

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
THE CHRIST HOSPITAL**

MEDICAL STAFF BYLAWS

*Adopted: July 16, 2014
Most Recent Revisions: August 24, 2016*

TABLE OF CONTENTS

	<u>PAGE</u>
1. GENERAL	1
1.A. DEFINITIONS.....	1
1.B. TIME LIMITS	1
1.C. DELEGATION OF FUNCTIONS	1
1.D. MEDICAL STAFF DUES.....	1
1.E. INDEMNIFICATION.....	2
2. CATEGORIES OF THE MEDICAL STAFF	3
2.A. ACTIVE STAFF.....	3
2.A.1. Qualifications.....	3
2.A.2. Prerogatives.....	3
2.A.3. Responsibilities.....	4
2.B. COURTESY STAFF	4
2.B.1. Qualifications.....	4
2.B.2. Prerogatives and Responsibilities	5
2.C. COMMUNITY AFFILIATE STAFF	6
2.C.1. Qualifications.....	6
2.C.2. Prerogatives and Responsibilities	6
2.D. HOUSE STAFF	7
2.D.1. Qualifications.....	7
2.D.2. Prerogatives and Responsibilities	8
2.E. HONORARY STAFF.....	8
2.E.1. Qualifications.....	8
2.E.2. Prerogatives and Responsibilities	8

	<u>PAGE</u>
2.F. ALLIED HEALTH PROFESSIONAL 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 of the Medical Staff	11
3.C.3. Secretary-Treasurer	12
3.C.4. Immediate Past President of the Medical Staff.....	12
3.D. NOMINATIONS	13
3.E. ELECTION	13
3.F. TERM OF OFFICE.....	13
3.G. REMOVAL.....	14
3.H. VACANCIES.....	14
4. SERVICE LINES AND DIVISIONS	15
4.A. ORGANIZATION	15
4.B. SERVICE LINES.....	15
4.B.1. Assignment to Service Lines	15
4.B.2. Functions of Service Lines.....	15
4.B.3. Selection, Evaluation, and Removal of Service Line Executive Medical Directors	15
4.B.4. Duties of Service Line Executive Medical Directors	16

	<u>PAGE</u>
4.C. DIVISIONS.....	17
4.C.1. Functions of Divisions	17
4.C.2. Selection and Removal of Division Chiefs.....	18
4.C.3. Duties of Division Chiefs.....	18
4.C.4. Medical Directors.....	19
5. MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS	21
5.A. MEDICAL STAFF COMMITTEES	21
5.A.1. General.....	21
5.A.2. Appointment of Committee Chairs and Members	21
5.A.3. Meetings, Reports, and Recommendations.....	21
5.B. MEDICAL EXECUTIVE COMMITTEE	22
5.B.1. Composition.....	22
5.B.2. Duties	22
5.B.3. Meetings.....	23
5.C. PERFORMANCE IMPROVEMENT FUNCTIONS	23
5.D. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES	25
6. MEETINGS.....	26
6.A. GENERAL MEDICAL STAFF MEETINGS	26
6.B. SERVICE LINE, DIVISION, AND COMMITTEE MEETINGS	26
6.B.1. Regular Meetings	26
6.B.2. Special Meetings.....	26
6.C. PROVISIONS COMMON TO ALL MEETINGS	26
6.C.1. Prerogatives of the Presiding Officer.....	26
6.C.2. Notice of Meetings.....	27
6.C.3. Quorum and Voting	27
6.C.4. Minutes, Reports, and Recommendations	28

	<u>PAGE</u>
6.C.5. Confidentiality	28
6.C.6. Attendance Requirements	28
7. BASIC STEPS AND DETAILS	29
7.A. QUALIFICATIONS FOR APPOINTMENT	29
7.B. PROCESS FOR PRIVILEGING	29
7.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT).....	30
7.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES.....	30
7.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION.....	31
7.F. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES	32
7.G. HEARING AND APPEAL PROCESS FOR MEDICAL STAFF MEMBERS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL.....	32
8. AMENDMENTS	34
8.A. MEDICAL STAFF BYLAWS	34
8.B. OTHER MEDICAL STAFF DOCUMENTS	35
8.C. CONFLICT MANAGEMENT PROCESS.....	36
8.C.1. Conflicts Between the Medical Staff and Medical Executive Committee.....	36
8.C.2. Conflicts Between the Medical Staff, Hospital Administration, and the Board	37

9. ADOPTION.....38

APPENDIX A – MEDICAL STAFF CATEGORIES SUMMARY

APPENDIX B – HISTORY AND PHYSICAL EXAMINATIONS

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the 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 Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff Leader is unavailable or unable to perform an assigned function, a Medical Staff Officer may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

- (1) Medical Staff dues shall be as established by the Medical Executive Committee and may vary by category.
- (2) Dues are payable January 1 of each year unless determined otherwise by the Medical Executive Committee. Dues are nonrefundable and will not be prorated.
- (3) Unless excused by the Medical Executive Committee for good cause, failure to render payment within 60 days of the due date may result, after special notice of the delinquency, in the automatic relinquishment of Medical Staff appointment (including all prerogatives) and clinical privileges until such time as the delinquency is remedied. If dues have not been paid within 90 days of the due date, the individual shall be deemed to have voluntarily resigned his or her Medical Staff appointment.
- (4) The Medical Staff Officers and VP & Chief Medical Officer shall be signatories to the Hospital's Medical Staff account. Any transaction greater than \$10,000 will require the proper authorization of two signatories.

