

# **THE MEDICAL STAFF BYLAWS**

**Part of the Yakima Valley Memorial**

**Medical Staff Bylaws, Policies, and Rules &  
Regulations**

# MEDICAL STAFF BYLAWS

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**ARTICLE 1**  
**GENERAL**

**1.A. HEADINGS AND FOOTNOTES**

The Article and Section headings and footnotes contained in these Medical Staff Bylaws, the Medical Staff Credentials Policy, and the Medical Staff Organization Manual are for ease of use and reference only and shall not be taken into consideration when applying official or legal interpretations to the documents.

**1.B. DEFINITIONS**

The definitions that apply to the capitalized terms used in the Medical Staff Bylaws, the Credentials Policy, and the Organization Manual are set forth in the Credentials Policy.

**1.C. TIME LIMITS**

Time limits referred to in these Bylaws, the Credentials Policy, and the Organization Manual are advisory only and are not mandatory, unless it is expressly stated. The Board, Hospital administrators, and Medical Staff Leaders will strive to be fair under the circumstances.

**1.D. DELEGATION OF FUNCTIONS**

Medical Staff functions and duties set forth in these Bylaws may be delegated to qualified Practitioners and Hospital employees as set forth in the Delegation of Functions provisions of Article 1 of the Medical Staff Credentials Policy.

**1.E. MEDICAL STAFF DUES**

- (1) Medical Staff dues may be required of Medical Staff Members and/or any other category of Practitioner eligible for Clinical Privileges, shall be in amounts recommended by the MEC and approved by the Board, and may vary depending upon staff category and/or Privilege status.
- (2) Dues are payable upon request (which may be annually or at the time of renewal of Membership or renewal of Privileges, as recommended by the MEC). Failure to pay dues by the time set forth on the request will result in automatic relinquishment, as set forth in the Medical Staff Credentials Policy.
- (3) Medical Staff dues are separate from Application fees (which are set, collected and retained by the Hospital). Dues collected will be retained in accounts as recommended by the MEC and approved by the Board (at the time of adoption of these Bylaws, dues are collected by the Hospital along with Application fees, both of which are retained in the Hospital's Medical Staff account).

- (4) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff, Vice-President of the Medical Staff, and Secretary of the Medical Staff, any one of whom may authorize spending from the account that complies with the laws governing the tax exempt status of the Hospital and is in furtherance of the Medical Staff functions set forth in these Bylaws, the Medical Staff Credentials Policy, the Medical Staff Organization Manual, the Medical Staff Professional Practice Evaluation Policy, and other Hospital and Medical Staff policies and Rules and Regulations

#### **1.F. ORGANIZED HEALTH CARE ARRANGEMENT**

The Hospital, all Members of the Medical Staff and other Practitioners, as well as non-employees who provide patient care under an approved scope of practice shall be considered Members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. An OHCA allows the Hospital to share information with other Members of the OHCA and their offices for purposes of payment and certain practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, other Practitioners, and non-employees who provide patient care under an approved scope of practice. All Members of the OHCA agree to comply with the Hospital's policies as adopted and amended from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI").

## ARTICLE 2

### MEDICAL STAFF MEMBERSHIP CATEGORIES

#### 2.A. ASSIGNMENT TO MEDICAL STAFF CATEGORIES

- (a) Only those individuals who have been granted Medical Staff Membership by the Board become Members of the Medical Staff and are eligible to be assigned to a Medical Staff category. Except as specifically stated herein, with respect to a particular category of Medical Staff Membership, all Members of the Medical Staff, in any category, must continuously satisfy the threshold eligibility criteria, and other qualifications and requirements for Membership to the Medical Staff, as set forth in the Medical Staff Credentials Policy. Failure to do so may result in automatic relinquishment of Medical Staff Membership and/or a determination that the individual is ineligible to apply for renewal of Membership or renewal of Clinical Privileges.
- (b) As set forth in the Medical Staff Bylaws, Medical Staff Credentials Policy, and other Medical Staff Rules and Regulations and policies, certain types of Clinical Privileges (e.g. temporary Privileges, telemedicine Privileges, Clinical Privileges for Licensed Independent Practitioners and Advanced Practice Professionals) may be granted to Practitioners even if they do not apply to become Members of the Medical Staff. Further, after consulting with the MEC, the Board may determine that Clinical Privileges without Medical Staff Membership may be granted to an individual or group or to Applicants/Practitioners within a particular specialty or service, in order to satisfy an operational or community need.
- (c) At the time of renewal of Membership, an individual who does not satisfy the requirements for the Medical Staff category to which he or she was assigned during the prior term of Membership may be automatically transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital, if applicable. Transfer to a different Medical Staff category is not a professional review action and does not give rise to hearing and appeal rights pursuant to these Bylaws or the Medical Staff Credentials Policy.
- (d) Members who are not eligible to apply for renewal of Membership in their current Medical Staff category, but who wish to remain in that category, may submit a written request for a waiver. The request will be managed pursuant to the process set forth in the Medical Staff Credentials Policy for waivers of threshold eligibility criteria for Membership and/or Privileges.
- (e) The Credentials Committee, MEC, and Board, when considering whether to recommend/grant a waiver related to Medical Staff categories, may consider (in addition to extraordinary circumstances and other qualifications of the individual, as set forth in the Credentials Policy) whether the individual has definitively demonstrated that his or her practice patterns or involvement in Medical Staff

functions has changed, such that he or she is likely to satisfy the requirements associated with Membership in the applicable Medical Staff category during the next term.

## **2.B. ACTIVE STAFF**

### **2.B.1. Eligibility:**

To be eligible to apply for assignment to the Active Staff category and to remain a Member of this staff category, a Practitioner must:

- (a) be a Physician, Dentist, Podiatrist, or Clinical Psychologist;
- (b) have completed at least 20 Patient Contacts during the previous two years. New Applicants (those who have not held Medical Staff Membership or Clinical Privileges at the Hospital during the 12 months immediately preceding the Application) will be exempt from this requirement at the time of the initial Application for Medical Staff Membership and will remain exempt throughout that Membership term; and
- (c) have paid applicable Application fees and dues.

### **2.B.2. Prerogatives:**

#### (a) All Active Staff Members

All Active Staff Members may not only be granted Clinical Privileges (if eligible), but also be permitted to admit patients, if consistent with their Clinical Privileges, any applicable Medical Staff policies, or any resolution or policy of the Board.

Active Staff Members may also:

- (i) vote in all general and special meetings of the Medical Staff and any departments and committees of which the individual is a Member; and
  - (ii) hold Medical Staff office, serve as a department chair, or serve as a chair or member of a Medical Staff committee.
- (b) Active Staff Members Over Age 62 With 20 Years of Membership
- (i) A Member of the Active Staff who has who has attained the age of 62 and has held Active Staff Membership at the Hospital for at least 20 cumulative years, during which the individual fulfilled all responsibilities of Medical Staff Membership related to the care of unassigned patients (including participating in on-call service for the Emergency Department, responding appropriately to consultation requests, and participating in follow-up care

as required by any applicable policies in effect at the time), is eligible to request to that the following responsibilities of Medical Staff Membership be waived:

- providing on-call coverage for unassigned patients presenting to the Emergency Department;
- accepting referrals from the Emergency Department for follow-up care of unassigned patients treated in the Emergency Department, and
- accepting inpatient consultation requests for unassigned patients.

All requests for waiver must be submitted to the Medical Staff Office. The request will be managed pursuant to the process set forth in the Medical Staff Credentials Policy for waivers of threshold eligibility criteria for Membership and/or Privileges.

