MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

ST. NICHOLAS HOSPITAL

MEDICAL STAFF BYLAWS

July 2019

MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

PAGE

1. GENERAL 1

1.A DEFINITIONS 1

1.B. TIME LIMITS 1

1.C. DELEGATION OF FUNCTIONS 1

2. CATEGORIES OF THE MEDICAL STAFF 2

2.A. ACTIVE STAFF 2

2.A.1. Qualifications 2
2.A.2. Prerogatives 3
2.A.3. Responsibilities 3

2.B. COURTESY STAFF 4

2.B.1. Qualifications 4
2.B.2. Prerogatives and Responsibilities 4

2.C. CONSULTING STAFF 5

2.C.1. Qualifications 5
2.C.2. Prerogatives and Responsibilities 6

2.D. AFFILIATE STAFF 6

2.D.1. Qualifications 6
2.D.2. Prerogatives and Responsibilities 7

2.E. LOCUM TENENS STAFF 8

2.E.1. Qualifications 8
2.E.2. Prerogatives and Responsibilities 8

PAGE

2.F. HONORARY STAFF 9

2.F.1. Qualifications 9
2.F.2. Prerogatives and Responsibilities 9

3. OFFICERS 10

3.A. DESIGNATION 10

3.B. ELIGIBILITY CRITERIA 10

3.C. DUTIES 11

3.C.1. President of the Medical Staff 11
3.C.2. President-Elect 12
3.C.3. Immediate Past President 12
3.C.4. Secretary 13

3.D. NOMINATIONS 13

3.E. ELECTION 14

3.F. TERM OF OFFICE 14

3.G. REMOVAL 14

3.H. VACANCIES 15

4. STAFF DEPARTMENTS 16

4.A. ORGANIZATION 16

4.B. ASSIGNMENT TO DEPARTMENT 16

4.C. FUNCTIONS OF DEPARTMENTS 16

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRPERSONS 16

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRPERSONS 16

PAGE

4.F. DUTIES OF DEPARTMENT CHAIRPERSONS 17

4.G. MEDICAL DIRECTORS 19

5. MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS 20

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS 20

5.B. APPOINTMENT OF COMMITTEE CHAIRPERSONS AND MEMBERS 20

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS 20

5.D. EXECUTIVE COMMITTEE 20

5.D.1. Composition 20
5.D.2. Duties 21
5.D.3. Meetings 23

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS 23

5.F. CREATION OF STANDING COMMITTEES 25

5.G. SPECIAL COMMITTEES/TASK FORCES 25

6. MEETINGS 26

6.A. MEDICAL STAFF YEAR 26

6.B. MEDICAL STAFF MEETINGS 26

6.B.1. Regular Meetings 26
6.B.2. Special Meetings 26

6.C. DEPARTMENT AND COMMITTEE MEETINGS 26

6.C.1. Regular Meetings 26
6.C.2. Special Meetings 26

PAGE

6.D. PROVISIONS COMMON TO ALL MEETINGS 26

6.D.1. Notice of Meetings 26
6.D.2. Quorum and Voting 27
6.D.3. Agenda 28
6.D.4. Rules of Order 28
6.D.5. Minutes, Reports, and Recommendations 28
6.D.6. Confidentiality 28
6.D.7. Attendance Requirements 28

7. INDEMNIFICATION 30

8. BASIC STEPS AND DETAILS 31

8.A. QUALIFICATIONS FOR APPOINTMENT 31

8.B. PROCESS FOR PRIVILEGING 31

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT) 31

8.D. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALATION 32

8.E. DISASTER PRIVILEGES 32

8.F. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES 32

8.G. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION 33

8.H. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES 33

8.I. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL 34

PAGE

9. AMENDMENTS 35

9.A. MEDICAL STAFF BYLAWS 35

9.B. OTHER MEDICAL STAFF DOCUMENTS 36

9.C. CONFLICT MANAGEMENT PROCESS 37

10. ADOPTION 38

APPENDIX A

APPENDIX B

APPENDIX C

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix A to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, podiatrists, and psychologists who:

(a) are involved in at least 24 patient contacts every two years; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category, or unless a specific waiver has been granted:

* Any member who has fewer than 24 patient contacts during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, or Affiliate. Transfer to the Affiliate Staff will be automatic for individuals who have zero patient contacts during their two-year appointment term).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings, by any method (e.g., mail, ballot, facsimile) designated in a notice presenting a question for vote;