1.E. INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, service line executive medical directors, division chiefs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

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 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, oral surgeons, podiatrists, and psychologists who:

- (a) are involved in at least 24 patient contacts per two-year appointment term; or
- (b) fail to meet the activity requirements of this category but have demonstrated a commitment to the Medical Staff through service on Medical Staff or Hospital committees or active participation in performance/quality improvement functions.

Guidelines:

- * Any member who has fewer than 24 patient contacts during his/her two-year appointment term and/or who is not sufficiently active in Medical Staff or Hospital functions shall not be eligible to request Active Staff status at the time of his/her reappointment, unless the member can definitively demonstrate to the satisfaction of the Credentials Committee, the Medical Executive Committee, and the Board at the time of reappointment that his/her practice patterns have changed, and that he/she will satisfy the activity requirements of this category going forward.
- ** If the member cannot definitively demonstrate that he/she will satisfy the activity requirements of this category, the member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy or Community Affiliate Staff).

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 service line, division, and committee meetings;
- (c) hold office, serve as a service line executive medical director, division chief, or medical director, serve on Medical Staff committees, and serve as a chair of a committee; 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;
- (c) providing inpatient 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 inpatient consultations, when requested;
- (g) paying 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, oral surgeons, podiatrists, and psychologists who are involved in fewer than 24 patient contacts per two-year appointment term and do not otherwise qualify for appointment to the Active Staff.

Guidelines:

- * Any member who has zero 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 (e.g. – Community Affiliate) unless the

member can definitively demonstrate to the satisfaction of the Credentials Committee, the Medical Executive Committee, and the Board that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this or another category going forward.

** Any member who has more than 24 patient contacts during his/her two-year appointment term must request Active Staff status, unless the member can definitively demonstrate to the satisfaction of the Credentials Committee, the Medical Executive Committee, and the Board at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category going forward).

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

- (a) may 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 applicable service line and division meetings (without vote) and applicable committee meetings (with vote), if invited to serve on the committee;
- (c) may not hold office;
- (d) may serve as a service line executive medical director, division chief, medical director, or committee chair;
- (e) shall provide specialty coverage for the Emergency Department;
- (f) shall provide inpatient care for unassigned patients;
- (g) shall cooperate in the professional practice evaluation and performance improvement processes;
- (h) shall exercise such clinical privileges as are granted to them; and
- (i) shall pay application fees, dues, and assessments.

2.C. COMMUNITY AFFILIATE STAFF

2.C.1. Qualifications:

The Community Affiliate Staff consists of those physicians, dentists, oral surgeons, podiatrists, and psychologists who:

- (a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital;
- (b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Affiliate Staff as outlined in Section 2.C.2; and
- (c) may wish to request only limited outpatient-related therapies for the care and treatment of their patients at the Hospital.

Guidelines:

Except as noted in (c), the Community Affiliate Staff is a membership-only category, with no clinical privileges being granted. The primary purpose of the Community 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.

2.C.2. Prerogatives and Responsibilities:

- (a) Community Affiliate Staff members:
 - (1) may attend meetings of the Medical Staff and applicable service lines or divisions (without vote);
 - (2) may not hold office;
 - (3) may serve as a service line executive medical director, division chief, medical director, or committee chair;
 - (4) shall generally have no staff committee responsibilities, but may be invited to serve on a committee (with vote);
 - (5) may attend educational activities sponsored by the Medical Staff and the Hospital;
 - (6) may refer patients to members of the Active Staff for admission and/or care;

- (7) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;
 - (8) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients, and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;
 - (9) may review the medical records and test results (via paper or electronic access) for any patients who are referred;
 - (10) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;
 - (11) except as noted in (b) below, may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;
 - (12) may refer patients to the Hospital's diagnostic facilities and order such tests; and
 - (13) must pay application fees, dues, and assessments.
- (b) Community Affiliate Staff members may also be granted limited privileges to order certain outpatient therapies (e.g., infusion therapy injections), but should these privileges be requested, (i) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies to the satisfaction of the Credentials Committee, the Medical Executive Committee, and the Board, and (ii) they must also establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients, should that be necessary;

2.D. HOUSE STAFF

2.D.1. Qualifications:

The House Staff shall include physicians, dentists, oral surgeons, podiatrists, and psychologists who:

- (a) are currently enrolled in good standing in an Accreditation Council for Graduate Medical Education ("ACGME") or American Osteopathic Association ("AOA") accredited residency or fellowship program; and
- (b) are graduates of an accredited medical school and licensed to practice in the state of Ohio, Kentucky, or Indiana, as appropriate for their place of practice.

2.D.2. Prerogatives and Responsibilities:

House Staff members:

- (a) may exercise those clinical privileges granted by the Board;
- (b) may attend meetings of the Medical Staff and applicable service lines, division, and committee (without vote, unless provided by the presiding officer), if invited to serve on the committee;
- (c) may not hold office or serve as a service line executive medical director, division chief, medical director, or committee chair; and
- (d) may attend educational activities sponsored by the Medical Staff and the Hospital.

2.E. HONORARY STAFF

2.E.1. Qualifications:

- (a) The Honorary Staff will consist of physicians, dentists, oral surgeons, podiatrists, and psychologists who:
 - (1) have a record of previous long-standing service to the Hospital and have retired from the active practice of medicine; or
 - (2) are recognized for outstanding or noteworthy contributions to the medical sciences.
- (b) None of the specific qualifications for appointment are applicable to members of the Honorary Staff.

2.E.2. Prerogatives and Responsibilities:

Honorary Staff members:

- (a) may not admit, attend, or consult on patients;
- (b) may attend Medical Staff and service line meetings when invited to do so (without vote);
- (c) may be invited to serve on a committee (with vote);
- (d) are entitled to attend educational programs of the Medical Staff and the Hospital;

- (e) may not hold office or serve as a service line executive medical director, division chief, medical director, or committee chair; and
- (f) are not required to pay application fees, dues, or assessments.

