

CONNECTICUT VALLEY HOSPITAL

BY-LAWS **of the** **GOVERNING BODY**

Helene Vartelas

Chief Executive Officer (CEO)
Chair, Governing Body

CONNECTICUT VALLEY HOSPITAL

THE BY-LAWS OF THE GOVERNING BODY

Article I Name and Principal Office

A. Name:

The name of this organization is the Connecticut Valley Hospital (CVH). CVH is located at 1000 Silver Street in Middletown, Connecticut.

B. Principal Office:

The principal office for the transaction of business by the Governing Body of CVH is located on the hospital campus at 1000 Silver Street, P.O. Box 351 in Middletown, Connecticut, 06457.

Article II Introduction

A. Role and Scope

CVH is a State operated psychiatric hospital with 386 inpatient beds and 10 residential beds, which provides services to adults (persons 18 years and over).

The hospital consists of two divisions:

1. General Psychiatry Division

2. Addiction Services Division

CVH is a facility for the treatment of patients with complex psychiatric and/or substance abuse disabilities, within a network of services provided by the Department of Mental Health and Addiction Services (DMHAS). The mission of the DMHAS, and therefore of CVH, is to recognize a special responsibility to those who are poor or medically indigent by designing programs to assure access to care for those in need. The hospital shall provide resources, support, and treatment services in the least restrictive environment necessary. Admissions may be on a voluntary or involuntary basis. No one is denied admission or treatment on the basis of race, color, religion, age, national origin, sex, sexual preference, physical disability or inability to pay.

B. Vision of CVH

To promote recovery through collaborative, compassionate, and culturally competent treatment in a safe and caring environment.

C. Mission of CVH

At Connecticut Valley Hospital, individuals receive treatment and services that assist them to better manage their illnesses, achieve personal goals, and develop the skills and supports that lead to living the most constructive and satisfying lives possible.

Article III Establishment and Organization of the Department of Mental Health and Addiction Services (DMHAS)

Statutory Authority

Pursuant to Public Act Sec. 17a-450 CGSA statutory authority is given for the creation and establishment of the DMHAS.

Article IV Structure and Composition

A. Governing Authority

In accordance with the Connecticut General Statutes Section 17a-451, there is a DMHAS headed by a Commissioner who is appointed by the Governor with the advice of the State Board of Mental Health and the approval of the General Assembly. The Department is operated with oversight by the Governor and the General Assembly and with the advice of the State Board of Mental Health and the regional and facility advisory boards. The Commissioner is the executive head of the state department and is a qualified person with experience in hospital, health, and mental health administration. The Commissioner functions as the Governing Authority of all offices, divisions, regions, facilities, and programs of the DMHAS. The Commissioner appoints facility directors. The Chief Executive Officer (CEO), the Chief Operating Officer (COO), and Division

Directors of CVH are all appointed by the Commissioner of the DMHAS. Ongoing communication occurs between the Office of the Commissioner and the Chief Executive Officer (CEO) of CVH through the Deputy Commissioner. The Chief of Professional Services (COPS), and the Chief of Staff are members of the DMHAS Clinical Chiefs, a group consisting of DMHAS facility clinical and Medical Directors which meets to review and discuss procedure matters. The Director of Care Management/Community Provider Relations participates in regional and community collaborative meetings. The COO participates in regional and community collaborative meetings.

B. Governing Body Authority, By-Laws, and Responsibilities

1. Authority

By directive of the Governing Authority, the Commissioner of the Department of Mental Health and Addiction Services, the CEO shall designate and appoint a Governing Body for CVH. The Governing Body of CVH will be chaired by the CEO. Membership in the Hospital's Governing Body will be appointed by the CEO and shall include Hospital leaders with representation as delineated in Article IV-C. Key leaders of CVH comprise the Governing Body of the hospital and are responsible to the Office of the Commissioner of the DMHAS for the operation of CVH. The Governing Body of CVH will meet at least monthly, and will report to the Office of the Commissioner through the CEO.

2. By-Laws

The Governing Body of CVH shall have By-Laws which specify the following:

- a. the role and purpose of the hospital;
- b. the duties and responsibilities of the Governing Body;
- c. the process and criteria for the selection of the Governing Body;
- d. the Governing Body's organizational structure;
- e. the requirement for the establishment of a medical staff;

- f. the mechanism for adopting the Governing Body By-Laws; and
- g. the mechanism of review and revision of the By-Laws.

