MEDICAL STAFF BYLAWS

HARTFORD HOSPITAL

February 26, 2018

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

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

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

1.D. MEDICAL STAFF DUES

(1) Medical Staff dues shall be established by the Medical Executive Committee and may vary by category.

(2) Dues shall be payable annually upon request. Failure to pay dues shall result in the ineligibility to apply for reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff and the Treasurer.

(4) Dues shall be maintained in the Medical Staff fund and shall be used in the interest of the Medical Staff.

1.E. INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, Department Chiefs, section/division chiefs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws and/or certificate of incorporation.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the categories listed below:

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff will consist of members of the Medical Staff who:

(a) meet the eligibility criteria set forth in Section 2.A.1 of the Medical Staff Credentials Policy; and

(b) are involved in at least 24 patient contacts at the Hospital during the two-year appointment term; or

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

Guidelines:

Unless an Active Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts per two-year appointment term or who is not sufficiently active in Medical Staff or Hospital functions shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must select and be transferred to another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy or Active Community Affiliate Staff).

2.A.2. Prerogatives:

Active Staff members may:

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

(b) vote in general and special meetings of the Medical Staff and applicable department, section/division, and committee meetings;

(c) hold office, serve on Medical Staff committees, and serve as Department Chief, section/division chief, or committee chair; and

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

2.A.3. Responsibilities:

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

(a) serving on committees, as requested;

(b) providing on-call coverage for the Emergency Department in accordance with applicable Departmental rules and regulations and consistent with Hospital requirements to meet patient needs;

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

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

(e) accepting inpatient consultations, when requested; and

(f) paying application fees, dues, and assessments.

2.B. ACTIVE COMMUNITY AFFILIATE STAFF

2.B.1. Qualifications:

The Active Community Affiliate Staff will consist of members of the Medical Staff who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital;

(b) meet the eligibility criteria set forth in Section 2.A.1 of the Medical Staff Credentials Policy but are exempt from the qualifications related to: location and coverage arrangements; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Active Community Affiliate Staff as outlined in Section 2.B.2.

Guidelines:

* The Active Community Affiliate Staff is a membership-only category, with no clinical privileges being granted. The primary purpose of the Active Community Affiliate Staff is to permit these individuals access to Hospital services for their patients by referral of patients to Active Staff members for admission and care and to promote professional and educational opportunities, including continuing medical education.

** Active Community Affiliate Staff members who are actively engaged in service on Medical Staff or Hospital committees and/or active participation in performance improvement or professional practice evaluation functions may request to be transferred to the Active Staff.

2.B.2. Prerogatives and Responsibilities:

Active Community Affiliate Staff members:

(a) may attend and participate in Medical Staff, department, and section/division meetings (with vote);

(b) may serve as Department Chiefs, section/division chiefs, or committee chairs but may not hold office;

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

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

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

(f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

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

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

(j) may not: admit patients, attend patients, request clinical privileges, write inpatient orders, write progress notes, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

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

(l) may refer patients to the Hospital's diagnostic facilities and order such tests; and

(m) must pay application fees, assessments and dues, which will be reduced for Active Community Affiliate Staff members.

2.C. COURTESY STAFF

2.C.1. Qualifications:

The Courtesy Staff will consist of members of the Medical Staff who:

(a) are involved in fewer than 24 patient contacts per appointment term;

(b) agree to either personally manage any complications that may arise in connection with patients receiving outpatient care or, if an outpatient needs to be admitted to the Hospital, has a written coverage arrangement with a member of the Active Staff who agrees to do the same on the Courtesy Staff member's behalf;

(c) meet the eligibility criteria set forth in Section 2.A.1 of the Medical Staff Credentials Policy; and

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

Guidelines:

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

* Any member who has zero patient contacts per two-year appointment term must move to another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (option – Active Community Affiliate). In the discretion of the Department Chief and VPMA, when coverage is necessary, quality clinical profile information may be obtained pursuant to 5.B.1 of the Credentials Policy for Reappointment in order to allow a staff member to remain in Courtesy category.