2.F. ALLIED HEALTH PROFESSIONAL STAFF

2.F.1. Qualifications:

The Allied Health Professional Staff consists of licensed independent practitioners, advanced dependent practitioners, and dependent practitioners who are not physicians but who are authorized by law and by the Hospital to provide patient care services within the Hospital. The Allied Health Professional Staff is not a category of the Medical Staff, but is included in this Article of the Bylaws for convenient reference.

2.F.2. Prerogatives and Responsibilities:

Allied Health Professional Staff members:

- (a) may function in the Hospital under the oversight of a Supervising/Collaborating Physician, where applicable, and as permitted by their license and clinical privileges or scope of practice;
- (b) may attend applicable service line or division meetings (without vote);
- (c) may serve on a committee, if invited (without vote, unless provided by the presiding officer);
- (d) must actively participate in the professional practice evaluation and performance improvement processes; and
- (e) must pay applicable fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

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

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 Medical Executive Committee and approved by the Board. They must:

- (1) have served on the Active Staff for at least two years;
- (2) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- (3) be willing to faithfully discharge the duties and responsibilities of the position;
- (4) have experience in a leadership position, or other involvement in performance improvement functions;
- (5) participate in Medical Staff leadership training, as determined by the Medical Executive Committee;
- (6) have demonstrated an ability to work well with others; and
- (7) disclose if they (i) are serving as a Medical Staff Officer, Board member, or department chair at any other hospital, or (ii) have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within an individual's office and billed under the same provider number used by the individual.

Any disclosures under paragraph (7) of this Section shall be reviewed by the Nominating Committee, the Medical Executive Committee, and the Board, to determine whether the relationship is such that it renders an individual ineligible for the position for which he or she is being considered.

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 VP & Chief Medical Officer and President & Chief Executive Officer in matters of mutual concern involving the care of patients in the Hospital;
- (b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the President & Chief Executive Officer and the Board;
- (c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;
- (d) serve as chair of the Medical Executive Committee (with a vote);
- (e) serve as a member of the Board (with vote), in accordance with the Hospital corporate bylaws;
- (f) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;
- (g) be the spokesperson for the Medical Staff in its external professional and public relations;
- (h) promote the educational activities of the Medical Staff;
- (i) perform all functions authorized in these Bylaws, and other applicable policies, including collegial intervention in the Credentials Policy; and
- (j) assume other such duties as are assigned by the Board.

3.C.2. President-Elect of the Medical Staff:

The President-Elect of the Medical Staff 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 Medical Executive Committee;
- (c) serve as chair of the Credentials Committee;

- (d) serve as a member of the Board (without vote), in accordance with the Hospital corporate bylaws;
- (e) automatically succeed the President of the Medical Staff at the completion of his/her term or in the event of a vacancy during his/her term; and
- (f) assume other such duties as are assigned by the President of the Medical Staff or the Board.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

- (a) assume all duties of the President of the Medical Staff and act with full authority as President in the absence of the President and President-Elect;
- (b) serve on the Medical Executive Committee;
- (c) serve on the Credentials Committee;
- (d) cause to be kept accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;
- (e) be responsible for the collection of, accounting for, and disbursements of all Medical Staff funds, dues, etc., and make disbursements authorized by the Medical Executive Committee;
- (f) automatically succeed the President-Elect at the completion of his/her term or in the event of a vacancy during his/her term; and
- (g) perform such other duties as are assigned by the President of the Medical Staff.

3.C.4. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

- (a) serve on the Medical Executive Committee;
- (b) serve as a member of the Board (with vote), in accordance with the Hospital corporate bylaws;
- (c) chair the Physician Leadership Development Committee;
- (d) serve as an advisor to other Medical Staff Leaders; and

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

3.D. NOMINATIONS

- (1) The Nominating Committee shall consist of at least the two most immediate Past Presidents who are members of the Active Staff and the current Medical Staff officers. The most immediate Past President shall serve as chair of the committee.
- (2) The Nominating Committee shall convene at three months prior to an election and shall submit to the Medical Executive Committee the names of one or more qualified nominees for each forthcoming vacancy in office. Each nominee must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.
- (3) Nominations may also be submitted in writing by petition signed by at least 10% of the voting members of the Medical Staff no later than 15 days before the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E. ELECTION

- (1) The election shall be held at the May meeting of the Medical Staff by voice vote. Those candidates who receive a majority of the votes cast shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first voice vote, 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 Medical Executive Committee, the election may be held by written ballot returned to Medical Staff Services. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in Medical Staff 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 assume office at the close of the general meeting of the Medical Staff held in September and shall serve for a term of two years or until a successor is elected pursuant to Section 3.H.

3.G. REMOVAL

- (1) Removal of an elected officer or member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Executive Committee, or by a two-thirds vote of all members of the Active Staff, or by the Board. Grounds for removal shall be:
 - (a) failure to comply with applicable policies, 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.
- (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 address the Medical Executive Committee or a committee of the Board, as applicable, prior to a vote on removal.
- (3) No removal shall be effective until approved by the Board.

3.H. VACANCIES

- (1) 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. A vacancy in the office of President-Elect shall be filled by the Secretary-Treasurer, who shall serve until the end of the President-Elect's unexpired term. In the event there is a vacancy in the Secretary-Treasurer office, the Medical Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the Medical Executive Committee.
- (2) Upon such succession, the President-Elect and/or Secretary-Treasurer shall have the discretion to assume his or her own two-year term as President or President-Elect, subject to confirmation by the Medical Executive Committee.