The Credentials Committee, MEC, and Board, when considering whether to recommend/grant a waiver related to Active Staff Member responsibility for on-call/ unassigned patient responsibilities may consider:

- (1) the Hospital's mission and its obligation to serve the health care needs of the community and to do so on a local basis;
- (2) fairness to the Medical Staff Member requesting waiver, including prior longstanding service to the Hospital and Medical Staff, the existence of numerous other demands on the Member, and other exceptional circumstances (for example, a health condition involving the Member or an immediate family Member);
- (3) fairness to the other Medical Staff Members who serve on the call roster for that specialty, including the effect that the removal would have on them;
- (4) the expectations of other Members of the Medical Staff who are in other specialties but who routinely rely on the specialty in question to care for patients who present to the Emergency Department;
- (5) any gaps in call coverage that might/would result from a Medical Staff Member's removal from the call roster and the feasibility and safety of transferring patients to other facilities in those situations; and



- (6) the Hospital’s compliance with all applicable laws and regulations, including the Emergency Medical Treatment and Active Labor Act (“EMTALA”).
- (ii) As of the date of the adoption of these Bylaws, any individual previously removed from the Emergency Department on-call schedule for his or her specialty, in accordance with the terms of prior Medical Staff Bylaws or other policy, will automatically and without the need for a request be deemed to have been granted a waiver as set above (even if the individual has not yet reached the age of 60).
- (iii) Any waiver of Medical Staff responsibilities for unassigned patient care is subject to change by the Board if it later determines, after consultation with the department chair and MEC that call coverage in the Practitioner’s specialty area is not adequate.

### **2.B.3. Responsibilities:**

All Active Staff Members must fulfill these responsibilities of Medical Staff Membership, unless they have been granted a waiver pursuant to the terms of these Bylaws or the Medical Staff Credentials Policy:

- provide on-call coverage for unassigned patients presenting to the Emergency Department;
- accept referrals from the Emergency Department for follow-up care of unassigned patients treated in the Emergency Department, and
- accept inpatient consultation requests for unassigned patients.

In addition to the clinical responsibilities set forth above, the Active Staff assumes primary responsibility for the fulfillment of administrative Medical Staff functions at the Hospital (and, in turn, are granted the prerogatives of leading and legislating Medical Staff policy, as set forth in the “Prerogatives” section, above). In support of the Active Staff’s vital and integral role to the success of the Medical Staff, Active Staff Members must assume all of the responsibilities listed below:

- (a) participating in Medical Staff orientation, mentoring, training, and ongoing education activities, upon request of the President of the Medical Staff. This may include activities that are in addition to those required of all Medical Staff Members and other who have been granted Clinical Privileges; for example: (i) providing education to fellow Medical Staff Members during grand rounds, M&M conferences, or other forums for teaching/CME, and (ii) serving as a clinical reviewer, second opinion/consulting provider, or proctor during the course of the professional practice evaluation process.

- (b) serving as a Medical Staff officer, department chairperson, or as a member or chair of a Medical Staff committee, as requested by the President of the Medical Staff or Leadership Council,
- (c) serving as a Practitioner representative on a Hospital committee that requires Medical Staff oversight or participation (e.g. infection control, performance improvement, pharmacy and therapeutics), as requested by the CEO or President of the Medical Staff;
- (d) participating in the evaluation of new Members of the Medical Staff, both through participation in credentialing activities, such as Applicant review, as well as through FPPE to confirm competence and professionalism (which may require involvement in proctoring, chart review, and other activities, in accordance with the Policy on FPPE to Confirm Competence and Professionalism);
- (e) participating in the professional practice evaluation and performance improvement processes of the Hospital and Medical Staff (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties); and
- (f) performing other duties as requested or assigned by the President of the Medical Staff, Medical Executive Committee, or Board.

## **2.C. COURTESY STAFF**

### **2.C.1. Eligibility:**

To be eligible to apply for assignment to the Courtesy Staff category and to remain a Member of this staff category, a Practitioner must:

- (a) be a Physician, Dentist, Podiatrist, or Clinical Psychologist;
- (b) for Applicants to this category, have been involved in fewer than 20 Patient Contacts during the two years prior to the Application, and for Members assigned to this category, have been involved in fewer than 20 Patient Contacts at any time during the previous two years (evaluated on a rolling basis). Compliance with activity requirements for Applicants/new Members may be evaluated continuously and failure to comply with the Patient Contact requirements set forth herein may result in automatic relinquishment of Membership/Privileges or reassignment to a different staff category (if eligible), upon Notice to the Practitioner; and
- (c) have paid applicable Application fees and dues.

### **2.C.2. Prerogatives and Responsibilities:**

Courtesy Staff Members:

- (a) may not only be granted Clinical Privileges (if eligible), but also be permitted to admit patients, except as otherwise provided in their specific delineation of Clinical Privileges, any applicable Medical Staff policies, or any resolution or policy of the Board;
- (b) may attend and participate in Medical Staff and department meetings (without vote);
- (c) may not serve as a Medical Staff Leader, unless waived by the MEC and ratified by the Board; and
- (d) are generally exempt from the following responsibilities of Medical Staff Membership, unless the Board, after consultation with the MEC, determines that an individual, group, or category of Practitioners (e.g., an entire specialty) must assume these responsibilities because there are not enough Practitioners within the specialty to otherwise satisfy operational or community needs:
  - providing on-call coverage for unassigned patients presenting to the Emergency Department;
  - accepting referrals from the Emergency Department for follow-up care of unassigned patients treated in the Emergency Department, and
  - accepting inpatient consultation requests for unassigned patients.

## **2.D. CONSULTING STAFF**

### **2.D.1. Eligibility:**

To be eligible to apply for assignment to the Consulting Staff category and to remain a member of this staff category, a Practitioner must:

- (a) be a Physician, Dentist, Podiatrist, or Clinical Psychologist;
- (b) provide a service that is not otherwise reasonably available from Members of the Active and Courtesy Medical Staff categories or, alternatively, that is in very limited supply (in the discretion of the CMO, after consultation with the President of the Medical Staff and relevant department chairs) on the Active/Courtesy Staffs. This requirement applies continuously and will be evaluated at the time of renewal of Membership and/or renewal of Clinical Privileges. Accordingly, if a particular service becomes reasonably available on the Active/Courtesy Staffs at any time, Consulting Staff Members providing that service will not be eligible to request Membership in the Consulting Staff category at the time of their next renewal of Membership Application; and

- (c) have paid applicable Application fees and dues.

## **2.D.2. Prerogatives and Responsibilities:**

Consulting Staff Members:

- (a) may not admit patients and may otherwise provide patient care services at the Hospital only when requested by a Member of the Active, Courtesy, or Locum Tenens Coverage Staff or by a Licensed Independent Practitioner or Advanced Practice Professional who has been granted Clinical Privileges at the Hospital;
- (b) may attend and participate in Medical Staff, department meetings (without vote);
- (c) may not serve as a Medical Staff leader, unless waived by the MEC and ratified by the Board; and
- (d) are exempt from the following responsibilities of Medical Staff Membership:
  - providing on-call coverage for unassigned patients presenting to the Emergency Department;
  - accepting referrals from the Emergency Department for follow-up care of unassigned patients treated in the Emergency Department, and
  - accepting inpatient consultation requests for unassigned patients.

## **2.E. LOCUM TENENS COVERAGE STAFF**

### **2.E.1. Eligibility:**

To be eligible for assignment to the Locum Tenens Coverage Staff category and to remain a Member of this staff category, a Practitioner must:

- (a) be a Physician, Dentist, Podiatrist, or Clinical Psychologist;
- (b) have one of the following types of coverage arrangements:
  - (i) a coverage arrangement with a Member of the Active, Courtesy, or Consulting Staff who is a member of the Applicant's group practice or who is part of a formalized coverage group (with a written agreement for rotational coverage between the Members of the group); or
  - (ii) a contract with the Hospital to provide coverage of a particular service (for example, a long-term locum tenens contract to fill a gap in service pending recruitment efforts).