(c) hold office, serve as department chairpersons, serve on Medical Staff committees, and serve as chairpersons of committees; and

(d) exercise such clinical privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) accepting consultations when requested;

(g) paying any applicable application fees, dues, and assessments; and

(h) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, podiatrists, and psychologists who:

(a) are involved in more than six, but fewer than 24, patient contacts every two years; and

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category, or unless a specific waiver has been granted:

* Any member who has fewer than six patient contacts during his/her two-year appointment term must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting or Affiliate. Transfer to the Affiliate Staff will be automatic for individuals who have zero patient contacts during their two-year appointment term unless the individual requests a waiver that is recommended by the Executive Committee and approved by the Board).

** Any member who has more than 24 patient contacts during his/her two-year appointment term must request Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) may attend and participate in Medical Staff and department meetings (without vote);

(c) may not hold office or serve as department chairpersons or committee chairpersons, unless waived by the Board;

(d) may be invited to serve on committees (with vote);

(e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician; and

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department; and

(3) will be required to provide specialty coverage if the Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(f) shall cooperate in the professional practice evaluation and performance improvement processes;

(g) shall exercise such clinical privileges as are granted to them;

(h) shall pay any applicable application fees, dues, and assessments;

(i) shall accept consultations when requested; and

(j) shall perform assigned duties.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, podiatrists, and psychologists who:

(a) demonstrate professional ability and expertise who provide a service not otherwise available (or is in very limited supply) on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments, unless a specific waiver has been granted);

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit or provide overall patient management for) patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as department chairpersons or committee chairpersons, unless waived by the Board;

(c) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);

(d) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients unless the Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes;

(f) shall pay any applicable application fees, dues, and assessments;

(g) shall accept consultations when requested; and

(h) shall perform assigned duties.

2.D. AFFILIATE STAFF

2.D.1. Qualifications:

(a) The Affiliate Staff shall consist of those physicians, dentists, podiatrists, and psychologists who desire to be associated with, but who do not intend to establish a practice at, the Hospital. It is a membership-only category, with no clinical privileges being granted. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care.

(b) Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed by the Credentials Policy. They are only required to satisfy the following eligibility criteria set forth in the Medical Staff Credentials Policy, Section 2.A.1: (a), (f), (g), (h), (i), (j), and (q).

2.D.2. Prerogatives and Responsibilities:

(a) Members of the Affiliate Staff:

(1) may attend meetings of the Medical Staff and applicable departments (all without vote);

(2) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(3) may attend educational activities of the Medical Staff and the Hospital;

(4) may refer patients to members of the Active Staff for admission and/or care;

(5) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(6) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical record;

(7) are encouraged to communicate with hospitalists and/or other Active Staff members about the care of any patients referred, and are encouraged to visit any patients who are hospitalized;

(8) may not: admit patients, attend patients, exercise any clinical privileges, write orders or progress notes, perform consultations, assist in surgery, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(9) may refer patients to the Hospital's diagnostic facilities subject to the rules and policies of the Hospital and the clinical departments;

(10) may actively participate in the professional practice evaluation and performance improvement processes;

(11) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(12) must pay any applicable application fees, dues, and assessments.

(b) The grant of Affiliate Staff appointment is a courtesy only, which may be terminated by the Board upon recommendation of the Executive Committee, with no right to a hearing or appeal.

2.E. LOCUM TENENS STAFF

2.E.1. Qualifications:

The Locum Tenens Staff shall consist of physicians, dentists, podiatrists, and psychologists who:

(a) desire clinical privileges to provide patient care services in the Hospital that would exceed the time frames set forth in Section 4.B.1 of the Medical Staff Credentials Policy pertaining to locum tenens temporary privileges;

(b) agree to satisfy all eligibility criteria as set forth in the Credentials Policy at all times when they are providing services in the Hospital; and

(c) complete a full Medical Staff application that will be processed in the same manner as any other applicant for appointment or reappointment to the Medical Staff.

2.E.2. Prerogatives and Responsibilities:

Locum Tenens Staff members:

(a) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(b) shall cooperate in the professional practice evaluation and performance improvement processes;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as department chairpersons or committee chairpersons (unless waived by the Board);

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote); and

(f) shall pay applicable fees, dues, and assessments.

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have attained the age of 75 and/or those practitioners who have retired from the active practice of medicine.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairpersons or committee chairpersons; and

(f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President, President-Elect, Immediate Past President, and Secretary-Treasurer.