ARTICLE 4

SERVICE LINES AND DIVISIONS

4.A. ORGANIZATION

- (1) The Medical Staff shall be organized into service lines and divisions as listed in the Medical Staff Organization Manual.
- (2) Subject to the approval of the Board, the Medical Executive Committee may create or eliminate service lines or divisions or otherwise reorganize the Medical Staff structure.

4.B. SERVICE LINES

4.B.1. Assignment to Service Lines:

- (a) Upon initial appointment to the Medical Staff, each member shall be assigned to a service line.
- (b) An individual may request a change in service line assignment to reflect a change in the individual's clinical practice. Requests for a change in service line assignment must be submitted in writing to the Credentials Committee for consideration. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee, which shall review the recommendation of the Credentials Committee and make its own a recommendation to the Board regarding whether to grant the individual's request.

4.B.2. Functions of Service Lines:

- (a) Service lines are established to lead the Medical Staff's transition to a patient-centric structure, by enhancing the delivery of care, clinical outcomes, and operational performance.
- (b) Each service line should assure that the care of the patient is the highest priority, with a focus on maximizing quality, safety, service and value.
- (c) Each service line has a service line executive medical director, a service line executive director, and a service line clinical director.

4.B.3. Selection, Evaluation, and Removal of Service Line Executive Medical Directors:

- (a) Each service line executive medical director shall be appointed by the Board after having received the recommendation of a search committee composed of Hospital and Medical Staff Leaders and input from the Medical Executive Committee.

- (b) Each service line executive medical director shall be evaluated pursuant to the terms of his or her contract.
- (c) Service line executive medical directors may be removed by the Board, with input from Hospital and Medical Staff Leaders and the Medical Executive Committee, in accordance with his or her contract.

4.B.4. Duties of Service Line Executive Medical Directors:

In addition to fulfilling the duties in their physician employment agreements, service line executive medical directors are also responsible for the following, either individually or in collaboration with Hospital personnel:

- (a) coordinating all clinically-related activities of the service line;
- (b) coordinating all administratively-related activities of the service line, unless otherwise provided for by the Hospital;
- (c) continuing surveillance of the professional performance of all individuals in the service line who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE);
- (d) recommending criteria for clinical privileges that are relevant to the care provided in the service line;
- (e) evaluating requests for clinical privileges for each member of the service line;
- (f) developing the on-call schedules for physicians within the service line;
- (g) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the service line or the Hospital;
- (h) integrating the service line into the primary functions of the Hospital;
- (i) coordinating and integrating services within the service line and between service lines;
- (j) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the service line;
- (k) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

- (l) determining the qualifications and competence of credentialed service line personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- (m) continuously assessing and improving the quality of care, treatment, and services provided within the service line, which may include a random audit of medical records in the service line to determine whether chart notations were accurate, complete, and acceptable in content and quality;
- (n) maintaining quality monitoring programs, as appropriate;
- (o) providing for the orientation and continuing education of all persons in the service line, and being responsible for teaching and research activities;
- (p) making recommendations for space and other resources needed by the service line;
- (q) being accountable to the Medical Executive Committee for all professional, quality, and administrative activities related to the medical services of the service line;
- (r) being responsible for implementation of service line-related actions taken by the Medical Executive Committee; and
- (s) performing all functions authorized in the Credentials Policy, including collegial intervention efforts.

4.C. DIVISIONS

4.C.1. Functions of Divisions:

- (a) Divisions may perform any of the following activities:
 - (1) continuing education;
 - (2) discussion of policy;
 - (3) discussion of equipment needs;
 - (4) development of recommendations to the service line executive medical director or the Medical Executive Committee;
 - (5) participation in the development of criteria for clinical privileges (when requested by the service line executive medical director); and

- (6) discussion of a specific issue at the special request of a service line executive medical director or the Medical Executive Committee.
- (b) No minutes or reports will be required reflecting the activities of divisions, except when the divisions are making formal recommendations to a service line, service line executive medical director, Credentials Committee, or Medical Executive Committee.
- (c) Divisions shall not be required to hold any number of regularly scheduled meetings.

4.C.2. Selection and Removal of Division Chiefs:

- (a) Each division chief must satisfy the eligibility criteria in Section 3.B.
- (b) Division chiefs shall be appointed and removed at the discretion of the service line executive medical director, after receiving input from division members and the Medical Executive Committee. They shall serve for an initial term of two years, but they may be selected by the service line executive medical director to serve for additional two-year terms.

4.C.3. Duties of Division Chiefs:

The division chief shall carry out those functions delegated by the service line executive medical director, which may include the following:

- (a) review and report on applications for initial appointment and clinical privileges;
- (b) review and report on applications for reappointment and renewal of clinical privileges;
- (c) evaluate individuals during the focused professional practice evaluation process to confirm competence for all initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment;
- (d) participate in the development of criteria for clinical privileges within the division;
- (e) review and report regarding the professional performance of individuals practicing within the division;
- (f) support the service line executive medical director in making recommendations regarding the coordination of service line activities, as well as the Hospital resources necessary for the division to function effectively; and

- (g) perform all functions authorized in the Credentials Policy, including collegial intervention efforts.