Compliance with the requirement for a valid coverage arrangement may be evaluated continuously and/or at the time of renewal of Membership and/or renewal of Clinical Privileges. Failure for any reason to maintain a valid coverage arrangement with an Active, Courtesy, or Consulting Staff Member or with the Hospital, as set forth in this Section, may result in automatic relinquishment of Membership and Clinical Privileges, upon Notice to the Practitioner. Further, a Locum Tenens Coverage Staff Member's Membership and Privileges will be deemed automatically relinquished, upon Notice to the Practitioner, if the Active, Courtesy, or Consulting Staff Member for whom the individual provides coverage (as applicable) fails to maintain Membership or Clinical Privileges at the Hospital;

- (c) have paid applicable Application fees and dues.

### **2.E.2. Prerogatives and Responsibilities:**

Locum Tenens Coverage Staff Members:

- (a) may admit patients and provide patient care services at the Hospital only:
  - (i) pursuant to a coverage arrangement with a Member of the Active, Courtesy, or Consulting Staff who is a Member of the Applicant's group practice or a formal coverage group (with a written agreement for rotational coverage between the Members of the group) and only during times when the Active, Courtesy, or Consulting Staff Member for whom coverage is being provided is absent from the Hospital (except when both are present in order to provide for patient care hand-offs); or
  - (ii) pursuant to a contract with the Hospital when it is providing coverage of a service to prevent a lapse.
- (b) may attend and participate in Medical Staff, department meetings (without vote);
- (c) may not serve as a Medical Staff Leader, unless waived by the MEC and ratified by the Board; and
- (d) must fulfill all responsibilities of Medical Staff Membership, with the proviso that a Locum Tenens Coverage Staff Member who is providing coverage for an Active, Courtesy, or Consulting Staff Member during that individual's absence must assume the Medical Staff Membership responsibilities related to patient care duties (including serving on the on-call schedule, responding to requests for consultation for unassigned patients, and providing follow up care to unassigned patients) only during times that he or she is actually providing coverage. (For example, a Locum Tenens Coverage Staff Member such as this would not be required to take a turn on the on-call rotation and would, instead, serve on the on-call roster for the Emergency Department only when providing coverage for a Member who would have been on call for the ED at that time).

## **2.F. LICENSED INDEPENDENT PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (LIP/APP) STAFF**

### **2.F.1. Eligibility:**

To be eligible to apply for assignment to the LIP/APP Staff category and to remain a Member of this staff category, a Practitioner must:

- (a) fall within a category of Licensed Independent Practitioners and/or Advanced Practice Professionals that has been approved by the Board to practice at the Hospital, as set forth in the Medical Staff Credentials Policy; and
- (b) have paid applicable Application fees and dues.

### **2.F.2. Prerogatives:**

- (a) All Members of the LIP/APP Staff:

All LIP/APP Staff Members may not only be granted Clinical Privileges (if eligible), but also be permitted to admit patients if consistent with their Clinical Privileges, any applicable Medical Staff policies, and the resolutions and/or policies of the Board.

- (b) Members of the LIP/APP Staff In Second Term

In addition, LIP/APP Staff Members who have already completed at least two years of LIP/APP Staff Membership also:

- (i) have the right to Notice of all general and special meetings of the Medical Staff and any departments of which the individual is a Member, and the right to attend and participate in any such meetings, including executive sessions, without vote;
- (ii) may serve on Medical Staff committees to which they are appointed (with vote, unless otherwise specified in the Medical Staff documents or at the time of appointment) and may serve as a committee chair if appointed or elected to that position, as applicable;
- (iii) may not serve as a Medical Staff officer or as a department chair; and
- (iv) may exercise the same rights and duties as other Members of the Medical Staff (for example, requesting an amendment to the Bylaws or Rules and Regulations or signing a petition to request a special meeting of the Medical Staff to be held) unless otherwise specified in the Medical Staff Bylaws and related documents, or other Hospital or Medical Staff policy.

### **2.F.3. Responsibilities:**

Members of the LIP/APP Staff are expected (and required) to work hand-in-hand with the Active Staff to fulfill the Medical Staff functions at the Hospital. Accordingly, Members of the LIP/APP Staff must fulfill all responsibilities of Medical Staff Membership and Clinical Privileges, as applicable. Notably, by law, Licensed Independent Practitioners and Advanced Practice Professionals are not eligible to serve on the Emergency Department on-call roster and, accordingly, that requirement does not apply to such individuals (though they may assist in responding to ED patients – for example, when assisting the on-call Physician – as consistent with the Licensed Independent Practitioner’s or Advanced Practice Professional’s Clinical Privileges and the Medical Staff Credentials Policy, Medical Staff Rules and Regulations, and any Hospital policies governing EMTALA or on-call). In all other respects, unless specifically exempted by the Medical Staff Bylaws and related documents, or other Hospital or Medical Staff policy, Members of the LIP/APP Staff are responsible for satisfying the same responsibilities as Active Staff Members.

### **2.G. EMERITUS STATUS**

#### **2.G.1. Eligibility:**

- (a) Emeritus Status is not Membership but, rather, a recognition. It may be granted at the discretion of the Board, after receiving the recommendation of the MEC, to individuals who were formerly Members of the Medical Staff or who formerly maintained Clinical Privileges at the Hospital, who have retired from the active practice of medicine (or their respective fields), have provided extensive and meritorious service to the Medical Staff, Hospital, or community over an extended period of time, and satisfy at least three of the following criteria:
  - (i) a history of at least 15 years of service on the Active Staff or 15 years actively exercising Clinical Privileges at the Hospital;
  - (ii) previous service at a department chairperson at the Hospital;
  - (iii) previous service as a Medical Staff Officer at the Hospital;
  - (iv) an exemplary record of community service;
  - (v) recommendation of the Medical Executive Committee.

Individuals who have been granted Emeritus Status are not granted Medical Staff Membership and, in turn, are not Members of the Medical Staff. Because they are retired from the practice of medicine, they are not eligible to request, and will not be granted, Clinical Privileges. Therefore, applicants for Emeritus Status do not need to satisfy any of the threshold eligibility criteria associated with Membership

or Privileges and will not be subject to focused professional practice evaluation or ongoing professional practice evaluation.

- (b) Once an individual has been granted Emeritus Status, that status is ongoing. Emeritus Status is a courtesy and honor that may be denied or terminated by the Board, after obtaining the recommendation of the MEC, with no right to a hearing or appeal by the individual.

### **2.G.2. Prerogatives and Responsibilities:**

Individuals who have been granted Emeritus Status may attend educational and social functions of the Hospital and its Medical Staff, may attend Medical Staff, department meetings (without vote), may visit and use the Medical Staff lounge, may have access to any reference materials made available to Emeritus Staff members through arrangement by the Hospital, and may serve on any Medical Staff committees to which they are appointed (with vote). Individuals with Emeritus Status shall not otherwise serve as Medical Staff Leaders, unless waived by the MEC and ratified by the Board.

## **2.H. TELEMEDICINE STATUS**

### **2.H.1. Qualifications**

Telemedicine Status is not Membership but, rather, a way to categorize those individuals who have been granted Clinical Privileges to participate in the care of patients solely through telemedicine link.

### **2.H.2. Prerogatives**

Individuals granted Telemedicine Status may:

- (a) Be granted telemedicine Privileges, pursuant to which they may care for Hospital patients, but may not admit or be solely responsible for managing a patient's care.
- (b) Attend meetings of any departments to which he or she is assigned, but may not vote or hold office in any department, or in the Medical Staff, or serve as the chair of any Medical Staff committee.

### **2.H.2. Responsibilities**

Individuals granted Telemedicine Status must:

- (a) Arrange for quality of care information to be submitted from the Practitioner's primary practice site to the Hospital, for credentialing and professional review activity functions at the Hospital.



- (b) Participate in Medical Staff functions (including performance improvement, professional practice evaluation, and quality) as reasonably requested by the MEC, consistent with his or her role within the Hospital.

## **ARTICLE 3** **OFFICERS**

### **3.A. DESIGNATION**

The Medical Staff will have the following officers:

- (1) President;
- (2) Vice-President; and
- (3) Secretary.