** Any member who has more than 24 patient contacts per two-year appointment term must move to Active Staff status. In the discretion of the Department Chief and VPMA, a member may continue as Courtesy staff if department, hospital and patient needs are being met.

2.C.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may admit, attend, treat and exercise such clinical privileges as are granted to them;

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

(c) may attend meetings of the Medical Staff (without vote);

(d) may attend applicable department and section/division meetings (without vote unless the member has been elected or appointed to serve as a Department Chief or section/division chief, in which case the member will serve with vote);

(e) may be invited to serve on committees (with vote) and serve as a committee chair;

(f) may not hold office; and

(g) must pay application fees, dues and assessments.

2.D. EMERITUS STAFF

2.D.1. Qualifications:

Emeritus Staff members will:

(a) be members in good standing of the Medical Staff at the time they are retired from active practice or at the time they cease to regularly admit, attend, treat or consult at the Hospital; and

(b) be nominated by the Department Chief, recommended by the Medical Executive Committee, and approved by the Board.

2.D.2. Prerogatives and Responsibilities:

(a) Appointment to the Emeritus Staff is a lifetime appointment and does not require renewal. In special circumstances, the Medical Executive Committee may

recommend withdrawal of the appointment. In such circumstances, an Emeritus Staff member does not have a right to a hearing as specified in these Bylaws.

(b) Emeritus Staff members:

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

(2) may continue to receive Hospital and Medical Staff communications;

(3) may attend Medical Staff, department, and section/division meetings when invited to do so (without vote);

(4) may be invited to serve on a committee (with vote);

(5) may not hold office or serve as a Department Chief, section/division chief or committee chair; and

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

2.E. RESIDENTS AND FELLOWS

2.E.1. Qualifications:

Residents and Fellows shall consist of all post-graduate residents and fellows of the Hospital during the term of their appointments and all those post-graduate residents and fellows of other institutions during periods of affiliation with departments of the Hospital.

2.E.2. Prerogatives and Responsibilities:

(a) Residents and Fellows:

(1) may not have admitting privileges;

(2) may attend Medical Staff, department, and section/division meetings when invited to do so (without vote);

(3) may not be eligible to hold office, serve as a Department Chief, section/division chief or committee chair of a Medical Staff committee; and

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

(b) Members of the Residents and Fellows category shall work under the guidance of their Program Director and shall be supervised by the member(s) of the Active Staff to whom they are assigned for their training.

(c) Residents and Fellows are permitted to function clinically only in accordance with written job responsibilities developed by the appropriate Program Director under the auspices of the Graduate Medical Education Committee ("GMEC").

(d) As a condition of participation in a post-graduate physician program, all Residents and Fellows who are not licensed to practice medicine and surgery in the State of Connecticut must have a permit for participation in a post-graduate physician program issued by the State of Connecticut Department of Public Health or such other permit or permits as may be required by law.

(e) Residents and Fellows may elect their own Council, subject to the approval of the Medical Executive Committee.

2.F. MOONLIGHTING RESIDENTS AND FELLOWS

2.F.1. Qualifications:

Moonlighting Residents and Fellows shall consist of licensed physicians employed part-time by the Hospital to perform duties in a specialty under the supervision of specific members of the Medical Staff, but who perform these duties outside the scope of an approved residency or fellowship program.

2.F.2. Prerogatives and Responsibilities:

Moonlighting Residents and Fellows:

(a) may exercise those clinical privileges granted by the Board;

(b) shall be appointed to a specific department and be approved in advance by the chief of the department in which they work;

(c) shall meet the CME requirements of the Medical Staff or be enrolled in an approved residency or fellowship program;

(d) shall not be responsible for the payment of dues;

(e) may attend Medical Staff, department, and section/division meetings when invited to do so (without vote); and

(f) may not be eligible to hold office, serve as a Department Chief, section/division chief or committee chair of a Medical Staff committee.