4.C.4. Medical Directors:

- (a) A medical director for a service within a division may be selected by the same process that is used for service line executive medical directors (except Board approval is not necessary), where required by regulation or as determined by the service line executive medical director, in consultation with the Hospital.
- (b) Candidates will be identified and recommended by the applicable service line executive medical director, in consultation with the Medical Executive Committee. Each medical director must meet the eligibility criteria in Section 3.B and shall report to the applicable division chief or service line executive medical director.
- (c) In addition to fulfilling the duties in his or her contract, the medical director shall carry out those regulatory functions required under federal and state law and assume all duties assigned by the division chief or service line executive medical director, which may include the following:
 - (1) ongoing development, growth, and oversight of the service within the division;
 - (2) promoting high standards of practice through the development and implementation of policies, protocols, and practice guidelines;
 - (3) monitoring performance improvement efforts;
 - (4) overseeing resident and staff education and research;
 - (5) organizing, directing, and integrating the program with all other service lines and divisions within the Hospital;
 - (6) promoting a cooperative and collaborative working environment among the clinical disciplines involved in patient care;
 - (7) providing advice and direction in recommending privileges for the division;
 - (8) assessing needs for equipment, supplies, and budget; and
 - (9) overseeing, participating in and developing projects that ensure the cost-effectiveness of care provided by physicians and the Hospital.

- (d) Medical Directors may be removed by the Board, with input from Hospital and Medical Staff Leaders, in accordance with his or her contract.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES

5.A.1. General:

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.A.2. Appointment of Committee Chairs and Members:

- (a) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff who shall serve *ex officio* (with vote) on all committees. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.
- (b) Unless otherwise provided, committee chairs and members shall be appointed for a term of two years and may be reappointed for additional two-year terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.
- (c) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the President & Chief Executive Officer, with input from the relevant committee chair. All such representatives shall serve on the committees, without vote.
- (d) Unless otherwise indicated, the VP & Chief Medical Officer and the President & Chief Executive Officer (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.A.3. 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 Medical Executive Committee and to other committees and individuals as may be indicated.

5.B. MEDICAL EXECUTIVE COMMITTEE

5.B.1. Composition:

- (a) Not counting *ex officio* members, the Medical Executive Committee shall consist of not more than 17 individuals, including the President of the Medical Staff, the President-Elect, the Secretary-Treasurer, the Immediate Past President of the Medical Staff, the service line executive medical directors, the chair of the Medical Staff Quality Committee, three physician members at large and such other medical practitioners as are appropriate from time to time, as appointed by the President of the Medical Staff. At all times, the Medical Executive Committee shall include at least two members who are ambulatory care practitioners and at least one member who is a hospital-based physician.
- (b) The President of the Medical Staff shall chair the Medical Executive Committee.
- (c) The President & Chief Executive Officer and VP & Chief Medical Officer shall be *ex officio* members of the Medical Executive Committee, without vote.
- (d) The President of the Medical Staff may invite other individuals to attend and participate at meetings of the Medical Executive Committee (without vote).

5.B.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement. This authority may be removed or modified by amending these Bylaws and related policies. The Medical 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 Medical Executive Committee meetings);
- (b) 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;
 - (3) applicants for Medical Staff appointment and reappointment;
 - (4) termination, restriction, and suspension of appointment and/or clinical privileges;
 - (5) delineation of clinical privileges for each eligible individual;

- (6) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
 - (7) the mechanism by which Medical Staff appointment may be terminated;
 - (8) hearing procedures; and
 - (9) reports and recommendations from Medical Staff committees, service lines, and other groups, as appropriate;
- (c) consulting with administration on quality-related aspects of contracts for patient care services;
 - (d) reviewing quality indicators to ensure uniformity regarding patient care services;
 - (e) providing leadership in activities related to patient safety;
 - (f) providing oversight in the process of analyzing and improving patient satisfaction;
 - (g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;
 - (h) providing and promoting effective liaison among the Medical Staff, Administration, and the Board; and
 - (i) performing such other functions as are assigned to it by the Board or as authorized in these Bylaws, the Credentials Policy, or other applicable policies.

5.B.3. Meetings:

- (a) The Medical Executive Committee shall meet at least ten times a year, and the President of the Medical Staff may otherwise electronically transmit matters to the membership for their consideration as an alternative to a formal meeting.
- (b) The Medical Executive Committee shall maintain a permanent record of its proceedings and actions.

5.C. 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) 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) health care-associated 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.D. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

- (1) The Medical Executive Committee may, by resolution, and without amendment of these Bylaws, establish additional standing committees to perform one or more staff functions, including professional practice evaluation activities.
- (2) The Medical Executive Committee may dissolve or rearrange the structure, duties, or composition of the Medical Staff committees as needed to better accomplish Medical Staff functions.
- (3) Any function required to be performed by these Bylaws which is not assigned to an individual or a standing committee shall be performed by the Medical Executive Committee.
- (4) Special task forces may also be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the Medical Executive Committee. Such special task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE 6

MEETINGS

6.A. GENERAL MEDICAL STAFF MEETINGS

- (1) The Medical Staff shall meet at least twice during the Medical Staff year, with regularly scheduled meetings during the months of May and September. The Medical Staff year begins at the close of the September meeting.
- (2) Special meetings of the Medical Staff may be called by the President of the Medical Staff, the Medical Executive Committee, the President & Chief Executive Officer, or the Board or by a petition signed by at least 10% of the Active Staff.

6.B. SERVICE LINE, DIVISION, AND COMMITTEE MEETINGS

6.B.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, each service line, division, and committee shall meet as often as necessary to accomplish their functions, at times set by the Presiding Officer.

6.B.2. Special Meetings:

A special meeting of any service line, division, or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the Medical Executive Committee, or the President & Chief Executive Officer, or by a petition signed by at least 10% of the voting members of the service line, division, or committee, but not by fewer than two members.

6.C. PROVISIONS COMMON TO ALL MEETINGS

6.C.1. Prerogatives of the Presiding Officer:

- (a) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, service line, division, or committee.
- (b) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.
- (c) The Presiding Officer shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference in the discretion of the Presiding Officer, it shall not be binding. Rather, specific

provisions of these Bylaws and Medical Staff, service line, division, or committee custom shall prevail at all meetings and elections.