### **3.B. ELIGIBILITY CRITERIA**

Only those Members of the Medical Staff who satisfy the following criteria initially and continuously will 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;
- (2) be a Member in Good Standing;
- (3) have not received notice from the state licensing board of an intended or pending action with respect to licensure or otherwise been notified of pending action from a state or federal agency, if related to clinical competence or professional conduct (in which case the individual shall remain ineligible for so long as the matter is pending);
- (4) not presently be serving as a medical staff officer, board member, or department chairperson at any other hospital and will not so serve during their terms of office;
- (5) be willing to faithfully discharge the duties and responsibilities of the position;
- (6) have experience in a related leadership position or other involvement in performance improvement functions for at least two years;
- (7) participate in Medical Staff leadership training, as determined by the Medical Executive Committee;
- (8) have demonstrated an ability to work well with others; and
- (9) not have a financial relationship (i.e., an ownership or investment interest) with an entity, other than an Affiliated Entity, that competes with the Hospital. This does

not apply to services provided within a Practitioner's office and billed under the same provider number used by the Practitioner.

### **3.C. DUTIES**

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

The President of the Medical Staff will:

- (1) act in coordination and cooperation with the Chief Medical Officer, the Chief Executive Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;
- (2) represent and communicate the views, policies, and needs, and report on the activities, of the Medical Staff to the Chief Executive Officer, Chief Medical Officer, and the Board;
- (3) call, preside at, and be responsible for the agenda of meetings of the Medical Staff and the Medical Executive Committee;
- (4) serve as a voting member of the Leadership Council;
- (5) promote adherence to the Bylaws, policies, manuals, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;
- (6) appoint ad hoc committees to: (1) assist in the development of Hospital policies and procedures; and (2) to provide a forum for consideration of plans of future growth or change in the Hospital organization, and for discussion of problems that arise in the operation of the Hospital. The President of the Medical Staff will cause written records of the proceedings and recommendations of ad hoc committees to be prepared and will forward those to the MEC and Chief Medical Officer; and
- (7) perform functions authorized in these Bylaws and other applicable policies, manuals, and the Rules and Regulations of the Hospital and/or Medical Staff, including collegial intervention in the Credentials Policy, and any other functions as may be assigned by the Medical Executive Committee or Board of Directors.

#### **3.C.2. Vice-President of the Medical Staff:**

The Vice-President of the Medical Staff will:

- (1) serve as a voting member of the Leadership Council and Medical Executive Committee;
- (2) assume the duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his/her absence;

- (3) perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee; and
- (4) automatically succeed the President of the Medical Staff at the conclusion of the President of the Medical Staff's term or sooner, if the office becomes vacated for any reason during the President's term of office.

### **3.C.3. Secretary:**

The Secretary will:

- (1) cause to be kept accurate and complete minutes of meetings of the Medical Executive Committee and Medical Staff;
- (2) give proper Notice of Medical Staff meetings;
- (3) oversee the collection of, and accounting for, the Medical Staff fund and make disbursements as authorized by the Medical Executive Committee;
- (4) perform other duties as are assigned by the President of the Medical Staff or the Medical Executive Committee;
- (5) in the temporary or permanent absence of the President of the Medical Staff and the Vice-President, assume all duties and responsibilities and have the authority of the President until such time as a new President and/or Vice-President are elected; and
- (6) automatically succeed the Vice-President of the Medical Staff at the conclusion of the Vice-President's term or sooner, if the office becomes vacated for any reason during the President's term of office.

### **3.D. NOMINATION AND ELECTION PROCESS**

#### **3.D.1. Nominating Process:**

- (1) Nominations of Officers/MEC Members by the Leadership Council:

The Leadership Council shall serve as the nominating committee for all Medical Staff Leader positions subject to election. The Leadership Council shall convene at least 60 days prior to any election, shall identify nominees for each Leader positions subject to election, and shall determine whether the identified individuals satisfy the eligibility criteria for officers and are willing to serve. The names of all nominees and the positions for which they are being nominated shall be forwarded to the Medical Staff Office, which will assist the Leadership Council in providing

Notice of the nominations to voting Members of the Medical Staff at least 30 days prior to the election.

(2) Nominations of Officers/MEC Members by Active Staff Member Petition:

Additional nominations may be made in the form of a written petition signed by at least 15 Members of the Active Staff and submitted to the Medical Staff Office at least 14 days prior to the election. All such nominations will be forwarded to the Leadership Council for a confirmation that the individual satisfies the eligibility criteria for officers and is willing to serve. If confirmed, the nominee will be added to the ballot (with no Notice to the Medical Staff required).

(3) Nominations from the Floor:

Nominations from the floor will not be accepted.

**3.D.2. Election:**

- (1) Elections shall be held solely by written or electronic ballot returned to the Medical Staff Office in the manner indicated on the ballot at the time it is distributed. Ballots shall be provided to all voting Members of the Medical Staff and completed ballots must be received in the Medical Staff Office by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.
- (2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those voting Members of the Medical Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.
- (3) 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.

**3.E. TERM OF OFFICE, VACANCIES, AND REMOVAL**

**3.E.1. Term of Office:**

- (1) Officers will assume office on the first day of the Medical Staff Year.

- (2) Medical Staff officers will serve two-year terms. Evaluation of officers' performance will be performed, and feedback provided, annually, as determined by the Medical Executive Committee.
- (3) At-large Members of the Medical Executive Committee will serve a two-year term and may be re-elected.

### **3.E.2. Vacancies:**

- (1) If there is a vacancy in the office of President of the Medical Staff, the Vice-President will serve until the end of the unexpired term of the President of the Medical Staff.
- (2) If there is a vacancy in the office of Vice-President, the Secretary will serve until the end of the unexpired term of the Vice-President of the Medical Staff.
- (3) If there is a vacancy in the office of Secretary, the Medical Executive Committee will appoint an individual who satisfies the qualifications set forth in Section 4.B of these Bylaws to fill the office until a special election can be held. The appointment will be effective upon approval by the Board of Directors.
- (4) If there is a vacancy in the position of an at-large member of the Medical Executive Committee, the Medical Executive Committee will appoint an individual who satisfies the qualifications set forth in Section 3.B of these Bylaws to fill the position until a special election can be held. The appointment will be effective upon approval by the Board of Directors.
- (5) In the temporary or permanent absence of both the President of the Medical Staff and the Vice-President, the Secretary shall assume all the duties and responsibilities and have the authority of the President of the Medical Staff until such time as a new President and Vice-President are elected.
- (6) In the temporary or permanent absence of all officers, the Board of Directors shall appoint interim officers to fill these positions and an election shall be conducted within 90 Days. The MEC shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following the nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

### **3.E.3. Removal:**

- (1) Removal of an elected officer or an at-large member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Staff, a majority vote of the Medical Executive Committee, or a majority vote of the Board of Directors for:

- (a) failure to comply with or enforce applicable Hospital policies, these Bylaws, the Credentials Policy, the Organization Manual, other Medical Staff policies, or the Medical Staff Rules and Regulations;
  - (b) failure to perform the duties of the position held;
  - (c) conduct detrimental to the interests of the Medical Staff or the Hospital;
  - (d) circumstances that render the individual incapable of fulfilling the duties of that office; or
  - (e) failure to continue to satisfy any of the eligibility criteria in Section 3.B of these Bylaw;
  - (f) failure to adhere to professional ethics; or
  - (g) failure to support the compliance of the Hospital and the Medical Staff with applicable federal and state laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services.
- (2) At least 10 days prior to a removal action, the individual shall be given written Notice of the concern and the date of the meeting at which removal action will be considered. The individual shall be afforded an opportunity to provide written input and/or to attend the Medical Staff, MEC, or Board meeting to discuss the concerns, but will be recused from all deliberations and voting on the matter. Failure of the Leader to provide input or attend a meeting will not preclude removal.

#### **3.E.4. Resignation:**

Any Medical Staff officer or an at-large member of the Medical Executive Committee may resign at any time by giving written Notice to the Medical Executive Committee. The acceptance of such resignation shall not be necessary to make it effective.