3.B. ELIGIBILITY CRITERIA

Only those members of the Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the Executive Committee and approved by the Board. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(4) not presently be serving as Medical Staff officers, Board members, or department chairpersons at any other hospital, other than St. Mary's Hospital Medical Center, St. Vincent Hospital, and St. Nicholas Hospital, and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions, for at least two years;

(7) attend continuing education relating to Medical Staff leadership and/or credentialing/peer review functions, prior to or during the term of the office;

(8) have leadership and communication skills and have demonstrated an ability to work well with others; and

(9) disclose any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with St. Nicholas Hospital, St. Mary's Hospital Medical Center, or St. Vincent Hospital, or any affiliate. This does not apply to services provided within a practitioner's office

and billed under the same provider number used by the practitioner. After considering the recommendation of the Executive Committee, the Board shall determine whether any such relationship disqualifies the member from serving in a Medical Staff leadership position.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CEO/COO and the Board in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies/directives, concerns, and needs, and report on the activities, of the Medical Staff to the CEO/COO and the Board;

(c) be accountable to the Board, in conjunction with the Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Executive Committee;

(e) appoint each department chairperson, all committee chairpersons, and committee members;

(f) serve as chairperson of the Executive Committee (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, without vote;

(g) promote adherence to the Bylaws, policies/directives, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

(h) in consultation with the CEO/COO, appoint the chairperson and alternate for special care units and for Hospital disaster and civil defense programs, appoint physician advisors to Hospital ancillary services requiring Medical Staff advisors, and recommend Medical Staff representatives to Hospital committees;

(i) perform all functions authorized in all applicable policies/directives, including collegial intervention in the Credentials Policy;

(j) be actively involved in communicating the Hospital's Corporate Compliance Program to the Medical Staff and seeking to ensure the Medical Staff's participation and compliance in such programs;

(k) receive and interpret the Policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide quality care;

(l) attend the Board of Directors meeting as a Medical Staff representative, without vote, and may serve as a member of the Board's Quality Care Committee;

(m) maintain confidentiality for all actions taken and recommendations made pursuant to the office and its duties;

(n) be actively involved in patient satisfaction initiatives and ensure the Medical Staff's participation and compliance with these initiatives;

(o) be responsible for the educational activities of the Medical Staff;

(p) act as spokesperson as requested for the Medical Staff in its external professional and public relations; and

(q) assume all such additional duties as are assigned to him or her by the Executive Committee or the Board.

3.C.2. President-Elect:

The President-Elect shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the Executive Committee and the Credentials Committee;

(c) be actively involved in quality improvement and patient satisfaction initiatives and ensure the Medical Staff's participation and compliance with these initiatives;

(d) automatically succeed the President when the President fails to serve for any reason during his/her term of office; and

(e) assume all such additional duties as are assigned to him or her by the President of the Medical Staff, the Executive Committee, or the Board.

3.C.3. Immediate Past President:

The Immediate Past President shall:

(a) serve on the Executive Committee;

(b) serve as an advisor to other Medical Staff leaders and as a consultant to the Medical Staff President;

(c) be actively involved in patient satisfaction initiatives and ensure the Medical Staff's participation and compliance with these initiatives; and

(d) assume all duties assigned by the President of the Medical Staff or the Executive Committee or the Board.

3.C.4. Secretary:

The Secretary shall:

(a) serve on the Executive Committee and as a consultant to the President of the Medical Staff and the President-Elect;

(b) cause to be kept accurate and complete minutes of all Executive Committee and Medical Staff meetings;

(c) call Medical Staff meetings on order of the President of the Medical Staff and record attendance;

(d) attend to all correspondence and perform such other duties as ordinarily pertain to the office of Secretary;

(e) oversee the Hospital's quality assessment program and serve on the joint Hospital/Medical Staff performance improvement committee, if applicable;

(f) be actively involved in patient satisfaction initiatives and ensure the Medical Staff's participation and compliance with these initiatives;

(g) temporarily assume the duties of the President in the absence of the President and President-Elect;

(h serve on the joint Hospital/Medical Staff Performance Improvement Committee; and

(i) perform such duties as are assigned by the President of the Medical Staff or the Executive Committee.

