded by the attending physician in the patient's medical record. If the patient is considered by the Vice President of Medical Affairs of Marianjoy to be in such condition as to require immediate detention for the protection of the patient or other persons, then upon the

request of the Vice President of Medical Affairs of Marianjoy, a peace officer may intervene and arrange to have the patient transported to the nearest appropriate facility.

3.7 Within 24 hours prior to discharge, the resident or attending physician is to re-examine the patient and record the findings in a progress note. This examination shall be adequate to identify or exclude the presence of any new acute or subacute medical problem requiring treatment prior to discharge or which may need to be brought to the early attention of the personal physician who will follow the patient after discharge. This examination should also re-evaluate the patient's impairment.

4.0 ORDERS FOR TREATMENT

4.1 All orders for treatment of inpatients shall be submitted electronically in accordance with applicable policies and shall be complete indicating test, drug, dosage, indication and termination of such orders, and shall be signed by a physician or allied health professional having appropriate clinical privileges or authorized resident physician.

4.2 A verbal order shall be considered to be in writing if dictated by a physician or allied health professional with appropriate privileges to an authorized person such as: registered nurse, registered pharmacist, registered dietician, registered respiratory therapist and registered therapist functioning within their sphere of competence and entered electronically by that person. The order will be signed by the responsible practitioner or another practitioner responsible for the patient's care within forty-eight (48) hours. All orders dictated over the telephone shall be read back for verification by the physician/practitioner with the read back documented and signed by the appropriate authorized person who received those orders with their name, date and time.

4.3 Practitioners may accept outpatient orders from other providers as permitted pursuant to applicable licensure requirements.

4.4 Unless indicated by a patient emergency, residents may change referring physician's medication orders only after consulting with either the attending or referring physician.

4.5 X-Ray and Special Imaging Test Requests. A physician or appropriately privileged allied health professional should include a statement of the reason for the x-ray and/or special imaging test with the test order, as required by applicable law and patient need.

5.0 ROLE OF CONSULTANT

5.1 Consultants are to see patients on request from an attending physician, appropriately privileged allied health professional or authorized resident physician who should indicate the problem by either telephone or written order. The consultant should promptly write or dictate their review and recommendation of the case as requested by the attending physician or resident. The reasons for the request for consultation should be explained to the patient and, as appropriate, to the family by the attending physician and the attending physician and consultant should make the patient (and family, as appropriate) aware of the results.

5.2 Consultation may be requested when, according to the judgment of the attending physician, President of the Medical Staff, or Vice President of Medical Affairs of Marianjoy:

5.2.1 When in the judgment of the attending physician or authorized resident physician or when a different level of expertise is required.

5.2.2 The diagnoses are obscure and/or complex.

5.2.3 The attending physician has questions about the medical diagnosis or management of the case and/or the progress of the patient.

6.0 COMMUNICATION

6.1 Marianjoy is a network of physical medicine and rehabilitation programs and services including a freestanding rehabilitation facility emphasizing tertiary care, subacute, comprehensive outpatient services, and outpatient programs and services dependent upon referrals from a wide area. To function in this fashion, effective and appropriate communication is essential. The Rules and Regulations that follow are designed, among other things, to facilitate communication.

6.2 Communication between health care providers and patients (and family, when appropriate) is encouraged, including decisions reached at patient care conferences, and their communications should be noted in the medical record. Patients, and when appropriate, their families shall be informed about the outcomes of care, including unanticipated outcomes whenever those outcomes differ significantly from the anticipated outcomes.

6.3 Communication can be undertaken with others outside of the institution regarding a patient only when consistent with federal and state law, or when expressly authorized in writing by the patient or the patient's legal representative.

6.4 Communication with the referring physician should be done regularly, as appropriate.

6.5 Referring physicians should receive complete and prompt communication. If the patient indicates that he or she does not want to return to the referring physician or the referring hospital for acute or continuing care, prompt phone contact should be made with the referring physician and his/her assistance obtained in arranging transfer to another physician or facility of the patient's choice. This should be followed by written documentation and the patient's choice should be noted in the record by the attending or assigned physician.

6.6 At the time of discharge, communications to the health care provider who will be providing ongoing care must include a summary of the patient's admission, admission goals, discharge status, discharge medications, the goals achieved and the goals not achieved during the course of care if an inpatient . Future goals and time frames must be defined with an end point for involvement by Marianjoy and/or staff.

