MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF COVENANT HEALTH

MEDICAL STAFF BYLAWS OF COVENANT CHILDREN'S HOSPITAL

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MEDICAL STAFF BYLAWS

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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. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of these Bylaws. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by these Bylaws.

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

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

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

2.A. ACTIVE STAFF

2.A.1. Qualifications:

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

(a) are involved in at least 24 patient contacts per two-year appointment term; and

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

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Centralized 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 during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

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

2.A.2. Prerogatives:

Active Staff members may:

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

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

(c) hold office, serve as department chairs or section chiefs, serve on Medical Staff committees, and serve as chairs of committees; and

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

2.A.3. Responsibilities:

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

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department as may be required by the Medical Staff On-Call Policy;

(c) providing care for unassigned patients;

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

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

(f) accepting inpatient consultations, when requested;

(g) paying any application fees and assessments; and

(h) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

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

(a) are involved in at least six, but fewer than 24, patient contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

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

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Centralized 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 six patient contacts during his/her two-year appointment term will be transferred to another staff category that accurately reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting or Affiliate).

** Any member who has 24 or more patient contacts during his/her two-year appointment term shall be automatically transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

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

(b) may not hold office or serve as department chairs, section chiefs, or committee chairs;

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

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

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

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

(3) may be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities, if required by the Medical Staff On-Call Policy;

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

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

(g) shall pay any application fees and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

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

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment);*

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

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

Guidelines:

It is the intent of the Medical Staff leadership and the Board that the Consulting Staff category be available to practitioners in sub-specialty areas that are generally not well represented on the Active Staff, but who provide a needed service to the community. Therefore, if practitioners in a specialty area that has traditionally been represented on the

Active Staff request to transfer to the Consulting Staff, the Centralized Credentials Committee, MEC, and the Board may determine that such transfer requests are inappropriate. An individual is not entitled to a hearing if the Board determines not to grant a request to move to the Consulting Staff category as such a determination is not a "denial" of appointment or clinical privileges.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as department chairs, section chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

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

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

(e) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients;

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

(g) shall pay any application fees and assessments.

2.D. AFFILIATE STAFF

2.D.1. Qualifications:

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

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in the Medical Staff Credentials Policy with the exception of Section 2.A.1(c), (d), (k), (l), (m), (n), (o), (q), (r), (s), and (t); and

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

The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to

access Hospital services for their patients by referral of patients to Active Staff members for admission and care.

2.D.2. Prerogatives and Responsibilities:

Affiliate Staff members:

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

(b) may not hold office or serve as department chairs or committee chairs;

(c) shall generally have no staff committee responsibilities, but 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 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 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, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(k) may refer to the Hospital's infusion center and write appropriate orders to the same;

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

(m) may refer patients to the Hospital's diagnostic facilities; and

(n) must pay any application fees and assessments.

2.E. HONORARY STAFF

2.E.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years, who are in good standing, and who have been recommended for Honorary Staff appointment by the MEC.

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

2.E.2. Prerogatives and Responsibilities:

Honorary Staff members:

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

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

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

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

(e) may not hold office or serve as department chairs, section chiefs, or committee chairs; and

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

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active 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 MEC and approved by the Board. They must:

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

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

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

(4) not presently be serving as Medical Staff officers, Board members, department chairs, or committee chairs at any other hospital that is not affiliated with Covenant Health, and shall not so serve during their term of office;

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

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) participate in Medical Staff Leadership training as determined by the MEC or Medical Staff Leaders, and attend continuing education relating to Medical Staff Leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office;

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

(9) not have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with the Executive Physician Advisory Council (EPAC), the CEO, and the Board in matters of mutual concern involving the care of patients in the Hospital;

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

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

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

(e) serve as chair of the MEC (with vote, as necessary) and the Leadership Council 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, in consultation with the Leadership Council;

(h) be the spokesperson for the Medical Staff in its external professional and public relations; and

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

3.C.2. Vice Chief of Staff:

The Vice Chief of Staff shall:

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

(b) serve on the MEC and the Leadership Council;

(c) assume all such additional duties as are assigned to him or her by the Chief of Staff or the MEC; and

(d) become Chief of Staff upon completion of the Chief of Staff's term.

3.C.3. Immediate Past Chief of Staff:

The Immediate Past Chief of Staff shall:

(a) serve on the MEC and the Leadership Council;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the Chief of Staff or the MEC.

3.D. NOMINATIONS

(1) The Leadership Council shall submit the name of at least one qualified nominee for Vice Chief of Staff to the MEC at least 60 days prior to the election. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(2) Additional nominations may also be submitted in writing by petition signed by at least 10% of the Active Staff at least 15 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Council, and be willing to serve.