**ARTICLE 4**  
**CLINICAL DEPARTMENTS**

**4.A. ORGANIZATION**

**4.A.1. Organization of Departments:**

- (1) The Medical Staff is organized into the clinical departments listed and described in the Medical Staff Organization Manual.
- (2) Subject to the approval of the Board, the Medical Executive Committee may create or eliminate departments or otherwise reorganize the department structure, as outlined more fully in the Medical Staff Organization Manual.

**4.A.2. Assignment to Departments:**

- (1) At the time of the granting of initial Medical Staff Membership or initial Clinical Privileges, each Practitioner will be assigned to a clinical department. Assignment to a particular department does not preclude a Practitioner from seeking and being granted Clinical Privileges typically associated with another department.
- (2) A Practitioner may request a change in department assignment to reflect a change in the Practitioner's clinical practice. The request will be subject to the approval of the Medical Executive Committee.

**4.A.3. Functions of Departments:**

- (1) Department Functions:

The departments shall perform the following functions:

- (a) serve as a forum for the exchange of clinical information regarding services provided by Practitioners assigned to the department;
- (b) provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Practitioners assigned to the department;
- (c) provide recommendations to the department chairperson regarding professional criteria for Clinical Privileges designed to assure the Medical Staff and Board of Directors that patients shall receive quality care. The recommendations shall include:
  - (i) criteria for granting, revoking, and modifying Clinical Privileges; and



- (ii) a procedure for applying these criteria to individuals who are requesting and/or who have been granted Clinical Privileges;
- (d) ensure that Practitioners provide appropriate and medically necessary care to patients of the Hospital;
- (e) ensure that the same level of quality of patient care is provided by all Practitioners within the department and across departments:
  - (i) by establishing uniform patient care processes;
  - (ii) by establishing similar criteria for similar Clinical Privileges; and
  - (iii) by using similar indicators in performance improvement activities;
- (f) provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;
- (g) ensure effective mechanisms for the Supervision of Advanced Practice Professionals and Dependent Professionals, as required;
- (h) provide information and/or recommendations to the department chairperson with regard to the criteria for granting Clinical Privileges within the department;
- (i) ensure that Practitioners within the department who admit patients have Clinical Privileges to do so and that all Practitioners within the department only provide services within the scope of Clinical Privileges granted;
- (j) provide information and/or recommendations to the department chairperson and/or the Medical Executive Committee with regard to Medical Staff policies;
- (k) provide recommendations to the department chairperson and/or the Medical Executive Committee with regard to appropriate call coverage by Practitioners assigned to the department;
- (l) pursuant to the Medical Staff Rules and Regulations and policies, including the Professional Practice Evaluation Policy, perform ongoing professional practice evaluation, initial focused professional practice evaluation, peer review, and other quality assessment activities relative to the performance of Practitioners in the department and report such activities to the Medical Executive Committee on a regular basis;

- (m) provide leadership for activities related to patient safety, including proactive risk assessments, root cause analyses in response to an unanticipated adverse event, responses to patient safety alerts, and implementation of procedures to comply with patient safety goals;
- (n) receive reports regarding Hospital performance improvement results that are applicable to the performance of the department and Practitioners assigned to the department, and integrate the department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital's Quality Plan; and
- (o) recommend medical educational programs to meet the needs of Practitioners assigned to the department, based on the scope of services provided by the department, changes in medical practice or technology, and the results of departmental performance improvement activities.

#### **4.B. DEPARTMENT CHAIRPERSONS**

##### **4.B.1. Qualifications:**

Each department chairperson will:

- (1) be an Active Staff Member;
- (2) be Board Certified in the relevant specialty or possess comparable competence, as determined through the credentialing and Privileging process set forth in the Medical Staff Credentials Policy; and
- (3) satisfy the eligibility criteria that apply to Medical Staff officers, as set forth in Section 3.B. of these Bylaws.

##### **4.B.2. Nomination, Election or Appointment, Term, and Removal of Department Chairpersons:**

- (1) Department Chairs Selected Pursuant to Contract

If the medical services within a department are offered exclusively by Practitioners employed by or under contract with the Hospital, the department chairperson will be chosen pursuant to the terms of the contract or, in the absence of such terms, will be appointed by the CMO.

- (2) Nomination and Election of Department Chairs

Except where the department chair is chosen pursuant to contract or appointed by the CMO, as described above, department chairs will be selected, vetted, and ratified as follows:

- (a) The Leadership Council shall be responsible for selecting a nominee to serve as the chair of the department.
  - (b) The Leadership Council shall vet the nominees to determine whether the identified individuals satisfy the eligibility criteria for department chairs. The Leadership Council will forward the name of the agreed upon nominee to the Medical Staff Office, which will assist in providing Notice of the nominations to voting members of the relevant department at least 30 days prior to the election.
  - (c) The election of department chairs will be conducted by written or electronic ballot and will take the form of a yay or nay ratification (e.g. only one nominee will be on the ballot and each voting member may elect to approve that nominee or to decline to approve that nominee). Ballots may be returned in person or by email to the Medical Staff Office, by the date indicated on the ballot;
  - (d) If the majority of the votes cast affirm the nominee, he or she shall be elected. If the majority of the votes cast do not affirm the nominee, the matter shall be referred back to the Leadership Council who will select a new nominee as set forth above.
  - (e) If no one is willing to serve as a department chair, the Leadership Council shall appoint an individual.
  - (f) Elected department chairs shall serve a term of two years and may be reelected.
- (3) Removal of Department Chairs
- (a) A department chair chosen pursuant to the terms of a contract or appointed by the CMO may be removed pursuant to the terms of the contract or, in the absence of such terms, may be removed by the CEO, CMO, or Board. Any vacancies in department chair positions that are chosen by contract may be filled through appointment by the CMO until such time as a new department chair can be chosen/appointed.
  - (b) An elected department chair may be removed through the same process and based on the same grounds that apply to removal of other elected Medical Staff Officers, as set forth in Section 3.E. of these Bylaws. In addition, elected department chairs may be removed by majority vote of those Medical Staff Members assigned to the department who have voting rights.

Any vacancies in elected department chair positions will be filled through appointment by the Leadership Council, until such time as a nominee can be identified and an election can be held.

#### **4.B.3. Duties of Department Chairs:**

Each department chairperson is responsible for the following functions, either individually, or in collaboration with Hospital personnel:

- (1) all clinically-related activities of the department;
- (2) all administratively-related activities of the department, unless otherwise provided for by the Hospital;
- (3) continuing surveillance of the professional performance of Practitioners in the department, including performing ongoing and focused professional practice evaluations;
- (4) recommending criteria for Clinical Privileges that are relevant to the care provided in the department;
- (5) evaluating requests and making recommendations for Clinical Privileges for each Member of the department;
- (6) assessing and recommending off-site sources for needed patient care, treatment, and services 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 interdepartment and intradepartment services;
- (9) the development and implementation of policies and procedures that advance quality and that guide and support the provision of care, treatment, and services;
- (10) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (11) determination of the qualifications and competence of department personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services;
- (12) continuous assessment and improvement of the quality of care, treatment, and services provided;
- (13) maintenance of quality monitoring programs, as appropriate;

- (14) the orientation and continuing education of persons in the department;
- (15) recommendations for space and other resources needed by the department;
- (16) performing functions authorized in the Credentials Policy, including collegial intervention efforts;
- (17) presiding at all department meetings;
- (18) serving as an *ex officio* Member of all departmental committees, if any, without vote, unless specifically stated otherwise in these Bylaws or the Rules and Regulations;
- (19) being accountable to the Medical Executive Committee with regard to the activities and functioning of the department; and
- (20) appointing and removing one or more department vice chairpersons as deemed necessary and appointing Members to serve on department committees, if any.