2.G. ALLIED HEALTH STAFF

2.G.1. Qualifications:

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

2.G.2. Prerogatives and Responsibilities:

Allied Health Staff members:

(a) may function in the Hospital under the oversight of a Supervising/Collaborating Physician, where applicable, and as permitted by their license and clinical privileges or scope of practice;

(b) may attend and participate in Medical Staff, department, and section/division meetings (without vote);

(c) may not hold office or serve as a Department Chief, section/division chief, or committee chair of a Medical Staff committee;

(d) may be invited to serve as a member of Medical Staff committees (with vote);

(e) must participate in the professional practice evaluation and performance improvement processes;

(f) may exercise such clinical privileges or scope of practice as granted; and

(g) must pay application fees, dues, and assessments.

2.H. ALLIED HEALTH COMMUNITY AFFILIATE

2.H.1. Qualifications:

The Allied Health Community Affiliate Staff consists of licensed independent practitioners and advanced dependent practitioners who are authorized by law to provide patient care services and who do not intend to establish a clinical practice at the Hospital.

2.H.2. Prerogatives and Responsibilities:

Allied Health Community Affiliate Staff members:

(a) may attend and participate in Medical Staff, department, and section/division meetings (without vote);

(b) may not hold office or serve as a Department Chief, section/division chief, or committee chair of a Medical Staff committee;

(c) may be invited to serve as a member of Medical Staff committees (with vote).

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be: the President of the Medical Staff, the Vice President of the Medical Staff, the Secretary, and the Treasurer. *[Roles of Secretary and Treasurer may be combined]*.

3.B. ELIGIBILITY CRITERIA

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

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

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

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

(4) not presently be serving as a Medical Staff officer, Board member, or department chief at any other hospital outside of Hartford HealthCare and shall 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 leadership position, or other involvement in performance improvement functions, for at least two years; and

(7) have demonstrated an ability to work well with others.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

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

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the VPMA and Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, and needs of the Medical Staff and report on the activities of the Medical Staff to the Board, the VPMA, and the Hospital President;

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

(d) appoint all committee chairs and committee members, in consultation with the Medical Executive Committee;

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

(f) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(g) recommend Medical Staff representatives to Hospital committees;

(h) perform all functions authorized in the Bylaws and other applicable policies, including collegial intervention;

(i) be a spokesperson for the Medical Staff in external professional and public relations; and

(j) assume other such duties as may be assigned.

3.C.2. Vice President of the Medical Staff:

The Vice President of the Medical Staff shall:

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

(b) serve on the Medical Executive Committee; and

(c) assume other such duties as are assigned by the President of the Medical Staff or the Medical Executive Committee.

3.C.3. Secretary:

The Secretary shall:

(a) serve on the Medical Executive Committee;

(b) cause to be kept accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings and perform such other duties as ordinarily pertain to the office of Secretary; and

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

3.C.4. Treasurer:

The Treasurer shall:

(a) serve on the Medical Executive Committee; and

(b) collect staff dues and make disbursements as authorized by the Medical Executive Committee or its designees.

3.D. NOMINATIONS

(1) The President of the Medical Staff shall appoint a Nominating Committee consisting of three members of the Active Staff for all general and special elections. The committee shall convene at least 40 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office and any at-large members of the Medical Executive Committee. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(2) Nominations may also be submitted in writing by petition signed by at least 10% of the voting members of the Medical Staff no later than ten days before the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) The election shall be held by written or electronic ballot returned to Medical Staff Services. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. The ballot shall be sent out to all voting members at least 30 days prior to

the annual meeting of the Medical Staff. Voting members shall have 14 days to submit their votes to Medical Staff Services.

(2) A quorum for purposes of an election shall be the number of responses returned to Medical Staff Services (but not fewer than two) by the date indicated.

(3) The candidates who receive a majority of the votes cast shall be elected, subject to Board confirmation.