3. **Responsibilities**

The Governing Body of CVH shall address issues of importance to the Hospital and to the Department of Mental Health and Addiction Services.

Responsibilities include:

- a. communicating between the Governing Body of CVH and the Office of the Commissioner;
- b. communicating among members of the Governing Body of CVH's administration, Medical Staff and Disciplines;
- c. strategic planning which incorporates the view of staff and service recipients;
- d. ensuring that patients receive care that is appropriate and medically necessary;
- e. ensuring sound fiscal management of resources;
- f. reviewing and approving clinical and performance standards relating to quality of care which ensures that one level of care is provided throughout the hospital;
- g. reviewing/approving all Operational Policies;
- h. developing a mechanism to review credentials and delineate individual clinical privilege;
- i. developing a mechanism to ensure the competence of all staff providing patient care services;
- j. taking action on the recommendations of the Medical Staff of CVH;
- k. taking action on the recommendations of other components of hospital leadership;
- l. reviewing and taking action on the procedures and results of the hospital's performance improvement activities;
- m. ensuring that CVH complies with State of Connecticut Ethical Guidelines and Policies for conducting fiscal operations;

- n. participating in due process procedures as specified in the Governing Body By-Laws and the By-Laws of the Medical Staff; and
- o. developing and implementing mechanisms to evaluate its own performance.

B. Duties and Responsibilities of the Chief Executive Officer (CEO)

The CEO of CVH shall be a competent and qualified person with experience in health, hospital, or mental health administration.

Responsibilities shall include:

- 1. to carry out all policies established by the Commissioner and to advise on the formation of policy;
- 2. to plan and coordinate administrative and patient care functions within the hospital; and to assure the inclusion, wherever pertinent, of members of the administration, of the Medical Staff, of the Nursing Discipline, and all other appropriate advisors as participants in the facility planning process;
- 3. to cooperate and coordinate with other departmental, facility-based, regional, and community programs, in establishing the hospital's procedures concerning program planning and development, patient admissions and discharges, rehabilitation, and follow-up services;
- 4. to assure the hospital's compliance with applicable law and regulation and to assure the review of and prompt action on reports of planning, regulatory, and inspecting agencies;
- 5. to meet the requirements of all pertinent regulatory bodies and, as directed by the Commissioner, to maintain accreditation with The Joint Commission (TJC) and certification by the Centers for Medicare and Medicaid Services (CMS);
- 6. to designate a person to act in the absence of the CEO;
- 7. to assure the establishment of efficient management and administrative functions throughout the hospital, including clear lines of responsibility and accountability;

8. to administratively oversee the Critical Incident Reporting Process in collaboration with the COPS.
9. to assure effective communication mechanisms between and among the administration, all functional components of the hospital, and the Governing Body;
10. to assure the implementation of a hospital-wide procedure on patient's rights and responsibilities;
11. to assure the implementation of a procedure requiring individual patient treatment plans;
12. to assure the planning, establishment, and implementation of an appropriate and effective Hospital-Wide Performance Improvement Program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems of patient care;
13. to assure that the impact on quality of care is considered in all hospital decisions and actions;
14. to assure the development of a compliance infrastructure that promotes adherence to applicable federal and state law, and the program requirements of federal, state and private health plans;
15. to assure effective and efficient personnel practices, to include the employment and retention of qualified personnel without regard to race, color, religion, age, national origin, sex, sexual preference, or physical disability. To assure that all personnel actions are in accord with state personnel statutes and regulations, and collective bargaining agreements, including those actions that are influenced by and initiated in response to issues arising from the requirements of the Governing Body By-Laws, the Medical Staff By-Laws, and monitoring of the quality of patient care;
16. to attain and maintain an approved affirmative action plan;
17. to select, subject to the approval of the Governing Authority, each

Department Director and each key manager with Hospital-wide responsibility;