#### **4.B.5. Performance Evaluation for Department Chairpersons:**

- (1) A performance evaluation of the department chairpersons will be periodically initiated by the Chief Medical Officer or the President of the Medical Staff, either of whom who may appoint a committee to assist in this function. The fact that an individual is subject to performance evaluation does not imply any wrong-doing or concern and such evaluations shall be conducted routinely, even when no cause for concern exists.
- (2) The following factors may be addressed as part of the evaluation:
  - (a) quality and support of the department as it interfaces with other Hospital departments;
  - (b) communication, coordination, quality and service of care within the department;
  - (c) effectiveness of the performance improvement program within the department;
  - (d) where appropriate, contribution to patient care, education and research.
- (3) The Chief Medical Officer will prepare a written report of the evaluation and provide a copy to the relevant department chairperson. The President of the Medical Staff will also receive a copy of the report and have an opportunity to comment on it.

- (4) If the report indicates a need for improvement, the Chief Medical Officer will monitor the department chairperson's improvement activities and report progress to the President of the Medical Staff and the Board of Directors.

**ARTICLE 5**  
**MEDICAL STAFF COMMITTEES**

**5.A. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS**

Unless the composition and functions of a committee are otherwise specified in these Bylaws or other Medical Staff policy, the following terms will apply to all chairs and members of Medical Staff committees:

- (1) Medical Staff committee chairs and members will be appointed by the Leadership Council. Committee chairs shall be selected based on the same eligibility criteria that apply to officers, as set forth in Section 3.B of these Bylaws;
- (2) The President of the Medical Staff, CMO, and CEO will serve as *ex officio* members of all Medical Staff committees and will serve without vote unless otherwise specified;
- (3) Licensed Independent Practitioners and Advanced Practice Professionals may be appointed to serve as committee members, with or without vote;
- (4) Hospital management, credentialing and quality/PPE support personnel, and other Hospital staff or representatives may be appointed to serve as members or standing guests/invitees of a Medical Staff committee and shall be appointed by the CMO after consulting with the CEO and the President of the Medical Staff. All such individuals shall serve without vote unless otherwise specified;
- (4) Chairs and members shall be appointed for initial terms of one year and may be reappointed and may serve consecutive terms;
- (5) All committee chairs and members must signify their willingness to meet basic expectations of committee membership as set forth in the Organization Manual; and
- (6) Appointed chairs and members may be removed, and their vacancies filled, by the Leadership Council. Elected Medical Staff leaders may be removed in accordance with the removal provisions set forth in these Bylaws for removal of officers and other leaders (Article 3).

**5.B. MEDICAL EXECUTIVE COMMITTEE**

**5.B.1. Composition:**

- (a) Members:

The MEC shall consist of the following members:

- (i) Voting Members:
  - (1) The President of the Medical Staff;
  - (2) The Vice-President of the Medical Staff;
  - (3) The Secretary of the Medical Staff; and
  - (4) Seven (to align with department chairs) at-large members, who shall be elected on a staggered basis by the Medical Staff in the manner set forth in these Bylaws for election of Medical Staff officers, after nomination by the Leadership Council. Nominations for at-large positions on the MEC shall be made with the goals of ensuring that a broad range of clinical specialties are available to provide valuable clinical perspective to the Committee.

(ii) Non-Voting Members:

- (1) The President;
- (2) The COO;
- (3) The CNE;
- (4) The CMIO;
- (5) The Chairperson of the Committee for Professional Enhancement;
- (6) The Chairperson of the Credentials Committee;
- (7) The Medical Staff Services Manager; and
- (8) The CMO

(b) Chair:

The President of the Medical Staff will chair the MEC.

(c) Guests:

Medical Staff Members, Hospital personnel, and others (whether affiliated with the Hospital or not) may be invited to attend one or more MEC meetings as guests, without vote, in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. Such individuals are an integral part of the committee's functioning and are expected to comply with the same confidentiality requirements as members of the MEC.

**5.B.2. Duties:**

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff Members and practitioners with Clinical



Privileges. The MEC's authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

- (a) acting on behalf of the Medical Staff in the intervals between Medical Staff 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 initial and renewed Medical Staff Membership;
  - (4) delineation of Clinical Privileges 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 and other Practitioners with Clinical Privileges;
  - (6) the mechanism by which Medical Staff Membership may be terminated; and
  - (7) hearing procedures;
- (c) consulting with the CEO and CMO on quality-related aspects of contracts for patient care services;
- (d) 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 significant departures from established or expected clinical practice patterns;
- (e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;
- (f) providing leadership in activities related to patient safety;
- (g) providing oversight in the process of analyzing and improving patient satisfaction;
- (h) prioritizing continuing medical education activities;
- (i) reviewing, or delegating to the Bylaws Committee the responsibility to periodically review the Bylaws, policies, Rules and Regulations, and associated documents of

the Medical Staff and recommending such changes as may be necessary or desirable; and

- (j) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, the Board or other applicable policies.

### **5.B.3. Meetings:**

The MEC shall meet as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

### **5.C. QUALITY AND PERFORMANCE IMPROVEMENT FUNCTIONS**

The Medical Staff is actively involved in quality and performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

- (1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;
- (2) the Hospital's and individual Practitioners' performance on the Centers for Medicare & Medicaid Services ("CMS") core measures, as well as any measures tracked by the organization(s) that accredit the Hospital (e.g. the Joint Commission);
- (3) medical assessment and treatment of patients;
- (4) use of information about adverse Privileging determinations regarding any practitioner;
- (5) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;
- (6) the utilization of blood and blood components, including review of significant transfusion reactions;
- (7) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
- (8) appropriateness of clinical practice patterns;
- (9) significant departures from established patterns of clinical practice;
- (10) education of patients and families;

- (11) coordination of care, treatment and services with other practitioners and Hospital personnel;
- (12) accurate, timely and legible completion of medical records;
- (13) the required content and quality of a history and physical examination, as well as the time frames required for completion, all of which are set forth in these Bylaws;
- (14) the use of developed criteria for autopsies;
- (15) sentinel events, including root cause analyses and responses to unanticipated adverse events;
- (16) nosocomial infections and the potential for infection;
- (17) unnecessary procedures or treatment; and
- (18) appropriate resource utilization.

#### **5.D. CREATION OF STANDING COMMITTEES**

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional standing committees to perform one or more Medical staff functions and 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 Medical Staff Member or a standing or ad hoc committee shall be performed by the MEC.

#### **5.E. AD HOC COMMITTEES**

Ad hoc committees may be created by the MEC or President of the Medical Staff, and the members of such committees that are Practitioner, along with the chair designation, shall be appointed by the President of the Medical Staff. Ad hoc committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

## **ARTICLE 6** **MEETINGS**

### **6.A. MEDICAL STAFF YEAR**

The Medical Staff year is January 1 to December 31.

### **6.B. MEDICAL STAFF MEETINGS**

#### **6.B.1. Regular Meetings:**

The Medical Staff shall meet as needed.

#### **6.B.2. Special Meetings:**

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the Board, or by a petition signed by not less than 10% of the Active Staff.

### **6.C. DEPARTMENT, SERVICE, AND COMMITTEE MEETINGS**

#### **6.C.1. Regular Meetings:**

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department, service, and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Chair.

#### **6.C.2. Special Meetings:**

A special meeting of any department or committee may be called by or at the request of the chair, the President of the Medical Staff, or by a petition signed by not less than 10% of the voting Active Staff Members who are 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 at least 14 days in advance of the meetings. It is expected that most often, Notice will be provided via e-mail, though any type of communication that constitutes "Notice" under these Bylaws and the related Medical Staff governance documents (as defined in the Medical Staff Credentials Policy) is permitted. All Notices shall provide the date, time, and place of the meetings.
- (b) When a special meeting of the Medical Staff, a department, or a committee is called, all of the provisions in paragraph (a) shall apply except that the Notice period shall

be reduced to 48 hours and posting may not be the sole mechanism used for providing Notice of a special meeting.

- (c) The attendance of an individual at any meeting shall constitute a waiver of that individual's objection to the Notice or Special Notice given for that meeting.