(4) 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.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected. Officers are eligible to serve two consecutive terms.

3.G. REMOVAL

(1) Removal of an elected officer or a member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Executive Committee, by a two-thirds vote of the voting staff, or by the Board. Grounds for removal may include:

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

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

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

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

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

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to address the Medical Executive Committee, the voting staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice President of the Medical Staff, who shall serve until the end of the President of the Medical Staff's unexpired term. In the event there is a vacancy in another office or any at-large member position on the Medical Executive Committee, the President of the Medical Staff shall appoint an individual to fill that position for the remainder of the term, subject to ratification by the Medical Executive Committee.

ARTICLE 4

DEPARTMENTS AND SECTIONS/DIVISIONS

4.A. ORGANIZATION

4.A.1. Organization of Departments and Divisions:

(a) The Medical Staff shall be organized into the departments and sections/divisions as listed in the Organization Manual.

(b) The Medical Executive Committee, after consultation with Hospital Administration, may create new departments, eliminate departments, create sections/divisions within departments, or otherwise reorganize the department structure, subject to the approval of the Board.

4.A.2. Assignment to Departments and Sections/Divisions:

(a) Upon initial appointment to the Medical Staff, each member shall be assigned to at least one clinical department. Members may also be assigned to one or more section/division, as applicable.

(b) An individual may request a change in his or her department or section/division assignment to reflect a change in the individual's clinical practice. A member may also be granted clinical privileges typically associated with another department, in which case the individual may be assigned to more than one department.

4.A.3. Functions of Departments:

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

(b) All clinical departments shall meet on a regular basis, at dates and times set by the chief, in order to fulfill the functions outlined in (a), review and evaluate the clinical work of the department, and to discuss other matters concerning the department. Minutes of the department's findings, proceedings, and actions will be prepared in accordance with Section 6.C.5.

4.A.4. Functions of Sections/Divisions:

(a) Sections/divisions may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs;

(4) development of recommendations to the Department Chief or the Medical Executive Committee;

(5) participation in the development of criteria for clinical privileges (when requested by the Department Chief); and

(6) discussion of a specific issue at the special request of a Department Chief or the Medical Executive Committee.

(b) No minutes or reports will be required reflecting the activities of sections/divisions, except when the sections/divisions are making formal recommendations to a department, Department Chief, Credentials Committee, or Medical Executive Committee.

(c) Section/divisions shall meet as directed by the applicable department.

4.B. DEPARTMENT CHIEFS

4.B.1. Qualifications:

Each Department Chief shall meet the qualifications set forth in Section 3.B of these Bylaws.

4.B.2. Selection of Department Chiefs:

(a) Except as otherwise provided by contract, when there is a vacancy in a Department Chief position, or a new department is created, the department, in consultation with Hospital Administration, will recommend the name(s) of an individual(s) eligible to serve as Department Chief. The recommendation of the department will be presented to the Medical Executive Committee for vote. The results of the election will be forwarded to the Board for confirmation.

(b) Where a vacancy arises in a contracted position, the Hospital Administration, in consultation with the Medical Staff Officers, will propose a process to select the Department Chief. Such process may include a search committee appointed by the President of the Medical Staff, the VPMA, and the Hospital President.

4.B.3. Removal of Department Chiefs:

(a) Any Department Chief who is elected by a department may be removed by a two-thirds vote of the clinical department members, subject to Board confirmation, or by a two-thirds vote of the Medical Executive Committee, subject to Board confirmation, or by the Board. Grounds for removal may include:

(1) failure to comply with applicable policies and Bylaws;

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

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

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

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

(b) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to address the department, the Medical Executive Committee, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

(c) In the case of a contracted Department Chief position, the members of the department may hold a vote of no confidence, but removal may only be effectuated by the Board, with input from the Hospital and Medical Staff leadership, in accordance with the terms of his or her contract.