6.7 Communication with medical/legal offices or regarding legal matters should be thoroughly documented. Questions regarding communications and matters of this type should be addressed to the Vice President of Medical Affairs of Marianjoy or his designee and/or legal counsel.

7.0 MEDICAL RECORDS

7.1 The medical record must contain information to justify admission and continued medical necessity, support the diagnosis, and describe the patient's progress and response to medications and services and facilitate continuity of care.

7.2 All entries must be legible and complete, and must be authenticated, dated, and timed promptly by the physician or provider who is responsible for ordering, providing, or evaluating the service furnished.

7.2.1 The author of each entry must be identified and must authenticate his own entry. Another practitioner may co-sign if he/she agrees with the documentation.

7.2.2 Authentication may include signatures, written initials or computer electronic signature.

7.3 All records must document the following, as appropriate:

7.3.1 Evidence of a history and physical completed within twenty-four (24) hours of admission.

7.3.2 Admitting diagnosis and medical necessity for level of care.

7.3.3 Results of all consultative evaluations of the patient and appropriate findings by physicians and other staff involved in the care of the patient.

7.3.4 Documentation of complications, hospital acquired infections, and unfavorable reactions to medication.

7.3.5 Properly executed informed consent forms for treatments as specified by the Medical Staff, or by applicable federal or state law.

7.3.6 All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

7.3.7 Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care. Subacute discharge summaries will be handwritten on a subacute discharge summary form.

7.4 All records are to be completed and signed promptly. The record should be completed at the time of the patient's discharge. In the event the completion of the record is not possible at the time of the patient's discharge, the attending physician shall see to it that the record is dictated within ten (10) working days of an inpatient’s discharge.

7.4.1 Prompt documentation of decisions reached at patient care conferences should be included in the medical record.

7.4.2 All entries in the record are to be made in accordance with the medical staff prohibited list of abbreviations as maintained in the Health Information Services Department.

7.4.3 Patient evaluations must be based on objective findings, prompt and functionally goal oriented, and meticulously complete, incorporating, a much as possible, a complete rehabilitation plan with indications for times of follow up and future care and termination of care.

7.5 Physicians will be notified of incomplete records consistent with the Delinquent Medical Record Fines and Suspension policy.

7.6 Residents on rotation shall receive weekly notification of their delinquent charts. In addition, on the last day of the rotation, each resident and that resident's attending will receive an updated medical record deficiency list that is current up to that day. Completion of medical records by the end of the rotation will be taken into account by the attending physician in the rotation evaluation.

7.7 All records and correspondence are to be maintained in confidential fashion, consistent with statutory and case law. Legal counsel should be contacted if there are any questions regarding these matters.

8.0 MEDICAL STAFF DOCUMENTATION GUIDELINES.

ENTRY	CONTENT	TIME FRAME
Pre-Admission Screening (PAS)	• Review PAS on eRehabdate form and document justification for admission • Provide electronic signature on PAS for Medicare, Medicaid, and Public Aid Pending patients and patients over 65.	Complete within 48 hours prior to admission
Post-Admission Evaluation	• Complete for Medicare, Medicaid, and Public Aid Pending patients and patients over 65. • Include with H&P • Identify relevant changes since PAS • Review patient's prior and current medical and functional conditions and co-morbidities	Complete within 24 hours of admission
Individualized Plan of Care	• Complete for Medicare, Medicaid, and Public Aid Pending patients and patients over 65. • Review, sign, date and time	Complete by fourth day of admission
History & Physical	• History of Present Illness/Chief Complaint/Reason for Admission • Past Medical History • Functional Limitations • Social & Family History • Review of Systems • Physical Examination • Functional Assessment • Program Goals • Initial Patient/Family Goals • Diagnoses • Summary & Plan	**Hospital**: Complete within twenty-four (24) hours of admission. **Subacute:** Complete within twenty-four (24) hours of admission.
Physician/Provider Orders	• Enter orders electronically • Specific Order (to include reason for diagnostic testing)	Verbal orders to be signed and dated within forty-eight (48) hours by ordering physician or another physician responsible for the patient's care.
Face Sheet	• Final Diagnosis	Sign after completed by Medical