3.D. NOMINATIONS

The President of the Medical Staff shall appoint a Nominating Committee consisting of the Immediate Past President (who shall serve as chair) and four additional members of the Active Staff for all general and special elections. The Committee shall convene at least three months prior to the election and shall submit to the Executive Committee the

names of one or more qualified nominees for each office and for the at-large members of the Executive Committee. Each nominee must meet the eligibility criteria in Section 3.B and must agree to serve in the office for which nominated, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election. Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Candidates receiving a majority of written votes cast at the meeting shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, at the discretion of the Executive Committee, the election shall be held solely by written ballot returned to the Office of Medical Services. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Office of Medical Services by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected.

3.G. REMOVAL

(1) Removal of an elected officer may be effectuated by a two-thirds vote of the Executive Committee; or by the Board for:

- (a) failure to comply with applicable policies/directives, Bylaws, or Rules and Regulations;

- (b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

- (c) failure to perform the duties of the position held;

- (d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office, based on the examination of two physicians with qualifications in the appropriate medical field.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Executive Committee or the Board, prior to a vote on removal.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the President-Elect, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the Executive Committee. Such appointment will be effective when approved by the Board.

ARTICLE 4

STAFF DEPARTMENTS

4.A. ORGANIZATION

(1) The Medical Staff shall be organized into departments as listed in the Medical Staff Organization Manual.

(2) Subject to the approval of the Board, the Executive Committee may create new departments, eliminate departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department, as indicated on the relevant department chairperson report. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department, upon approval of the Executive Committee and the Board.

(2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges or a scope of practice in a given department, and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRPERSONS

Each department chairperson shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Board after considering the recommendation of the Executive Committee.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRPERSONS

(1) Except as otherwise provided by contract, department chairpersons shall be appointed by the President of the Medical Staff, after considering the recommendations of the members of the department. The appointment shall become effective upon approval of the Board.

(2) Any department chairperson may be removed by a two-thirds vote of the department members, subject to Board confirmation; or by a two-thirds vote of the Executive Committee, subject to Board confirmation; or by the Board, after reasonable notice and opportunity to be heard. Grounds for removal shall be:

(a) failure to comply with applicable policies/directives, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) suspected conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) Prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action shall be taken, at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the department, the Executive Committee, or the Board, as applicable, prior to a vote on such removal.

(4) Department chairpersons shall serve a term of two years. Reappointment may be made for additional two-year terms thereafter.

4.F. DUTIES OF DEPARTMENT CHAIRPERSONS

Department chairpersons shall work in collaboration with Medical Staff leaders, medical directors, and other Hospital personnel to collectively be responsible for the following:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each provider in the department;

(6) assessing and recommending off-site sources for needed patient care services, including telemedicine, not provided by the department or the Hospital;

(7) the integration of the department into the primary functions of the Hospital;

(8) the coordination and integration of interdepartmental and intradepartmental services;

(9) the development and implementation of policies/directives and procedures that guide and support the provision of services in the department;

(10) recommendations for a sufficient number of qualified and competent persons to provide patient care, treatment, and services;

(11) determination of the qualifications and competence of department personnel who provide patient care services;

(12) continuous assessment and improvement of the quality of patient care, treatment, and services;

(13) maintenance of quality monitoring programs, as appropriate;

(14) the orientation and continuing education of all persons in the department;

(15) recommendations for space and other resources needed by the department;

(16) active participation as a member of the Executive Committee;

(17) performing all functions authorized in the Credentials Policy, including collegial intervention;

(18) appointing one or more vice chairpersons as deemed necessary, subject to approval of the Executive Committee; and

(19) delegation to a vice chairperson such duties as appropriate, including, but not limited to, the review of applications for appointment, reappointment, authorization, reauthorization, clinical privileges, or scope of practice, or questions that may arise if the chairperson has a conflict of interest with the individual under review.

4.G. MEDICAL DIRECTORS

In the event the Hospital requires input into administrative matters relative to a Hospital department, service, or clinical program, the CEO/COO, after consultation with Medical Staff leadership, may appoint a Medical Staff member as a Medical Director to provide the required input. The Medical Director shall:

(1) report to the CEO/COO in connection with the administrative services performed; and

(2) assist the Medical Staff in its responsibility for credentialing, privileging, and professional performance evaluation, upon request of the appropriate department chairperson.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRPERSONS AND MEMBERS

(1) The Executive Committee shall appoint all committee chairpersons and committee members. Committee chairpersons shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairpersons and members shall be appointed for initial terms of two years. Reappointments may be made thereafter for additional two-year terms, with no limitation on the number of terms they may serve.