4.B.4. Duties of Department Chiefs:

At a minimum, each Department Chief is accountable for the following in collaboration with the VPMA (or his or her designee(s)), where appropriate:

(a) coordinating all clinically related activities of the department;

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

(c) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the applicable peer review/professional practice evaluation policy;

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

(e) evaluating requests for clinical privileges for each member of the department;

(f) developing the on-call schedules for physicians within the department subject to the approval of the Medical Executive Committee;

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

(h) integrating the department into the primary functions of the Hospital;

(i) coordinating and integrating interdepartmental and intradepartmental services;

(j) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department;

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

(l) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(m) continuously assessing and improving the quality of care, treatment, and services provided within the department;

(n) maintaining quality monitoring programs, as appropriate;

(o) providing for the orientation and continuing education for all persons in the department;

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

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

(r) communicating the views, policies, and activities of the Medical Executive Committee to the department;

(s) supporting research activities, as appropriate, within the department;

(t) if the chief is also the program director of an approved residency, meeting all the program director qualifications and responsibilities outlined in the program director requirements for that residency; and

(u) appointing an associate chief and section/division chief, as deemed necessary, subject to approval of the Medical Executive Committee and the Hospital Administration. If an associate chief is appointed, that individual assumes all of the duties of the chief and acts with the authority of the chief in his or her absence.

4.C. SECTION/DIVISION CHIEFS

4.C.1. Selection and Removal of Section/Division Chiefs:

(a) Each section/division chief shall meet the qualifications set forth in Section 3.B of these Bylaws.

(b) Section/division chiefs shall be appointed and removed at the discretion of the Department Chief, after receiving input from the Hospital Administration and the section/division members.

4.C.2. Duties of Section/Division Chiefs:

The section/division chief shall carry out those functions delegated by the Department Chief, including the following:

(a) review and report on applications for initial appointment and clinical privileges;

(b) review and report on applications for reappointment and renewal of clinical privileges;

(c) evaluate individuals during the focused professional practice evaluation period;

(d) participate in the development of criteria for clinical privileges within the section/division;

(e) assist the Department Chief in developing the on-call schedules for physicians within the department;

(f) review and report regarding the professional performance of individuals practicing within the section/division; and

(g) support the Department Chief in making recommendations regarding the coordination of departmental activities, as well as the hospital resources necessary for the section/division to function effectively.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT, PEER REVIEW, AND CREDENTIALING FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

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

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Except as otherwise provided in these Medical Staff Bylaws or in the Medical Staff Organization Manual:

(a) all committee chairs and members shall be appointed by the President of the Medical Staff, in consultation with the Medical Executive Committee. Committee chairs shall be selected based on their standing on the Medical Staff and willingness to serve;

(b) committee chairs and members shall be appointed for terms of two years and may be reappointed for additional terms. To the extent possible, the terms may be staggered; and

(c) all Hospital and administrative representatives on the committees shall be appointed by the VPMA.

(2) The President of the Medical Staff, the VPMA, and the Hospital President (or his or her respective designees) shall be members, *ex officio*, without vote, on all committees, unless otherwise indicated.

5.C. MEETINGS, REPORTS, AND RECOMMENDATIONS

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

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The Medical Executive Committee shall consist of no more than 21 voting members, including the following:

- the officers of the Medical Staff;
- Six (6) Chiefs who will be elected by all the Department Chiefs (who shall serve two year terms);
- Seven (7) at-large members (who shall serve two-year terms). At-large members shall be nominated and elected by the Medical Staff in accordance with Section 3.D and Section 3.E of these Bylaws.

    * The number of at-large members shall be selected to ensure that at least 50% of the voting membership of the Medical Executive Committee is composed of members elected by the Medical Staff (i.e., Officers and at-large members).

(b) The VPMA and the Hospital President will be *ex officio* members, without vote.

(c) The President of the Medical Staff will chair the Medical Executive Committee.