6.C.2. Notice of Meetings:

- (a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of service lines, divisions, and committees at least 14 days in advance of the meetings. Notice may also be provided by posting in a designated location at least 14 days 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 service line, a division, and/or a committee is called, notice must be given at least 48 hours prior to the special meeting. In addition, posting may not be the sole mechanism used for providing notice of any special meeting.
- (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.C.3. Quorum and Voting:

- (a) For any regular or special meeting of the Medical Staff, service line, division, 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 Medical Executive Committee, the Credentials Committee, the Medical Staff Quality Committee, and the Peer Review Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and
 - (2) for any amendments to these Medical Staff Bylaws, at least 10% of the Active Staff shall constitute a quorum.
- (b) Recommendations and actions of the Medical Staff, service lines, divisions, 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 of the votes cast by the voting staff at the meeting.
- (c) As an alternative to a formal meeting, and at the discretion of the Presiding Officer, the voting members of the Medical Staff, a service line, division, 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 Medical Executive Committee, the Credentials Committee, the Medical Staff Quality Committee, and the Peer Review Committee (as noted in (a)), a quorum for

purposes of these votes shall be the number of responses returned to the Presiding Officer (but not fewer than two) 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.

6.C.4. Minutes, Reports, and Recommendations:

- (a) Minutes of all meetings of the Medical Staff, service lines, and committees (and applicable division meetings) 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, service lines, divisions, and committees shall be transmitted to the Medical Executive Committee. The Board shall be kept apprised of the recommendations of the Medical Staff and its service lines, divisions, and committees.
- (c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.C.5. Confidentiality:

All Medical Staff business conducted by committees, service lines, or divisions 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. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.C.6. Attendance Requirements:

- (a) Attendance at meetings of the Medical Executive Committee, the Credentials Committee, the Medical Staff Quality Committee, and the Peer Review Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.
- (b) Each Active Staff member is expected to attend and participate in Medical Staff meetings and applicable service line, division, and committee meetings each year.

ARTICLE 7

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

7.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or the Allied Health Professional Staff, or for the grant of clinical privileges or scope of practice, an applicant must meet the threshold eligibility criteria set forth in the Credentials Policy, including geographic residency requirements, and demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges or scope of practice requested.

7.B. PROCESS FOR PRIVILEGING

- (1) Requests for privileges or scope of practice are provided to the applicable service line executive medical director or division chief, who reviews the individual's education, training, and experience and prepares a report (on a form provided by Medical Staff Services) stating whether the individual meets all qualifications. The Credentials Committee then reviews the service line executive medical director's or division chief's assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical 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 it does not adopt the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual is notified by the President & Chief Executive Officer of the right to request a hearing.
- (2) When the request for privileges or scope of practice is made by an allied health professional, the Allied Health Professional Committee shall review the report of the applicable service line executive medical director or division chief and make a recommendation to the Credentials Committee and subsequently follow the process outlined above.
- (3) Once a request for clinical privileges or scope of practice is deemed complete, it is expected to be processed within 90 business 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.

- (4) When the disaster plan has been implemented, the President & Chief Executive Officer, the VP & Chief Clinical Officer, or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

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

- (1) Complete applications are provided to the applicable service line executive medical director or division chief, who reviews the individual's education, training, and experience and prepares a report (on a form provided by Medical Staff Services) stating whether the individual meets all qualifications. The Credentials Committee then reviews the service line executive medical director's or division chief's assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical 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 it does not adopt the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual is notified by the President & Chief Executive Officer of the right to request a hearing.
- (2) When the request for appointment is made by an allied health professional, the Allied Health Professional Committee shall review the report of the applicable service line executive medical director or division chief and make a recommendation to the Credentials Committee and subsequently follow the process outlined above.
- (3) Once an application is deemed complete, it is expected to be processed within 90 business 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.

7.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

- (1) Appointment and clinical privileges or scope of practice may be automatically relinquished if an individual:
 - (a) fails to do any of the following:

- (i) satisfy threshold eligibility criteria;
 - (ii) provide requested information;
 - (iii) undergo a requested evaluation or execute any of the appropriate releases;
 - (iv) attend a special meeting to discuss issues or concerns;
 - (v) complete and/or comply with training, counseling, or educational requirements; or
 - (vi) pay applicable Medical Staff dues in a timely manner;
- (b) is involved or alleged to be involved in specific criminal activity as defined in the Credentials Policy;
 - (c) makes a misstatement or omission on an application form;
 - (d) remains absent on leave for longer than one year, unless an extension is granted by the Credentials Committee or Medical Executive Committee; or
 - (e) in the case of an allied health professional, fails, for any reason, to maintain an appropriate supervision/collaborating relationship with a Supervising/Collaborating Physician.
- (2) Except as otherwise provided in the Credentials Policy, an automatic relinquishment of appointment and clinical privileges or scope of practice will be effective immediately upon actual or special notice to the individual.

7.E. 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 Medical Executive Committee, the President of the Medical Staff, the President-Elect, the service line executive medical director, the VP & Chief Medical Officer, or the President & Chief Executive Officer is authorized to suspend or restrict all or any portion of an individual's clinical privileges or scope of practice pending an investigation.
- (2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by (i) the Medical Executive Committee or (ii) the President & Chief Executive Officer, who shall consult with the President of the Medical Staff.

- (3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.
- (4) The Medical Executive Committee will review the reasons for the suspension within a reasonable time under the circumstances, 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 Medical Executive Committee.