(3) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) The election shall be held solely by written or electronic ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

(2) In the alternative, at the discretion of the MEC, an election may also occur at a called meeting of the Medical Staff. Candidates receiving a majority of written votes cast at the meeting shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

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

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Board. Grounds for removal shall be:

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

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

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

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

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

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active 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 Chief of Staff shall be filled by the Vice Chief of Staff, who shall serve until the end of the Chief of Staff's unexpired term. In the event there is a vacancy in the Vice Chief of Staff, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

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

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

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

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

4.C. FUNCTIONS OF DEPARTMENTS

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

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND DEPARTMENT CHAIRS ELECT

Each department chair and chair elect shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Board after considering the recommendation of the MEC.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS AND DEPARTMENT CHAIRS ELECT

(1) Except as otherwise provided by contract, department chairs shall be elected by the department, subject to MEC approval and confirmation by the Board. Candidates for department chair shall be identified by the Leadership Council,

must meet the qualifications in Section 3.B, unless waived by the MEC, and be willing to serve. The election shall be by written or electronic ballot. Ballots may be returned in person, by mail, or by facsimile. All ballots must be received by the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected.

(2) Any department chair may be removed by a two-thirds vote of the department members, subject to Board confirmation; or by a two-thirds vote of the MEC, subject to Board confirmation; or by the Board. Grounds for removal shall be:

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

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

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

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

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

(3) 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 speak to the department, the MEC, or the Board, as applicable, prior to a vote on such removal. No removal shall be effective until approved by the Board.

(4) Department chairs shall serve a term of two years.

(5) The qualifications, election, removal, and term for the position of department chair elect shall be the same as that for clinical department chairs; however, the department chair elect shall automatically succeed the department chair at the end of the department chair's term. The department chair elect shall also automatically assume the position of the department chair if the department chair is unable or unwilling to complete the term for any reason.

4.F. DUTIES OF DEPARTMENT CHAIRS

Department chairs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

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

(2) coordinating all administratively-related activities of the department;

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

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

(5) evaluating requests for clinical privileges for each 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) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating interdepartmental and intradepartmental services;

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

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

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

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

(13) maintaining quality monitoring programs, as appropriate;

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

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

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

(17) appointing and removing section chiefs and a chair elect as deemed necessary, subject to approval of the MEC.

4.G. SECTIONS

4.G.1. Functions of Sections:

(a) Sections 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 chair or the MEC;

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

(6) discussion of a specific issue related to credentialing, professional practice evaluation, and/or performance improvement, at the request of a department chair or the MEC.

(b) No minutes or reports will be required reflecting the activities of sections, except when a section is making a formal recommendation to a department, department chair, Centralized Credentials Committee, or MEC.

(c) Sections shall not be required to hold any number of regularly scheduled meetings.

4.G.2. Qualifications and Appointment of Section Chiefs and Vice Chiefs:

(a) Unless otherwise provided by contract, section chiefs and vice chiefs shall be elected by the Active Staff members of the relevant section, subject to approval by the MEC. Candidates for section chiefs and vice chiefs shall be identified by the Leadership Council and must meet the same qualifications as department chairs as set forth in Section 3.B of these Bylaws, unless waived by the MEC.

(b) The removal and term for section vice chiefs shall be the same as that for clinical department chairs; however, section vice chiefs shall automatically succeed the section chief at the end of the section chief's term. The vice chief shall also automatically assume the position of the section chief if the section chief is unable or unwilling to complete the term for any reason.

4.G.3. Duties of Section Chiefs and Vice Chiefs:

The section chief and vice chief shall carry those functions delegated by the department chair or the MEC, which may include the following:

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

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

(c) evaluate individuals who are granted privileges in order to confirm competence;

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

(e) review and report regarding the professional performance of individuals practicing within the section; and

(f) support the department chair in making recommendations regarding the coordination of section activities, as well as the hospital resources necessary for the section to function effectively.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

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

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated by a specific committee composition, all committee chairs and members shall be appointed by the Leadership Council. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws. All committee chairs and members must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Medical Staff Organization Manual.

(2) Unless otherwise provided by a specific committee composition, committee chairs shall be appointed for an initial term of two years, and may serve additional terms. All appointed chairs and members may be removed and vacancies filled by the Chief of Staff at his/her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the EPAC, in consultation with the Leadership Council. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Chief of Staff, the EPAC, and the CEO shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

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

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the following voting members:

- the Chief of Staff;
- the Vice Chief of Staff;
- the Immediate Past Chief of Staff;
- the department chairs;
- the Hospital Representative Credentials Committee;
- the Medical Director of Trauma;
- representative members of the Active Staff to include two pediatricians (one primary care pediatrician and one pediatric hospitalist), one representative from obstetrics and gynecology, one representative from the Emergency Department, one representative from the NICU, one representative from the PICU, and one representative from Anesthesia (all of whom shall be selected by the Leadership Council to serve two-year terms); and
- four at-large members of the Medical Staff who shall be selected by the Leadership Council to be representative of the specialties of the Medical Staff who shall serve two-year terms.