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

5.D.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The committee is responsible for the following:

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

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

(1) the Medical Staff's structure;

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

(3) applicants for Medical Staff appointment and reappointment;

(4) termination, restriction, and suspensions of appointment and/or clinical privileges;

(5) delineation of clinical privileges for each eligible individual;

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

(7) the mechanism by which Medical Staff appointment may be terminated;

(8) hearing procedures; and

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

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

(d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) providing and promoting effective liaison among the Medical Staff, administration, and the Board;

(h) approving clinical protocols and care sets;

(i) reviewing, at least every three years, 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, or other applicable policies.

5.D.3. Meetings:

(a) The Medical Executive Committee shall meet as often as necessary to fulfill its responsibilities. As an alternative to a formal meeting, the President of the Medical Staff may also electronically transmit matters to the membership for its consideration.

(b) The Medical Executive Committee shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

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

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

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

(c) medical assessment and treatment of patients;

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

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

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

(g) appropriateness of clinical practice patterns;

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

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

(j) the use of developed criteria for autopsies;

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

(l) health care-associated infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

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

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

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

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

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

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

5.F. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

(1) The Medical Executive Committee may, by resolution and without amendment of these Bylaws, establish additional standing committees to perform one or more staff functions.

(2) The Medical Executive Committee may dissolve or rearrange structure, duties, or composition of the Medical Staff committees as needed to better accomplish Medical Staff functions.

(3) Any function required to be performed by these Bylaws which is not assigned to an individual or a standing committee shall be performed by the Medical Executive Committee.

(4) Special task forces may also be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the Medical Executive Committee. Such special task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE 6

MEETINGS

6.A. GENERAL MEDICAL STAFF MEETINGS

(1) The Medical Staff shall meet at least once a year during the Medical Staff year, which runs from October 1 to September 30.

(2) Special meetings of the Medical Staff may be called by the President of the Medical Staff, the Medical Executive Committee, the Board, or by a petition signed by not less than 10% of the voting staff.

6.B. DEPARTMENT, SECTION/DIVISION, AND MEDICAL STAFF COMMITTEE MEETINGS

6.B.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, each department, section/division, and Medical Staff committee shall meet as often as necessary, and at least annually, to accomplish their functions at times set by the Presiding Officer.

6.B.2. Special Meetings:

A special meeting of any department, section/division, or Medical Staff committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, or by a petition signed by at least 10% of the voting members of the department, section/division, or committee, but not by fewer than two members.

6.C. PROVISIONS COMMON TO ALL MEETINGS

6.C.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff at least two weeks in advance. The notice period for regular meetings of departments, sections/divisions, and Medical Staff committees will be one week in advance of the meetings. Notice may also be provided by posting in a designated location, posting on the Hospital intranet, or by other electronic means. All notices shall state the date, time, and place of the meetings.

(b) When special meetings of the Medical Staff, departments, sections/divisions, and/or Medical Staff committees are called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, electronic notice will be given. Posting in a designated

location may not be the sole mechanism used for providing notice of special meetings.

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

6.C.2. Quorum and Voting:

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

(1) for meetings of the Medical Executive Committee, the Credentials Committee, and the [Peer Review/Professional Practice Evaluation Committee], the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

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

(b) Recommendations and actions of the Medical Staff, departments, sections/divisions, and Medical Staff 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 voting members present.

(c) As an alternative to a formal meeting and at the discretion of the Presiding Officer, the voting members of the Medical Staff, a department, a section/division, or a Medical Staff committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the President of the Medical Staff, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the Medical Executive Committee, the Credentials Committee, and the [Peer Review/Professional Practice Evaluation Committee] (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer (but not fewer than two) by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

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

6.C.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, section/division, or Medical Staff committee.

6.C.4. Rules of Order:

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

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

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

(b) A summary of all formal recommendations and actions of the Medical Staff, departments, sections/divisions, and committees shall be transmitted to the Medical Executive Committee.