18. to assure that all applicable licensure, certification, and registration is current and verified;
19. to prepare an annual hospital budget developed with the participation of the Medical Staff and all other leaders of the hospital to be submitted to the Governing Authority, for inclusion in the DMHAS consolidated budget;
20. to develop and revise annually a long-term capital expenditure plan for the hospital to be submitted for inclusion in the DMHAS long-term capital expenditure plan;
21. to prepare an annual report, developed with the participation of all divisions and departments of the hospital, and submit it to the Office of the Commissioner for integration with the Commissioner's Annual Report to the Governor;
22. to prepare and submit any other report or information requested by the Office of the Commissioner;
23. to attend the meetings of the Office of the Commissioner's Senior Staff or assure representation;
24. to regularly attend meetings of the CVH Advisory Council;
25. to be an ex-officio member of all hospital committees; and
26. to not undertake employment with another State Agency or DMHAS facility through part-time position, contractual agreement or fee for service arrangement that would conflict with his/her 24 hour, 7 days a week, on call responsibilities.

C. Selection and Designation of the Governing Body

In order to provide for the proper discharge of the duties and responsibilities of the Governing Body, the CEO shall select, with the approval of the Commissioner, a Chief of Professional Services (COPS); a Chief Operating Officer (COO); Chief of Staff (COS); a Director of Fiscal Services and Plant Operations; a Director of Facility Operations/Safety Officer; a Director of

Compliance and Performance Improvement; a Director of Staff Development, a Director of Patient Care Services/Nurse Executive; a Director of Ambulatory Care Services; a Director of Care Management/ Community Provider Relations, a Director of Accreditation and Regulatory Compliance; a Facility Human Resources Director; and a Director of Recovery and Consumer Affairs. In addition the President and President-elect of the Medical Staff, who are elected by the Medical Staff, will serve on the Governing Body.

The CEO delegates to each director the executive authority and responsibility for duties in his/her respective area(s) of administrative and technical expertise. As a group, these individuals are charged to actively promote consumer and family involvement and to ensure patient's rights. They are also designated by the CEO as the Governing Body of CVH, and each officer thereof.

D. The Organizational Structure of the Governing Body

1. Mechanism for Selecting Officers of the Governing Body

By virtue of authority and responsibility as the executive head and by appointment by the Governing Authority, the CEO shall function as Chairperson of the Governing Body. When absent, the CEO designates the Chief of Professional Services to function as Chairperson.

The CEO designates each member of the Governing Body as an officer thereof with duties and responsibilities as described in Article IV, D2. The CEO may delegate other duties within the Governing Body at any time as deemed necessary.

2. Responsibilities of Officers of the Governing Body

a. The CEO shall discharge the duties and responsibilities specified in Article IV-B. The CEO, as Chairperson, shall preside at all meetings of the Governing Body and shall assure secretarial service to prepare an agenda and give proper notice for each meeting, to record minutes of all

meetings, and retain the minutes in a permanent file. The CEO shall be responsible for assuring that approved procedures and programs are executed satisfactorily and in accord with these By-Laws and other DMHAS policies, as well as with State and Federal statutes and regulations, and that the impact on the quality of care is considered in all CVH decisions and actions.

The **Chief of Professional Services (COPS)** shall be a qualified psychiatrist licensed to practice medicine in Connecticut and shall have experience in hospital, health, or mental health administration. He/she shall be Board certified in Psychiatry by the American Board of Psychiatry and Neurology. He/she reports to the CEO, and is an active member of the hospital's Medical Staff.

Responsibilities shall include:

1. to oversee the hospital's day to day administrative operations as related to the functions of the patient care divisions of the hospital;
2. to oversee all clinical disciplines and competencies;
3. to oversee the function of the Division Medical Directors and the Medical Staff at large;
4. to serve as the Hospital Risk Manager and administratively oversee all Risk Management functions;
5. to provide administrative supervision for the Department of Ambulatory Care Services;
6. to be a member of the DMHAS Clinical Chiefs' Committee;
7. to serve and/or chair hospital committees at the discretion of the CEO; and
8. to assure, in coordination with the recommendations of the Division Medical Directors, the prompt, accurate preparation of clinical and educational contracts for the approval of the CEO, and appropriate administration

thereof.

- b. The **Chief of Staff (COS)** shall be a qualified psychiatrist licensed to practice medicine in Connecticut and shall have experience in hospital, health, or mental health administration. He/She shall be Board certified in Psychiatry by the American Board of Psychiatry and Neurology. He/She reports to the COPS, and is an active member of the hospital's Medical Staff.