(3) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the CEO/COO or designee. All such representatives shall serve on the committees without vote.

(4) The President of the Medical Staff, and the CEO/COO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Executive Committee and to other committees and individuals as may be indicated.

5.D. EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The Executive Committee shall include:

- the officers of the Medical Staff;

- the department chairpersons;
- the chairperson of each standing committee; and
- a representative of each of the following specialties or groups of specialties, who is elected by the Active Staff members of the specialty/specialties:

  Anesthesia
  Emergency Medicine
  Family Practice
  General Surgery &/or Specialty Surgery
  Internal Medicine
  OB/GYN
  Orthopedics
  Pathology
  Radiology

- a representative of the Advance Practice Council as a non-voting member of the Executive and Business Sessions.

(b) The President of the Medical Staff will serve as chairperson of the Executive Committee.

(c) The CEO/COO, and the Chief Nursing Officer shall be *ex officio* members of the Executive Committee, without vote.

(d) Other Medical Staff members or Hospital personnel may be invited to attend a particular Executive Committee meeting (as guests, without vote) in order to assist the Executive Committee in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Executive Committee.

5.D.2. Duties:

The Executive Committee is delegated the primary authority over professional activities and functions related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies. Its members shall maintain confidentiality for all actions taken and recommendations made by the committee.

The Executive Committee is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Executive Committee meetings);

(b) providing liaison between the Medical Staff, the CEO/COO, and the Board;

(c) provide a mechanism to create a uniform standard of quality in the provision of patient care, treatment, and services;

(d) recommending directly to the Board on at least the following:

  (1) the Medical Staff's structure;

  (2) the mechanism used to review credentials and to delineate individual clinical privileges and scopes of practice;

  (3) applicants for Medical Staff appointment and reappointment and allied health professionals for authorization and reauthorization;

  (4) delineation of clinical privileges or scope of practice for each eligible individual;

  (5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

  (6) the mechanism by which Medical Staff appointment or allied health professional authorization may be terminated;

  (7) hearing procedures; and

  (8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(e) coordinating the implementation of policies/directives adopted by the Executive Committee;

(f) providing oversight of the Hospital's quality improvement plan, patient safety plan, patient satisfaction process, and environment of care plan, as they affect the Medical Staff, and being responsible to the Board for the same;

(g) consulting with administration on quality related aspects of contracts for patient care services;

(h) providing advice to the CEO/COO on sources of clinical services to be provided by telemedicine, consultation, contractual arrangement, or other agreements;

(i) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are variances from established or expected clinical practice patterns;

(j) reviewing the performance of department chairpersons and holding them accountable for the performance of their duties and responsibilities;

(k) prioritizing continuing medical activities;

(l) reviewing the Bylaws, policies/directives, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable;

(m) ensuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital and regulatory requirements affecting the Hospital; and

(n) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies/directives.

5.D.3. Meetings:

The Executive Committee shall meet as necessary, but at least ten times a year, to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) the use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the Executive Committee.

5.G. SPECIAL COMMITTEES/TASK FORCES

Special committees and task forces shall be created and their members and chairpersons shall be appointed by the President of the Medical Staff. Such committees and task forces shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year begins at 12:01 a.m. on the Friday following the fourth Thursday in January and ends at 12:00 midnight on the fourth Thursday in January of the following year.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least once a year.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the Executive Committee, the Board, or by a petition signed by not less than one-fourth of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department shall meet as often as is necessary to perform its functions, at times set by the chairperson. Each committee shall meet at least semiannually, or at the discretion of the chairperson.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the chairperson, the President of the Medical Staff, or by a petition signed by not less than one-third of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees in advance of the meetings. Notice may also be provided by posting in a designated location

prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, or a committee is called, notice must be given at least 48 hours prior to the special meeting, and posting may not be the sole mechanism used for providing notice.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the Executive Committee and the primary peer review committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum;

(2) for meetings of the Credentials Committee, the presence of at least 25% of the voting members of the committee shall constitute a quorum; and

(3) for amendments to the Medical Staff Bylaws, at least 10% of the voting members shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand delivery, telephone, or other technology approved by the President of the Medical Staff, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the Executive Committee, the primary peer review committee, and the Credentials Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The presiding officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the Executive Committee and CEO/COO. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy/directive. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the Executive Committee, Credentials Committee, and the primary peer review committee is required. All members are strongly encouraged to attend 50% of all regular and special meetings of these committees.