**7.F. 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 Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges or scope of practice based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

**7.G. HEARING AND APPEAL PROCESS FOR MEDICAL STAFF MEMBERS,
INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS
AND THE COMPOSITION OF THE HEARING PANEL**

- (1) The Credentials Policy outlines those adverse recommendations and actions that would entitle an individual to a hearing.
- (2) 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.
- (3) The Hearing Panel will consist of at least three members.
- (4) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.
- (5) A stenographic reporter will be present to make a record of the hearing.
- (6) 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.

- (7) 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.
- (8) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence before rendering a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.
- (9) The Hearing Panel shall deliver its report to the President & Chief Executive Officer who shall send a copy of the report to the individual who requested the hearing and the Medical Executive Committee.
- (10) The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel to the Board.
- (11) A modified hearing approach, as described in the Credentials Policy, may be used for Allied Health Professionals.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

- (1) Neither the Medical Executive Committee, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.
- (2) Amendments to these Bylaws may be proposed by the Medical Executive Committee or by a petition signed by at least 10% of the voting members of the Medical Staff.
- (3) All proposed amendments to these Bylaws must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee may, in its discretion, provide a report on them 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 Medical Executive Committee may also present proposed amendments to these Bylaws to the Active Staff by written ballot or e-mail, to be returned to Medical Staff Services by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical 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 voting staff, and (ii) the amendment must receive a majority of the votes cast.
- (5) The Medical Executive Committee shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, 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 Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the representatives 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 President & Chief Executive Officer to take place within two weeks after receipt of a request.

8.B. OTHER MEDICAL STAFF DOCUMENTS

- (1) In addition to the Medical Staff Bylaws, there shall be policies, 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, 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 documents include, but are not limited to, the Credentials Policy, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.
- (2) The Credentials Policy, the Medical Staff Organization Manual, and all other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.
- (3) An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to the Rules and Regulations shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the Medical Executive Committee.
- (4) The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee with regard to the adoption of the provisional amendments to the Medical Staff Rules and Regulations, the amendments shall stand. If there is conflict over the provisional amendments that are supported by a petition signed by 10% of the Active Staff, then the process for resolving conflicts set forth below shall be implemented.
- (5) Amendments to the Credentials Policy, the Medical Staff Organization Manual, the Rules and Regulations, and all other policies of the Medical Staff 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 Medical

Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

- (6) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.
- (7) The present Medical Staff Rules and Regulations 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.

8.C. CONFLICT MANAGEMENT PROCESS

8.C.1. Conflicts Between the Medical Staff and Medical Executive Committee:

- (a) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 10% of the Active Staff, with regard to the adoption of a new or amended Medical Staff rule, regulation, or policy proposed by the Medical Executive Committee, a special meeting of the Medical Staff to discuss the conflict may be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the new or amended rule, regulation, or policy at issue.
- (b) If the differences cannot be resolved, the Medical 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.
- (c) 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.
- (d) 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 Bylaws, 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 President & Chief Executive Officer, who will forward the request for communication to the Chair of the Board. The President & Chief Executive Officer will also provide notification to the Medical 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).

8.C.2. Conflicts Between the Medical Staff, Hospital Administration, and the Board:

- (a) In the event there are irreconcilable differences between the Medical Staff, the Hospital Administration, and/or the Board with regard to proposed corrections, changes, adoption, and/or amendments to the Medical Staff Bylaws, upon written request submitted to the Chairman of the Board by a member of the Medical Executive Committee or a member of the Board, an ad hoc committee comprised of the Chairman of the Board, the President & Chief Executive Officer, the President of the Medical Staff, and the President-Elect of the Medical Staff shall make a recommendation to the Board to resolve such conflict within 60 days of said written request. After consideration of the recommendation of the ad hoc committee, the Board shall make the final decision on the proposed correction, changes, adoption, or amendments.

- (b) Any difference in the recommendation of the Medical Staff, Hospital Administration, and/or the Board concerning Medical Staff appointments, reappointments, terminations of appointments, and the granting or revision of clinical privileges shall be addressed by the Joint Conference Committee in a good faith effort to resolve such differences within a reasonable period of time. A description of the composition and duties of the Joint Conference Committee is contained in the Medical Staff Organization Manual.

ARTICLE 9

ADOPTION

These Medical Staff 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, manuals, or Hospital policies pertaining to the subject matter thereof.

Originally adopted by the Medical Staff on May 13, 2014 and approved by the Board on July 16, 2014.

Revised: Medical Executive Committee – August 25, 2015
Medical Staff – September 8, 2015
Board – October 28, 2015.

Revised: Medical Executive Committee – June 28, 2016
Medical Staff – August 19, 2016
Board – August 24, 2016.

Revised: Medical Executive Committee – July 27, 2016
Medical Staff – August 19, 2016
Board – August 24, 2016.

THE CHRIST HOSPITAL – MEDICAL STAFF BYLAWS

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Community	House	Honorary
Basic Requirements					
Number of hospital contacts/2-year	≥ 24 or MS Service	>1 and < 24 and no MS Service	N	N	N
Rights					
Admit	Y	Y	N	N	N
Exercise clinical privileges	Y	Y	N*	Y	N
May attend meetings	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	P	P
Hold office	Y	N	N	N	N
Prerogatives and Responsibilities					
Serve on committees	Y	I	I	I	I
Emergency call coverage	Y	Y	F/C	N	N
Dues	Y	Y	Y	N	N
Participate in PPE and PI processes	Y	Y	N*	Y	N

Y = Yes

N = No

I = By invitation

P = Partial

F/C = Follow-up care

* = May be granted limited privileges for outpatient-related therapies

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(1) Situations in Which a History and Physical Examination (“H&P”) is Required

An H&P shall be completed:

- (a) for all inpatient admissions;
- (b) for patients in observation status;
- (c) prior to any inpatient or outpatient surgery; and
- (d) prior to any inpatient or outpatient procedure requiring anesthesia services, with “anesthesia services” being defined to include general anesthesia, major regional anesthesia and monitored anesthesia care (e.g., deep sedation/analgesia).