#### **6.D.2. Quorum and Voting:**

- (a) Voting at Meetings. 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. Voting may be by written ballot at the discretion of the chair.
- (b) Voting Without a 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, website posting, or telephone and their votes returned to the Medical Staff Office by the method designated in the Notice. Except for amendments to these Bylaws (which, in the absence of a meeting, require 10% of the voting members of the Medical Staff to return a response in order for there to be a Quorum) and actions by the MEC, Credentials Committee, Committee on Professional Enhancement, and Leadership Council (which, in the absence of a meeting, require 50% of the voting members of the Committee to return a response in order for there to be a Quorum), a Quorum for purposes of these votes shall be the number of responses returned to the Medical Staff Office by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.
- (c) Proxy voting is not permitted.

#### **6.D.3. Agenda:**

The chair for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department or committee and be responsible for ensuring that appropriate Notice of the agenda is sent to members (particularly in the case of special meetings, wherein the business to be conducted is limited to the matters outlined in the Notice of the meeting).

#### **6.D.4. Rules of Order:**

While Robert's Rules of Order Revised may be used for reference at meetings and elections, neither that resource, nor any other authority on parliamentary or other procedures, shall be binding. Specific provisions of these Bylaws, as well as the relevant Medical Staff, department or committee custom shall instead be influential in determining how those bodies should conduct their affairs. In all cases, the chair shall have the authority to rule definitively on matters of procedure and the chair's determination will be final.

#### **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 Medical Staff Members, the recommendations made, and the votes taken on each matter. For the sake of efficiency, minutes of previous meetings may be distributed to members of the relevant body in advance of meetings and included on a consent agenda, in which case they shall be subject to discussion only if a member registers a concern about the minutes. Otherwise, they shall be deemed approved by the relevant body. Thereafter, the minutes shall be signed by the chair after preparation, to signify that they have been reviewed and are accurate and complete.
- (b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC, as well as to the CEO for purposes of ensuring a record of Medical Staff activities is maintained, and for the purpose of keeping the Board apprised of the activities of the Medical Staff and its departments and committees.
- (c) A permanent file of the minutes of all Medical Staff meetings shall be maintained by the Hospital.

#### **6.D.6. Confidentiality:**

All Medical Staff business conducted by committees and departments as well as Medical Staff Leaders acting on their behalf, is considered confidential and proprietary and should be treated as such. In addition, 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.D.7. Attendance Requirements:**

- (a) Members are expected to be Present at meetings of the MEC, Credentials Committee, and Committee on Professional Enhancement. All members are required to be Present for at least 75% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in removal or replacement of the individual as a member of the committee.
- (b) Each Active Staff Member is expected to be Present and participate in all regularly-scheduled Medical Staff meetings and to attend special meetings whenever reasonably possible. In addition, all Medical staff Members are expected to attend and participate in any meetings of the departments and committees of which he or

she is a member, including making every effort to attend special meetings for which appropriate Notice has been provided.

**ARTICLE 7**  
**BASIC STEPS FOR CREDENTIALING AND PEER REVIEW**

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

**7.A. QUALIFICATIONS FOR INITIAL OR RENEWED MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

To be eligible to apply for initial or renewed Medical Staff Membership or Clinical Privileges, an individual must submit an Application and through the credentialing process, demonstrate continuous satisfaction of all threshold criteria for Membership, as well as all other factors for consideration outlined in the Medical Staff Credentials Policy and other Hospital and Medical Staff policies, including appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested.

**7.B. INITIAL PROCESS FOR CREDENTIALING AND PRIVILEGING**

The Medical Staff Office will verify Applications, with the burden being placed on the Applicant to provide all information that is requested. As a preliminary step, the Medical Staff Office will review the Application to make sure that all questions have been answered and that the Applicant satisfies all threshold eligibility criteria set forth in the Credentials Policy.

**7.C. PROCESS FOR CREDENTIALING AND PRIVILEGING**

- (1) Complete Applications for Membership and Clinical Privileges will be transmitted to the applicable department chairperson, who will review the Applicant's education, training, and experience and prepare a written report stating whether the Applicant meets all qualifications. The report(s) will be forwarded to the Credentials Committee..
- (2) The Credentials Committee will review the chairperson's report and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the department chairperson's report, to the Medical Executive Committee for review and recommendation.
- (3) The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the Application back to the Credentials Committee for further review or specific questions, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee entitles the individual to request a hearing, the Chief Executive Officer will send Special Notice of the recommendation and the hearing rights available under the Medical Staff Bylaws documents. If the recommendation of the Medical Executive Committee does not entitle the



individual to request a hearing, the recommendation will be forwarded to the Board for final action.

- (4) When the Hospital Emergency Operations Plan has been implemented, the CEO or President of the Medical Staff may use a modified credentialing process to grant disaster Privileges after verification of the volunteer's identity and professional license.
- (5) When an important patient care need exists or when an Applicant has made an initial Application for the Clinical Privileges that is awaiting review by the MEC and Board, the CEO may use a modified credentialing process to grant temporary Clinical Privileges, for a period not to exceed 120 days, to certain, qualified individuals.

#### **7.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF MEMBERSHIP AND/OR PRIVILEGES**

- (1) Membership and/or Clinical Privileges may be automatically relinquished if a Practitioner:
  - (a) fails to do any of the following:
    - (i) timely pay dues;
    - (ii) timely complete medical records;
    - (iii) satisfy threshold eligibility criteria;
    - (iv) complete and comply with educational or training requirements;
    - (v) provide requested information;
    - (vi) attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration; or
    - (vii) comply with a request for fitness for practice evaluation or clinical competency evaluation;
  - (b) is arrested, charged, indicted, convicted, or pleads guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (iv) violence; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse; or

- (c) makes a misstatement or omission on an Application or in conjunction with the credentialing process.
- (2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved and the individual is reinstated, if applicable.

**7.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION OR RESTRICTION**

- (1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Leadership Council, Medical Executive Committee, Board, or any two of the following individuals, acting together as a professional committee, may immediately suspend or restrict all or any portion of a Practitioner's Clinical Privileges: (a) the Chief Executive Officer, (b) the President of the Medical Staff, (c) the Vice-President of the Medical Staff, (d) the Chair of the Committee on Professional Enhancement, (e) the chairperson of the relevant clinical department, and/or (f) the Chief Medical Officer.
- (2) A precautionary suspension or Restriction is effective immediately and will remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee.
- (3) The Practitioner will be provided a brief written description of the reason(s) for the precautionary suspension or Restriction.
- (4) The Medical Executive Committee will review the reasons for the suspension or Restriction within a reasonable time under the circumstances, not to exceed 10 Days.
- (5) As part of this review, the Practitioner will be given an opportunity to meet with the Medical Executive Committee.

**7.F. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS**

Following an investigation, the Medical Executive Committee may recommend suspension, Restriction or revocation of Membership or Clinical Privileges, based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the Bylaws, policies, manuals, and Rules and Regulations of the Hospital or the Medical Staff; (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; (d) ability to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership or Clinical Privileges; or (e) the Practitioner's qualifications for Membership and Clinical Privileges.

## **7.G. HEARING AND APPEAL PROCESS**

The details associated with the hearing and appeals processes are contained in the Credentials Policy.

- (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 may be conducted by a Hearing Panel, which will consist of at least three Members, or, in the alternative, may be conducted by 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; (d) to have representation by counsel who may call, examine, and cross-examine witnesses or present the case; (e) to submit a written statement at the close of the hearing; and (f) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (6) The personal presence of the affected Practitioner is mandatory. If the Practitioner who requested the hearing does not testify, he or she may be called and questioned.
- (7) The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.
- (8) The affected Practitioner and the Medical Executive Committee may each request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.