Failure to attend at least 50% of the meetings may result in replacement of the member.

(b) For all other meetings (Medical Staff, department, and committee), each Active Staff member is encouraged to attend and participate.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff Officers, department chairpersons, committee chairpersons, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges as an Allied Health Professional, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials and Allied Health Professionals Policies.

8.B. PROCESS FOR PRIVILEGES

Requests for privileges are provided to the applicable department chairperson, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chairperson's assessment, the application, and all supporting materials and makes a recommendation to the Executive Committee. The Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Executive Committee to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the Executive Committee is unfavorable, the individual is notified by the CEO/COO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chairperson, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chairperson's assessment, the application, and all supporting materials and makes a recommendation to the Executive Committee. The Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Executive Committee to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the Executive Committee is unfavorable, the individual is notified by the CEO/COO of the right to request a hearing.

(a) Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

(b) For a patient care need, defined in the Credentials Policy, the granting of clinical privileges in these situations will not exceed 120 days. In exceptional situations, this period of time may be extended in the discretion of the CEO/COO and the President of the Medical Staff.

8.D. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence.

(2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

8.E. DISASTER PRIVILEGING

When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO/COO/CPE or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care. Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

8.F. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges will be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) comply with training or educational requirements; and

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.G. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, the chairperson of a clinical department, the chairperson of the Credentials Committee, the CEO/COO, or the Executive Committee is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO/COO or Executive Committee.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The Executive Committee will review the reasons for the suspension within a reasonable time, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Executive Committee.

8.H. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

8.I. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the Executive Committee may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a signed petition of not less than 10% of the Active Staff or by the Executive Committee.

(2) Neither the Executive Committee, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.

(3) All proposed amendments to these Bylaws must be reviewed by the Executive Committee prior to a vote by the Medical Staff. The Executive Committee may, in its discretion, provide a report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The Executive Committee may also present proposed amendments to these Bylaws to the voting staff by written ballot or e-mail, to be returned to the CEO/COO by the date indicated by the Executive Committee. Along with the proposed amendments, the Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the staff eligible to vote, and (ii) the amendment must receive a majority of the votes cast.

(5) The Executive Committee shall have the power to adopt such technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the Executive Committee or the Medical Staff, the Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO/COO within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies/directives, procedures, and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies/directives, procedures and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents are the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Credentials Policy or the Policy on Allied Health Professionals may be made by a majority vote of the members of the Executive Committee present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments to these two documents shall be posted on the Medical Staff bulletin board for each hospital at least 14 days prior to the Executive Committee meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the Executive Committee. If there is any disagreement between the Executive Committees, a joint meeting shall be scheduled to discuss and resolve the disagreement.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these two documents shall be posted on the Medical Staff bulletin board for each hospital at least 14 days prior to the Executive Committee meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the Executive Committee.

(4) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

(5) All other policies/directives of the Medical Staff may be adopted and amended by a majority vote of the Executive Committee. No prior notice is required.

(6) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies/directives will become effective only when approved by the Board.

(7) The present Medical Staff Rules and Regulations of the Hospital are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Executive Committee with regard to:

(a) proposed amendments to these Medical Staff Bylaws;

(b) proposed amendments to the Medical Staff Rules and Regulations;

(c) proposed amendments to an existing policy that is under the authority of the Executive Committee; or

(d) a new policy proposed by the Executive Committee,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than one-fourth of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO/COO, who will forward the request for communication to the Chair of the Board. The CEO/COO will also provide notification to the Executive Committee by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies/directives, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: February 24, 2011, August 30, 2012, April 25, 2013

Approved by the Board: March 17, 2011, September 18, 2012, May 16, 2013

Revisions approved by the Medical Staff: February 26, 2015, September 22, 2016

Revisions approved by the Board: March 19, 2015, November 17, 2016

Revisions approved by the Medical Staff MEC and Board: (Appendix B & C)
October 26, 2017 and November 16, 2017

Revisions (8.C (a), (b) approved by the Medical Staff MEC: November 30, 2017
Revisions approved by the Board: December 11, 2017

Revisions approved by the Medical Staff MEC (Appendix B): August 23, 2018
Revisions approved by the Board: September 20, 2018

Revisions approved by the Medical Staff MEC (5.D.1): December 6, 2018
Revisions approved by the Board: January 17, 2019

Revisions approved by the Medical Staff MEC (5.D.1.a): June 27, 2019
Revisions approved by the Board: July 18, 2019