(b) The Chief of Staff will chair the MEC.

(c) The CEO, the EPAC, shall be *ex officio* members of the MEC, without vote.

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

5.D.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. This authority may be removed 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 (the officers are empowered to act in urgent situations between MEC 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) 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;

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

(7) hearing procedures; and

(8) 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) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(h) providing and promoting effective liaison among the Medical Staff, Administration, and the Board; and

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

5.D.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.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) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

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

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

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

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

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

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

5.F. CREATION OF STANDING COMMITTEES

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

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the Chief of Staff and/or the MEC. Such special 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 at least once a year.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the MEC, the CEO, the Board, or by a petition signed by at least 10% of the Active Staff.

6.C. DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

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

6.C.2. Special Meetings:

A special meeting of any department, section, or committee may be called by or at the request of the Presiding Officer, the Chief of Staff, the CEO, or by a petition signed by at least 10% of the Active Staff members of the department, section, or committee (but in no event 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, sections, and committees at least 14 days in advance of the meetings. Notice may also be provided by posting in a designated location at least 14 days prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, a section, and/or a committee is called, the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

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

6.D.2. Quorum and Voting:

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

(1) for meetings of the MEC and the Committee for Professional Enhancement ("CoPE"), the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

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

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

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, a section, or a committee may also be presented with any question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the Chief of 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 MEC and the CPE (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

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

7.D.3. Agenda:

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

6.D.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, section, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

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

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

(b) A summary of all recommendations and actions of the Medical Staff, departments, sections, and committees shall be transmitted to the MEC. The Board shall be kept apprised of the recommendations of the Medical Staff and its clinical departments, sections, and committees.

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

6.D.6. Confidentiality:

All Medical Staff business conducted by committees, departments, or sections 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.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, the Regional Credentials Committee, and the CoPE is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

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

ARTICLE 7

INDEMNIFICATION

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

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Advance Practice Providers in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

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

8.B. PROCESS FOR PRIVILEGING

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

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

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

8.D. DISASTER PRIVILEGING

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

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

(1) Appointment and clinical privileges 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) provide requested information;

(iv) complete and/or comply with educational or training requirements;

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

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

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

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

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

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR one of the Chief of Staff, the Vice Chief of Staff, or the chair of a clinical department, acting in conjunction with either the EPAC or the CEO, is authorized to suspend or restrict all or any portion of an individual's clinical privileges as a precaution pending an investigation.

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

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

(4) The MEC 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 may be given an opportunity to meet with the MEC.

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Board may unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC 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 MEC prior to a vote by the Medical Staff.

(4) The MEC shall present proposed amendments to these Bylaws to the voting staff by written ballot or e-mail, to be returned to the Medical Staff Office by the date indicated by the MEC, which date shall be at least 14 days after the notice was provided. Along with the proposed amendments, the MEC 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) an amendment must receive a majority of the votes cast.

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

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

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

9.B. OTHER MEDICAL STAFF DOCUMENTS

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

Credentials Policy, the Policy on Advance Practice Providers, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Credentials Policy, Medical Staff Organization Manual, Policy on Advance Practice Providers, or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place. Any member of the voting staff may submit written comments on the amendments to the MEC.

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

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

(5) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Advance Practice Providers, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(6) 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.

9.C. CONFLICT MANAGEMENT PROCESS

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

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

(b) a new policy proposed or adopted by the MEC, or

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

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 10% of the voting staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

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

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

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff 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 CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Chief of Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

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

Adopted by the Medical Staff: November 17, 2017

Approved by the Board: December 5, 2017

Last Amended: March 21, 2023

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

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

Y = Yes
N = No
NA = Not Applicable
P = Partial (with respect to voting, only when appointed to a committee)

APPENDIX B

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

- chief complaint;
- history of present illness;
- social history, including any abuse or neglect;
- relevant past history appropriate to be patient's age
- physical examination
- assessments
- plan of treatment

(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 of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges to perform histories and physicals.

(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) 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, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, the operation or procedure will be canceled or delayed until an appropriate 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, a written progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis recorded before surgery will suffice.

The attending physician will complete and document a complete history and physical examination immediately following the emergency procedure.

(d) Short Stay Documentation Requirements

An assessment may be used in place of a History and Physical for patients undergoing non-invasive imaging procedures with sedation and for ambulatory or same day procedures otherwise appropriate for an office setting (e.g,, dental procedures). The assessment must be completed by a member of the medical staff and should include 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) 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.