Responsibilities shall include:

1. in conjunction with the President of the Medical Staff, to be responsible for the enforcement of Medical Staff By-Laws, Rules, and Regulations; to implement sanctions where these are indicated; and to ensure Medical Staff compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
2. to ensure the appropriateness of the Performance Improvement functions of the committees of the Medical Staff; and
3. in conjunction with the President of the Medical Staff, to receive and implement the procedures of the hospital related to Medical Staff functions.

- c. The **Chief Operating Officer (COO)** shall be a qualified person with clinical competency and shall have experience in mental health administration, and is appointed by the Commissioner and reports to the CEO.

Responsibilities shall include:

1. to oversee the hospital's day to day administrative operations as related to the functions of the patient care Divisions of the hospital;
2. to cooperate and coordinate with other departmental, facility-based regional and community programs, in

- establishing the hospital's procedures concerning program planning and development, patient admissions and discharges, rehabilitation, and follow-up services;
3. to actively promote consumer and family involvement and to ensure patient's rights;
 4. to systematically review the hospital's clinical programs through co-chairmanship with the COPS of the hospital's Clinical Management Committee (CMC);
 5. to make decisions on behalf of the CEO in his/her absence when designated to do so;
 6. to serve and/or chair hospital committees at the discretion of the CEO; and
 7. in the event that the COO position is vacant, the CEO will assign responsibility for these functions to other individuals within the organization.

- d. The **Director of Fiscal Services and Plant Operations** shall have experience in business, hospital, health, or mental health administration.

Responsibilities shall include:

1. to function as executive head of the Department of Fiscal Services and Plant Operations of CVH;
2. to oversee the general administration of all financial operations, the operations of all buildings and grounds at CVH to assure, in coordination with the proponent members of the Governing Body, the prompt, accurate preparation of contracts and grant requests for the approval of the CEO, and appropriate administration thereof;
3. to assure, in coordination with the COPS, that the impact on quality of patient care is considered in all administrative decisions and actions;

4. to provide technical assistance to the Directors of Divisions and Departments at CVH;
5. to prepare annually, for the CEO's consideration and approval, a single, consolidated budget for the CVH;
6. to develop and monitor long-term capital expenditure and information management plans for CVH;
7. to coordinate the Hospital's Safety Program in compliance with all applicable standards and regulations; and
8. to designate a Fiscal Services and Plant Operations representative for each Division with whom the respective Division leadership and staff can readily consult regarding Fiscal Services and Plant Operations.

- e. The **Director of Facility Operations/Safety Officer** shall have experience in hospital safety, construction, current Life Safety Code maintenance operations and the management of the Environment of Care.

Responsibilities shall include:

1. to coordinate the Hospital's Safety Program in compliance with all applicable standards and regulations;
2. to review, revise and update The Joint Commission Statement of Conditions;
3. to develop and monitor long-term capital expenditure projects for CVH;
4. to provide technical assistance to the division directors and hospital leadership;
5. to submit quarterly and annual reports on the Environment of Care for review and approval by the Governing Body; and
6. to act as Chair of the campus Environment of Care Committee in compliance with all applicable Joint

Commission standards.

- f. The **Director of Compliance and Performance Improvement** shall be a qualified professional by education and experience in hospital, health or mental health administration.

Responsibilities shall include:

1. to oversee the development and implementation of the Hospital Compliance Program;
2. to oversee the implementation of the Health Insurance Portability and Accountability Act (HIPAA) including privacy, security, and transaction regulations;
3. to develop and oversee the hospital Performance Improvement Plan in collaboration with the COPS;
4. to provide leadership in planning, implementing and evaluating performance improvement initiatives throughout the hospital;
5. to administratively oversee Performance Improvement, ~~and~~ Health Information Management, and the Department of Staff Development;
6. to oversee strategic planning, survey and accreditation activities and procedure development in collaboration with the CEO, COO, COPS, and the Director of Accreditation and Regulatory Compliance; and
to represent the hospital on the DMHAS Compliance Officers Committee.
7. To administer and oversee the CIR process with COPS....(see COO)

- g. The **Facility Human Resources Director** shall have experience in hospital, health or mental health administration, reflecting a broad scope of experience and training in Human Resources

management.