ENTRY	CONTENT	TIME FRAME
	• Procedures • Consultants • Length of Stay	Record staff.
Progress Notes	• Clinical Observations from face-to face visit • Assessment of medical and functional status • Medical management and Response to Care/Results of Therapy • Comment on Any Significant Abnormal Result of Laboratory or Other Investigations • A team conference note must document physician concurrence with decisions made by the team • Patient's Condition on Discharge	Document to be completed by the next calendar day.
Transfer Form	Diagnoses (for emergency transfer only)	Sign at the time of transfer or within thirty (30) days post-discharge.
Procedure Reports	• Indication for procedure • Preparation for procedure • Patient monitoring • Post Procedure Care • Patient education regarding results Procedure Verification form	Dictate or write immediately after the procedure. Complete Procedure Verification form prior to performing procedure
Request for Consultation	• Reason for Consult • Name of Consultant • Type of Consult Requested • Level of Authority • Diagnoses	Enter order requesting consult in Meditech.
Consultation Report	• To Be Completed by Consultant • Examination of the Patient and the Record • Diagnosis • Recommendations for Treatment, as appropriate	At time of consult pending dictated report.

ENTRY	CONTENT	TIME FRAME
Discharge Summary	• Admission Date • Discharge Date • Reason for Hospitalization • Significant Findings During Hospitalization • Treatment Rendered • Achieved Functional Abilities and Goals • Patient's Condition on Discharge • Functional Abilities of Patient on Discharge • Instructions (to include medications and diet) • Follow-up Care • Diagnoses	**Hospital**: Dictate within ten (10) days post-discharge. **Subacute:** Complete discharge form at the time of discharge and send to the referring physician.

9.0 HOSPITAL CLOSURE OR CHANGE OF OWNERSHIP

In the event of closure or change of ownership of the Hospital, the medical staff credentials and quality files will be retained by Northwestern Medicine.

10.0 INVESTIGATIVE DRUGS AND NEW THERAPIES

10.1 Medical staff members engaged in research protocols or the use of investigative drugs or devices are required to have prior approval from the Institutional Review Board.

10.2 It is the responsibility of the physician engaging in research protocols or the use of investigative drugs or devices to present required documentation and to comply with applicable law and Institutional Review Board requirements.

10.3 The Medical staff member, drug or device supplier, or manufacturer shall not, under any circumstances, use any of their activities as a form of advertising, directly or indirectly, or use it in anything other than a curriculum vitae or publication in a juried professional journal or in-house education program.

10.4 The use of an investigative drug or device or research protocol can be terminated by the Vice President of Medical Affairs or his designee at his discretion, which is to be subsequently reviewed by the Institutional Review Board, at its regular meeting.

11.0 DISCIPLINE

11.1 Every staff member shall have a credentialing and quality file in the office of Medical Services, which shall be available to the Medical Executive Committee when so needed. This credentialing file is to be supplemented with information related to peer review, including, but not limited to, notations from appropriate committees and supervising medical staff with comments limited to the quality of medical care of the specific medical staff member.

11.2 Any failure of any medical staff member in following the Medical Staff Bylaws or Rules and Regulations regarding the delivery of medical care is to be documented, dated and placed in the member's quality file.

11.3 Medical staff compliance with Peer Review Organization (PRO) requirements is considered necessary. If full compliance is not maintained and lack of cooperation is substantiated, corrective action, including the denial of medical staff privileges for any physician, may be instigated. The proper hearing procedures as so defined in the Bylaws will be adhered to.

11.4 All medical staff members are required to report to the Vice President of Medical Affairs any matters involving a potential or possible professional liability action within thirty days and to report exclusion from a Federal healthcare program or other governmental sanction involving such member within twenty four hours of learning of the same.

12.0 IMPAIRED PHYSICIANS

REFER TO THE PHYSICIAN HEALTH POLICY

13.0 ORGANIZED HEALTH CARE ARRANGEMENTS AND SHARING OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BY MARIANJOY AND ITS MEDICAL AND ALLIED HEALTH STAFF MEMBERS

13.1. General Background on HIPAA Privacy Rules

13.1.1 The Health Insurance Portability Act of 1996 and its implementing regulations ("HIPAA"), among other things, regulate how providers can use and disclose individually identifiable protected health information ("PHI") with one another.