Note: “anesthesia” does not include moderate (also known as conscious) sedation/analgesia, minimal sedation, or topical or local anesthesia.

(2) Contents of the H&P and an Update H&P

- (a) An H&P includes:
 - patient identification;
 - chief complaint;
 - history of present illness;
 - review of systems, as pertinent;
 - personal medical history, including medications and allergies;
 - family medical history;
 - social history, including any abuse or neglect;
 - physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
 - pertinent data reviewed;
 - assessments, including problem list;

- plan of treatment; and
 - if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.
- (b) An Update History and Physical Examination (“Update H&P”) includes the review of the original H&P and an assessment or examination of the patient for any changes in the patient’s conditions since the patient’s original H&P was performed that might be significant for the planned course of treatment. The physician or other qualified licensed individual (including, but not limited to, nurse practitioners, physician assistants, and other Allied Health Professionals) performing the Update H&P uses his/her clinical judgment, based on his/her assessment of the patient’s condition and co-morbidities, if any, in relation to the patient’s planned course of treatment to decide the extent of the Update H&P needed.

(3) Pathway Requirements for Completion of H&P

- (a) In non-emergency situations, for each patient undergoing surgery or a procedure requiring anesthesia services (collectively, “Procedure”), an H&P must be both completed and documented in the medical record for each patient in the time frame and manner described in either one of the Pathways set forth below:

(1) Pathway I Requirements: Pre-Admission and Update H&P.

- (i) An H&P is completed within the 30-day period prior to the patient’s admission or registration (“Original H&P”). If so, a durable, legible copy of the Original H&P report may be used in the patient’s medical record.

- (a) Any H&P completed more than 30 days prior to a patient’s admission or registration would not be in compliance with this requirement and may not be entered into the medical record for these purposes.

- (b) The overall purpose of an H&P is to obtain the most current, relevant information regarding a patient’s overall condition in relation to the patient’s planned procedure or course of treatment. This helps physicians and the Hospital mitigate risks to patient safety and avoid potential adverse outcomes. Therefore, to be effective, the Original H&P should consider the patient’s overall condition in

conjunction with the planned procedure or course of treatment.

- (ii) The Original H&P is completed by a physician or other qualified licensed individual. Please note, the physician or other qualified licensed individual performing the Original H&P is not required to be a member of the Hospital's Medical Staff or have admitting privileges at the Hospital as long as he/she is licensed in the state in which the Original H&P is performed and he/she is acting within his/her scope of practice.
- (iii) An Update H&P is completed within 24 hours after admission or registration (but in all cases prior to the Procedure). Stated differently, the Update H&P must be completed within 24 hours after admission or registration, or prior to the Procedure, whichever comes first. For example, an H&P that is completed within 24 hours of the patient's admission or registration, but after the Procedure, would not be in compliance with this requirement.
- (iv) Unlike the Original H&P, the Update H&P must be completed by a physician or other qualified licensed individual who has been credentialed and granted privileges by the Hospital to perform histories and physicals.
- (v) Both the Original H&P and Update H&P are documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to the Procedure).
- (vi) At a minimum, the Update H&P documentation or update note must reflect any changes in the patient's condition since the date of the Original H&P that might be significant for the planned course of treatment or state that there have been no changes in the patient's condition.
- (vii) If the practitioner performing the Update H&P finds that the Original H&P is incomplete, inaccurate, or otherwise unacceptable, the practitioner may disregard the Original H&P and conduct a new H&P pursuant to Pathway II Requirements below.

(2) Pathway II Requirements: Post-Admission H&P.

- (i) An H&P is completed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to the Procedure). Stated differently, the H&P must be completed and documented in the patient's medical record within 24 hours after admission or registration, or prior to the Procedure,

whichever comes first. For example, an H&P that is completed within 24 hours of the patient's admission or registration, but after the Procedure, would not be in compliance with this requirement.

- (ii) The H&P must be completed by a physician or other qualified licensed individual who has been credentialed and granted privileges by the Hospital to perform histories and physicals.

(4) Cancellations, Delays, and Emergency Situations

- (a) When the H&P is not recorded in the medical record before surgery or a procedure requiring anesthesia, the procedure will be canceled or delayed until a complete H&P is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.
- (b) In an emergency situation, when there is no time to record a complete H&P, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a full H&P.

(5) Moderate (also known as Conscious) Sedation Requirements

Prior to a procedure utilizing moderate (conscious) sedation, a Moderate (also known as conscious) Sedation MD assessment form, approved by the Medical Executive Committee, may be utilized. These forms shall document:

- (a) The chief complaint or reason for the procedure;
- (b) Relevant history of the present illness or injury, including:
 - (1) allergies;
 - (2) current medications;
 - (3) last oral intake;
 - (4) past medical history;
 - (5) past surgical history;
 - (6) tobacco use;
 - (7) alcohol use; and

- (8) substance abuse;
- (c) The patient's physical exam, including:
 - (1) current vital signs;
 - (2) general appearance;
 - (3) cardiovascular;
 - (4) pulmonary; and
 - (5) other relevant major organ abnormalities; and
- (d) Assessment of current clinical condition:
 - (1) ASA risk assessment;
 - (2) sedation plan; and
 - (3) Mallampati.
- (6) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.