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Consulting	Affiliate	Coverage	Honorary
Basic Requirements						
Number of hospital contacts/2-year	≥ 24	> 6 & < 24	NA	N	NA	N
Rights						
Admit	Y	> 6 & < 24	Y	N	P	N
Exercise clinical privileges	Y	Y	Y	N	P	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Emergency call coverage	Y	Follow-Up Care	N	Follow-Up Care	P	N
Meeting requirements	Y	N	N	N	N	N
Dues	Y	Y	Y	Y	Y	N
Comply w/ guidelines	Y	Y	Y	N	Y	N

Y = Yes
N = No
P = Partial (with respect to voting, only when appointed to a committee; with respect to patient care activity, only when acting for a member of the Active Staff)

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(1) <u>General Documentation Requirements</u>

(a) H&P Performed After Admission/Registration:

1) Inpatients; and outpatients with anesthesia: A History and Physical examination must be documented in the medical record within 24 hours after admission/arrival at the hospital or prior to surgery (whichever is first).
2) The H&P is documented in the EHR by a MSM or AHP who has been granted privileges by the Hospital to perform histories and physicals.

(b) Scope of the History and Physical will include, when pertinent:

1. History – include the following:

- Chief complaint
- Present illness (includes symptoms/indications for the visit/surgical procedure)
- Past medical history
- Past surgical history
- Family history (pertinent)
- Social history (pertinent)
- Review of systems (as appropriate to the encounter per provider discretion)
- List of medications & dosages (unless available in EHR)
- Allergies
- Admitting diagnosis
- Plan

2. Physical examination - Include, as medically indicated:

- HEENT
- Neck
- Breasts
- Heart
- Lungs
- Abdomen
- Extremities
- Neurologic
- Pelvic/genitalia, and rectal
- Mental status

3. An obstetrical record includes prenatal information, including history of complications, Rh determination, and other necessary information. Prenatal information may be provided on a legible office copy of the recorded information. An H&P update must be dictated or written on admission, whether the delivery is vaginal or by C-section.
   (See MR-009 5.1.1 for the content.)

4. Newborn physical:

   - HEENT
   - Heart
   - Lungs
   - Abdomen
   - Extremities
   - Neurologic

5. Content for outpatient diagnostic procedures requiring anesthesia services matches elements as listed on the Anesthesia Preprocedure Evaluation.

6. H&P Requirement for Procedural Sedation- see Procedural Sedation policy (PH-012)

2. <u>H&P Performed Prior to Admission/Registration</u>

   a) A history and physical performed more than 30 days prior to an admission/registration is invalid.

   b) An H&P completed no more than 30 days prior to inpatient admission or outpatient procedure requiring an H&P (outpatients with anesthesia) may be incorporated into the medical record under the following conditions:
      - The previous H&P is in the medical record. If completed in a provider's office by an NP or PA, the H&P will be accepted by the hospital with the signature of the NP or PA.
      - The MSM or AHP with approved privileges that include performing and documenting H&P updates examines the patient and completes an H&P update to document any changes to the previous H&P or to note there are no changes; and to document the planned treatment and/or procedure is still necessary.
      - The H&P Update must be documented no later than 24 hours after admission, or in the case of surgical patients, prior to surgery or a procedure involving anesthesia, whichever comes first. The H&P Update must be dated, timed and authenticated or countersigned by the MSM.

3. Emergency Situation

In case of an emergency where there is no time to perform and document the H&P prior to surgery or a procedure involving anesthesia due to the patient's condition, it will be completed as soon as possible after surgery.

* **Amendments to Appendix B**

The Executive Committee shall have the power to adopt such amendments to Appendix B which are needed to meet regulatory agencies' standards or requirements that have been implemented by the Hospital.

MEC approved revisions of Appendix B: 9/24/2015

APPENDIX C

QUALIFIED MEDICAL PERSONNEL (QMP)

For purposes of the Hospital's Policy on Screening, Treatment and Transfer (EMTALA), "Qualified Medical Personnel" means the personnel who are to conduct the medical screening exam, which includes Medical Staff Appointees, physician assistants (PA-C), sexual assault nurse examiners-trained registered nurse, and advanced practice registered nurse/nurse practitioner and registered nurses trained for labor and delivery and Libertas Treatment Center who have completed the comprehensive orientation and skills inventory in accordance with professional Standards and Practice Guidelines.