13.1.2 HIPAA also requires a provider with a direct treatment relationship with an individual (including, among others, hospitals, providers and allied health professionals) to provide the individual with a notice of its privacy practices. The notice must afford the individual with adequate notice of the provider's uses and disclosures of PHI, the individual's rights and the provider's responsibilities with respect to PHI. The notice of privacy practices must be furnished to the individual upon the first service delivery, except in emergency situations, in which case it may be provided as soon as reasonably practicable.

13.1.3 HIPAA further requires a provider with a direct treatment relationship with an individual to make a good faith effort to obtain a written acknowledgment of the individual's receipt of the provider's notice of its privacy practices. If the acknowledgment cannot be obtained, the provider must document in good faith its efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained.

13.1.4 Under HIPAA, if two or more providers (including a hospital and its medical staff) are part of the same "Organized Health Care Arrangement" ("OHCA"), they may issue a joint notice of their privacy practices and obtain a joint acknowledgment from the individual. Accordingly, for patients treated through the OHCA, only one notice and one acknowledgment are required for all of the providers in the OHCA.

13.1.5 Notwithstanding, under HIPAA, if a provider is a member of an OHCA, and that same provider also has his or her own private practice, and his or her privacy practices in his private office are different than that of the OHCA, for patients that provider treats outside of the OHCA, the provider must still deliver his/her own notice of privacy practices and obtain his/her own acknowledgement.

13.2 Marianjoy and Medical Staff are an OHCA.

Marianjoy and its Medical and Allied Health Staff Members (referred to for purposes of this Section 12 as "Members") operate as an OHCA in that they provide direct patient care services through clinically integrated settings (e.g., inpatient or outpatient hospital settings and/or other hospital-based clinic settings).

13.3 Joint Acknowledgment and Joint Notice of Privacy Practices.

13.3.1 Members treating patients at any of the clinically integrated settings of Marianjoy's OHCA shall use a joint acknowledgment and joint notice of privacy practices, as described herein.

13.3.2 The joint acknowledgment and joint notice of privacy practices shall be in such forms as are designated by Marianjoy and such joint acknowledgment and joint notice of privacy practices shall meet the requirements of HIPAA.

13.3.3 Each Member shall abide by the terms of the joint notice of privacy practices with respect to PHI created or received by such Member as part of its participation in Marianjoy's OHCA.

13.3.4 Each Member shall take reasonable steps to ensure the privacy and security of all PHI, including PHI created, used, transmitted or maintained as part of Marianjoy's OHCA. Such reasonable steps should be in place for all PHI, in all forms, including verbal, written and/or electronic (including but not limited to e-mail, Personal Data/Digital Assistants and other means).

13.4 Corrective Action

Failure of any member to comply with the requirements of this Article may subject such member to corrective action as provided in the Medical Staff Bylaws.

13.5 DISCLAIMER OF LIABILITY

NOTWITHSTANDING THE FOREGOING OHCA RELATIONSHIP DESCRIBED IN THIS ARTICLE, MARIANJOY HEREBY EXPLICITLY DISCLAIMS ANY AND ALL LIABILITY TO MEMBERS AND/OR ANY THIRD PARTIES, WHETHER UNDER THEORIES OF APPARENT AGENCY OR ANY OTHER THEORY OF LIABILITY, FOR THE ACTS AND OMISSIONS OF ITS MEMBERS.

13.6 Effective Date

The terms and conditions of this Article shall become effective as of March 31, 2003.

Board Approved: 03/26/91
Board Approved: 04/06/93
Board Approved: 05/24/95
Board Approved: 04/01/96
Board Approved: 07/29/96
Board Approved: 04/28/97
Board Approved: 04/27/98
Board Approved: 06/05/01
Board Approved: 08/05/03
Board Approved: 10/12/05
Board Approval: 08/15/07
Board Approval: 03/03/11
Board Approval: 10/25/17

Board Approved: 07/28/92
Board Approved: 04/26/94
Board Approved: 10/16/95
Board Approved: 06/03/96
Board Approved: 09/30/96
Board Approved: 06/30/97
Board Approved: 05/24/99
Board Approved: 04/09/03
Board Approved: 02/11/04
Board Approved: 08/09/06
Board Approved: 06/18/09
Board Approved: 08/14/14