Responsibilities shall include:

1. to implement and ensure compliance with State, DMHAS and CVH procedures, Federal Labor Standards, State Regulations, including OSHA, The Joint Commission, CMS and applicable collective bargaining agreements;
2. to provide expertise and consultation in workforce planning and development to the hospital;
3. to serve as liaison for the hospital to the Employment Services Bureau, Payroll Services Bureau, and Labor Management Services Bureau;
4. to establish and implement operational procedures for the development and administration of functional job descriptions and ongoing competency based performance appraisals; and
5. to provide patient centered, dynamic and responsive Human Resource leadership and support necessary to enhance the effectiveness of our multidimensional organizational design, which emphasizes shared values and program/treatment team specific competencies.
6. to ensure that the hospital provides for a work environment which promotes and advocates for the benefits of a culturally diverse workforce, and one in which both professional growth and self-development is fostered.

- h. The **Director of Client Rights** shall be a qualified mental health professional and shall have experience in hospital, health or mental health administration.

Responsibilities shall include:

1. to oversee and coordinate recovery activities, plans and initiatives for the hospital;

2. monitor and oversee patient rights and the patient advocacy and grievance process;
3. to provide oversight for the development, implementation, and evaluation of patient advocacy;
4. to assure the hospital's compliance with statutes, internal and DMHAS Commissioner's policies and regulatory requirements for advocacy and grievance processes, patient rights, and recovery;
5. to monitor and develop performance improvement indicators for patient rights and recovery;
6. to act as liaison with division leadership with respect to issues regarding advocacy grievance and recovery;
7. to act as liaison and interface with relevant stakeholders and community constituents;
8. to provide consultation/training and direction to hospital divisions regarding advocacy grievance, patient rights, and recovery.

- i. The **Director of Patient Care Services** is the Nurse Executive of the hospital and shall be a qualified Registered Nurse with a Master's Degree in Psychiatric Mental Health Nursing or related field, licensed to practice nursing in Connecticut, and shall have experience in hospital, health or mental health administration.

Responsibilities shall include:

1. to function as the Nurse Executive for the hospital;
2. to oversee all professional nursing treatment activities; including the development of standards of practice and care for nursing;
3. to be chairperson of CVH's Nursing Executive Committee;
4. to provide technical supervision, consultation, and performance reports to each Division;
5. to ensure that all nursing staff are appropriately oriented

and trained for assigned/respective functions, and work units; and

6. to oversee patient safety initiatives for the hospital.

- j. The **Director of Staff Development** is the chief of training for the hospital, in-service training, and staff development and shall have primary responsibility for planning, developing, coordinating and implementing a staff development program.

Responsibilities shall include:

1. to develop the biennial Education Plan for the hospital;
2. to direct staff and operations of the training unit;
3. to plan and manage training activities;
4. to formulate program goals and objectives;
5. to assist in development of training and staff development procedures;
6. to interpret and administer pertinent laws and regulations concerning agency training;
7. to evaluate staff on the unit;
8. to maintain contacts with individuals both within and outside of agency who might impact on program activities; and
9. to provide consultative services to agency managers regarding organization development, and demonstrates commitment to meeting the CVH mission through providing services that reflect shared values, specific competencies and integrated service structures by providing excellent customer service in a recovery model.

- k. The **Director of Ambulatory Care Services** shall have experience in hospital, health or mental health administration.

Responsibilities shall include:

1. to facilitate that medical and surgical care be provided for

- the patients at CVH;
- 2. to administratively oversee the Patient Clinic
- 3. to assign staff of the Ambulatory Care Services to their posts and administratively supervise and evaluate their performance;
- 4. to administratively oversee:
 - a. the Dentistry Service;
 - b. the Pharmacy Unit;
 - c. Infection Control Service; and
 - d. Dietician Services
 - e. Speech Pathology
- 5. to oversee contracted medical support services including, but not limited to:
 - a. Podiatry Service;
 - b. Dialysis Service;
 - c. Laboratory Services;
 - d. Neurology Services;
 - e. Optometry;
 - f. Pharmacy Services;
 - g. Electrocardiograph (EKG) services;
 - h. Nephrology;
 - i. Portable Radiology Services.
- 6. to develop specialty clinics as appropriate to patient care needs.
- 7. Maintain Memorandums of Understanding (MOU) with Middlesex Hospital and St. Francis Hospital for emergency department services and medical/surgical specialty care.