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

6.C.6. Confidentiality:

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

6.C.7. Executive Sessions:

(a) Discussions or meetings of a Medical Staff committee or department or section/division may be conducted in Executive Session, meaning only the voting Medical Staff members of the committee, department, or section/division may attend, along with the Hospital President, the VPMA and any other invitees of the Presiding Officer.

(b) An Executive Session may be called at the discretion of the Presiding Officer and is intended to be utilized to discuss peer review issues, personnel issues, or any

other issues requiring confidentiality. The conduct and activities of the committee, department, or section/division while in Executive Session shall be consistent with the duties and responsibilities of the committee or department. In addition, discussions or meetings shall be conducted in a manner consistent with applicable federal and state law, which includes maintaining the strict confidentiality of the proceedings.

6.C.8. Attendance Requirements:

(a) Attendance at meetings of the Medical Executive Committee, the Credentials Committee, and the [Peer Review/Professional Practice Evaluation Committee] is required. All members are required to attend 50% of all regular and special meetings of these committees during the course of the Medical Staff year. Failure to attend the required number of meetings may result in replacement of the member in the discretion of the chair of the relevant committee.

(b) Each member of the Active Medical Staff is expected to attend and participate in all other general Medical Staff meetings and applicable department, section/division, and Medical Staff committee meetings each year.

ARTICLE 7

BASIC STEPS

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

7.A. QUALIFICATIONS FOR APPOINTMENT AND REAPPOINTMENT

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

7.B. PROCESS FOR CREDENTIALING AND PRIVILEGING

(1) Complete applications for appointment and privileges will be transmitted to the applicable Department Chief, who will review the individual's education, training, and experience and prepare a written recommendation stating whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee *[or Allied Health Credentials Committee, as applicable]*. Once an application is deemed complete, it is expected to be processed within 120 days. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within the precise time period.

(2) The Credentials Committee will review the chief's recommendation, the application, and supporting materials and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the Department Chief's report, to the Medical Executive Committee for review and recommendation.

(3) When the request for privileges or scope of practice is made by an allied health practitioner, the Allied Health Credentials Committee shall review the report of the applicable Department Chief and make a recommendation to the Medical Executive Committee and subsequently follow the process outlined above.

(4) The Medical Executive Committee may accept the recommendation of the Credentials Committee *[or Allied Health Committee]*, refer the application back to the Credentials Committee *[or Allied Health Committee]* for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee *[or Allied Health Committee]*. If the recommendation of the Medical Executive Committee is to grant appointment or reappointment and

privileges, it will be forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual will be notified by the Hospital President of the right to request a hearing.

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

(1) Appointment and clinical privileges and scope of practice may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) complete and comply with educational or training requirements;

(iv) provide requested information; or

(v) attend a mandatory meeting to discuss issues or concerns;

(b) is arrested, charged, indicted, convicted, pleads guilty or enters a plea of no contest pertaining to any felony or misdemeanor involving the following, which will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) driving under the influence ("DUI"); (e) violent act; (f) sexual misconduct; (g) moral turpitude; or (h) child or elder abuse;

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

(d) in the case of an allied health practitioner, fails, for any reason, to maintain an appropriate supervision/collaborative relationship with a Supervising/ Collaborating Physician as defined in the Credentials Policy.

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

7.D. DISASTER PRIVILEGING

When the disaster plan has been implemented, the Hospital President, the VPMA, or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

7.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, any two of the following are authorized to suspend or restrict all or any portion of an individual's clinical privileges and scope of practice pending an investigation: the Hospital President, the President of the Medical Staff, the relevant Department Chief, the VPMA, the Medical Executive Committee, or the Board Chair.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Hospital President or the Medical Executive Committee.

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

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

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

7.F. INDICATIONS AND PROCESS FOR PROFESSIONAL REVIEW ACTIONS

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

7.G. HEARING AND APPEAL PROCESS

(1) The hearing will begin no sooner than 30 days, and no later than 90 days, after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members.

(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 be present but may not 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 individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

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

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

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

(2) Amendments to these Bylaws may be proposed by the Medical Executive Committee or by a petition signed by at least 10% of the voting members of the Medical Staff.