**ARTICLE 8**  
**AMENDMENTS**

**8.A. MEDICAL STAFF BYLAWS**

- (1) Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting Members of the Medical Staff or by the Medical Executive Committee.
- (2) Proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee will provide Notice of proposed amendments, including amendments proposed by the voting Members of the Medical Staff as set forth above, to the voting staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff or at a special meeting called for such purpose.
- (3) 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, the amendment must receive a majority of the votes cast by the voting staff at the meeting.
- (4) In the alternative, the Medical Executive Committee may present any proposed amendments to the voting Members of the Medical Staff for voting by mail, facsimile, e-mail, hand delivered, website posting, or telephone and their votes returned to the Medical Staff Office by the date (which shall be no earlier than 14 Days from when Notice of the proposed amendments was provided). 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, at least 10% of the voting members of the Medical Staff must return a response (to satisfy the Quorum requirement) and the amendment must receive a majority of the votes cast.
- (5) The Medical Executive Committee will have the power to adopt any amendments to these Bylaws that are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.
- (6) Amendments will be effective only after approval by the Board of Directors.
- (7) If the Board of Directors 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 officers of the Board and the officers of the Medical Staff. Such conference will 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 Chief Executive Officer within two weeks after receipt of a request.

- (8) Neither the Medical Executive Committee, the Medical Staff, nor the Board can unilaterally amend these Bylaws.

## **8.B. OTHER MEDICAL STAFF DOCUMENTS**

- (1) In addition to the Medical Staff Bylaws, there will be policies, procedures, and Rules and Regulations that are applicable to Practitioners. Those policies, procedures and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but shall be amended in accordance with this Section.
- (2) An amendment to the Credentials Policy, the Organization Manual, or the 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 any proposed amendments to these documents will be provided to each voting Member of the Medical Staff at least 21 Days prior to the vote by the Medical Executive Committee. Any voting Member may submit written comments on the amendments to the Medical Executive Committee.
- (3) 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.
- (4) Amendments to the Credentials Policy, the Organization Manual, the Rules and Regulations, or any other Medical Staff policy may also be proposed by a petition signed by at least 25% of the voting Members of the Medical Staff. Notice of any such proposed amendment to these documents will be provided to the Medical Executive Committee at least 21 Days prior to being voted on by the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendment before it is forwarded to the Medical Staff for vote.
- (5) The Medical Executive Committee and the Board will have the power to provisionally adopt urgent amendments to the 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 provisionally adopted amendments will be provided to each Member of the Medical Staff as soon as possible. The Medical Staff will have 21 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, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.
- (6) Adoption of and changes to the Credentials Policy, the Organization Manual, the Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board of Directors.

- (7) Amendments to Medical Staff policies are to be distributed or otherwise made available to Practitioners in a timely and effective manner.

## **8.C. CONFLICT MANAGEMENT PROCESS**

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

- (1) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 25% of the voting staff, with regard to:
  - (a) a new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an amendment to an existing Rule and Regulation;  
or
  - (b) a new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

a special meeting of the Medical Staff to discuss the conflict will be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the Rules and Regulations or policy at issue.

- (2) If the differences cannot be resolved at the meeting, the President of the Medical Staff or the dissenting Members of the Medical Staff may request that the matter be referred to a Joint Conference Committee within 30 Days. The Joint Conference Committee shall consist of:
  - (a) three officers of the Medical Staff;
  - (b) three voting Members of the Medical Staff who signed the petition;
  - (c) the chairperson of the Board of Directors; and
  - (d) the Chief Executive Officer and Chief Medical Officer.
- (3) If the matter cannot be resolved by the Joint Conference Committee, the recommendations of the Medical Staff and Medical Executive Committee will be forwarded to the Board for final action.
- (4) 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.
- (5) 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 of Directors. Communication from Medical Staff Members to the Board of Directors will be directed through the Chief Executive Officer, who will forward the request for communication to the Board Chairperson. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the President of the Medical Staff of such exchanges. The Board Chairperson will determine the manner and method of the Board's response to the Medical Staff Member(s).

### **8.C.2. Conflicts Between the Medical Executive Committee and Board of Directors:**

- (1) When there is a conflict between the Medical Executive Committee and the Board of Directors with regard to:
  - (a) a new Medical Staff Rule and Regulation proposed by the Medical Executive Committee or an existing Rule or Regulation; or
  - (b) a new Medical Staff policy proposed by the Medical Executive Committee or an amendment to an existing policy,

either a Member of the Board of Directors or the Medical Executive Committee may submit a written request to the Chairman of the Board that the matter be referred to a Joint Conference Committee.

- (2) The Joint Conference Committee shall consist of:
  - (a) three officers of the Medical Staff;
  - (b) one other Medical Executive Committee Member;
  - (c) the chairperson, vice chairperson and secretary of the Board of Directors or other designees of the Board of Directors; and
  - (d) the Chief Executive Officer and Chief Medical Officer.
- (3) If the Joint Conference Committee does not reach a resolution within 30 Days, the Board of Directors shall take final action on the matter.
- (4) This conflict management Section is limited to the matters noted above.

**ARTICLE 9**  
**HISTORY AND PHYSICAL**

(1) Timing of the History and Physical Examination

- (a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration and in all cases prior to surgery or a procedure requiring anesthesia services. The history and physical examination must be performed by a Practitioner who has been granted Clinical Privileges by the Hospital to perform histories and physicals.
- (b) If a medical history and physical examination has been completed within the 30-Day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, if the history and physical examination was performed by a Physician, oral maxillofacial surgeon, Physician assistant, or advanced practice registered nurse. In such cases, within 24 hours after admission/registration or prior to surgery/ procedure requiring anesthesia services, whichever comes first, the patient must be reassessed by a Practitioner who has been granted Clinical Privileges by the Hospital to perform histories and physicals. The purpose of this assessment is to identify any changes subsequent to the original examination. The Practitioner must update the history and physical examination to reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.
- (c) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or procedure requiring anesthesia services, the operation or procedure will be canceled unless the attending Physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart, with an admission note by the attending Physician. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

(2) Scope of the History and Physical Examination

The scope of the medical history and physical examination will include, as applicable:

- (a) patient identification;
- (b) chief complaint;
- (c) history of present illness;



- (d) review of all relevant systems, to include at least two systems and, in the event surgery or anesthesia is planned for the patient, to include the cardiac and respiratory systems, at minimum;
- (e) personal medical history, including medications and allergies;
- (f) family medical history;
- (g) any relevant social history, including any abuse or neglect;
- (h) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- (i) data reviewed;
- (j) assessments, including problem list;
- (k) plan of treatment;
- (l) 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 will be documented in the plan of treatment; and
- (m) in the case of a pediatric patient, weight and immunization status and, if relevant: (i) developmental age; (ii) length or height; and (iii) head circumference.

**ARTICLE 10**  
**ADOPTION**

These Bylaws are adopted and made effective upon adoption by the Medical Staff and subsequent approval of the Board, superseding and replacing any previous Medical Staff Bylaws, and any inconsistent provisions of the Rules and Regulations, Medical Staff policies or manuals or Hospital policies pertaining to the subject matter contained herein.

Adopted by the Medical Staff:

\_\_\_\_\_  
**12/12/2023**

Approved by the Board of Directors:

\_\_\_\_\_  
**12/20/2023**

Previous Board Approval:

12/2023: Deletion of 2.B. ACTIVE STAFF (Page 6) 2.B.2 Prerogatives: (a)All Active Staff Members in Second Term and the modification of the 5. B. MEDICAL EXECUTIVE COMMITTEE 5.B.1. Composition: (page 31) both voting and non-voting members.

12/2022: Deletion of Article 3 Officers 3B.(1) ...for at least three years.

12/2021: Deletion of 2.B.1 (c) and 2.F.1 (b) 5 hours of Active Staff responsibilities as a requirement of Active Staff and APP Staff status.

5/24/2021: Revision to 4.B.3 (5) Duties of Department Chairs (added "recommendations")

12/21/2020: Revisions to 6.D.2: Voting without a meeting criteria. 8.A (4) revisions to allow for alternative (non-meeting) methods to return ballots.

6/22/2020

Orig: 1/28/2020