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

(4) The Medical Executive Committee may also present proposed amendments to these Bylaws to the voting staff by written ballot or e-mail, to be returned to Medical Staff Services by the date indicated by the Medical Executive Committee, which date shall be at least 14 days after the proposed amendment was provided to the voting staff. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

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

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

(7) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between representatives of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and

permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Hospital President to take place within two weeks after receipt of a request.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but shall be amended in accordance with this section. These documents include, but are not limited to, the Medical Staff Credentials Policy, policies and charters within the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) The Credentials Policy may be adopted and amended by a majority vote of the Medical Executive Committee, provided that (i) the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee; and (ii) notice of all proposed amendments is then provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place.

(3) An amendment to the policies and charters in the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to these two documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(4) The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee with regard to the adoption of the provisional amendments to the Medical Staff Rules and Regulations, the amendments shall stand. If there is conflict over the provisional amendments that are supported by a petition signed by 10% of the Active Staff, then the process for resolving conflicts set forth below shall be implemented.

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

(6) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 10% of the voting staff. Any such proposed amendments will be forwarded to the Medical Executive Committee for its final action.

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

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

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Medical Executive Committee supported by a petition signed by 10% of the voting staff, with regard to:

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

(b) a new policy proposed or adopted by the Medical Executive Committee; or

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

a special meeting of the Medical Staff to discuss the conflict may be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

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

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

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

8.D. UNIFIED MEDICAL STAFF PROVISIONS

8.D.1. Adoption of a Unified Medical Staff:

If the Board of Hartford HealthCare elects to adopt a single unified Medical Staff that includes the Hospital, the voting members of the Medical Staff may approve or opt out of the unified Medical Staff structure by conducting a vote in accordance with the process outlined in Section 8.A for amending these Medical Staff Bylaws.

8.D.2. Bylaws, Policies, and Rules and Regulations of the Unified Medical Staff:

Upon approval of a unified Medical Staff structure, the unified Medical Staff will adopt Medical Staff bylaws, policies, and rules and regulations that:

(a) take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and

(b) address the localized needs and concerns of Medical Staff members at each of the participating hospitals.

8.D.3. Opt-Out Procedures:

If a unified Medical Staff structure is approved, the voting members of the unified Medical Staff may later vote to opt out of the unified Medical Staff. Any such vote will be conducted in accordance with the process outlined in the Medical Staff Bylaws in force at the time of the vote.

ARTICLE 9

ADOPTION

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

Adopted by the Medical Staff:

December 14, 2017
(Date)

Approved by the Board of Trustees:

February 26, 2018
(Date)

APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) 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 (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) Documentation of the medical history and physical examination will be in accordance with the applicable Rules and Regulations of the Department, consistent with the patient's age, and must support the reason for admission and indications for surgical procedure(s), as appropriate. Documentation of the history and physical examination must include a provisional diagnosis with relevant positive and negative findings resulting from past medical history and review of systems and medical necessity for planned procedures/admission.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) 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. However, in these circumstances, the patient must also be evaluated within 24 hours after the time of admission/registration but prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination shall be based upon an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(c) H&Ps Performed by Allied Health Practitioners

(1) When a history and physical examination (or update to a history and physical examination) has been completed by an allied health practitioner who is required by Hospital policy to have medical record documentation

countersigned by a Supervising/Collaborating Physician, the documentation of the history and physical shall be countersigned by the Supervising/Collaborating Physician within twenty-four (24) hours after registration or admission (but in all cases prior to surgery or an invasive procedure requiring anesthesia services).

(2) When a history and physical examination has been completed by an allied health practitioner who has not been privileged by the Hospital, the admitting physician may either countersign the history and physical or conduct his or her own examination of the patient.

(d) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

(e) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the Medical Executive Committee, may be utilized. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings (e.g., general appearance, vital signs, etc.).

(f) Prenatal Records

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