1. The **Director of Care Management/Community Provider Relations:**

Responsibilities shall include:

- 1. to cooperate and coordinate with other departmental,

facility-based regional and community programs, in establishing the hospital's procedures concerning program planning and development, patient admissions and discharges, and follow-up services;

2. to provide oversight to the Department of Recovery and Consumer Affairs;
3. to provide oversight to the operation of the Admissions Department and the Utilization Review Management Department; and
4. to co-chair the facility-wide Utilization Committee which reports to the Governing Body twice per year.

m. The **Director of Accreditation and Regulatory Compliance** shall have experience in hospital, health, or mental health administration.

Responsibilities shall include:

1. to coordinate all Joint Commission and CMS Survey preparation, on-site activities and accreditation and regulatory Plans of Correction (POC);
2. to coordinate the hospital's input into the State Plan for Mental Health;
3. to coordinate Operational Procedure development through leadership of the Operational Policy and Procedure Committee. to coordinate the development of the hospital's Strategic Plan, Operational Plan and schedule of hospital planning activities;
4. to coordinate the Governing Body schedule of activities including revisions of the Governing Body By-Laws as needed; and
5. to oversee functioning of the Health Information Management (HIM) Unit.

- n. The President and President-Elect of the Medical Staff serve on the Governing Body as representatives of the Medical Staff.

Responsibilities shall include:

1. to communicate to the Governing Body findings, trends, and recommendations related to Medical Staff performance improvement;
2. in consultation with the Executive Committee of the Medical Staff, to appoint Medical Staff members to all Medical Staff Committees, except the Executive Committee, and to recommend candidates to the CEO for appointment to the hospital committees;
3. to represent the views and concerns of the Medical Staff to the Chief of Staff (COS) and the Governing Body;
4. in conjunction with the COS, to be responsible for the enforcement of Medical Staff By-Laws, Rules and Regulations, to implement sanctions where these are indicated, and to ensure Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
5. to recommend to the Governing Body the appointment and privileges of Medical Staff members;
6. in the absence of the COS, to receive and interpret the procedures of the hospital to the Medical Staff.

- o. The Division Directors shall be qualified persons with experience in the field of mental health or addiction services as appropriate for their assigned division.

Responsibilities shall include:

1. to function as the executive head of a clinical division in all its day-to-day operations, both clinical and administrative,

- subject to procedures established by the hospital;
2. to assess the needs of the patient populations in order to provide the appropriate clinical staff and administrative support for the operation of patient programs;
 3. to plan, coordinate, supervise and monitor a division's clinical and administrative functions in conjunction with other hospital divisions and departments;
 4. to ensure the development and enhancement of staff's skills, abilities, knowledge and attitudes to achieve the level of competencies required for treatment of specific population of patients;
 5. to develop, maintain and improve the necessary community linkages to ensure continuity of care for all patients;
 6. to establish and maintain division representation on the facility's Utilization Management Committee;
 7. to ensure a division's compliance with applicable laws and regulations, and to assure the review of, and prompt action on, reports from regulatory and inspecting agencies;
 8. to meet the requirements of all relevant regulatory and accrediting bodies, as directed by the COO;
 9. to ensure effective communication mechanisms between and among the administration, hospital-wide committees, and all professional components of the division through the implementation of Division Executive Committee meetings and Division Operations meetings;
 10. to ensure the implementation of hospital procedures on patient's rights and responsibilities in a Division;
 11. to assure the implementation of the hospital-wide procedures requiring individual patient treatment plans based on a comprehensive assessment of needs;
 12. to assure the planning, establishment, and implementation

of an appropriate and effective division-wide performance improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems of patient care;

13. to participate in the hospital's budget preparation and monitoring including the long term capital improvement plan;
14. to prepare an annual report for integration with the CEO's report to the Commissioner;
15. to ensure efficient communication as necessary with the Attorney General's Office, Superior Courts, Probate Courts, State's Attorney's Office, Public Defenders Office, individual attorneys, and patient conservators in order to comply with applicable State Statutes and to resolve medicolegal problems of patient care;
16. to attend meetings and participate in regional and statewide planning for service delivery system development; and
17. to represent the division, hospital, and DMHAS at community and interagency meetings, boards, and task force committees, or work groups.

1. **Meetings of the Governing Body**

- a. Meetings of the Governing Body shall be held at least monthly. All members shall attend, or be represented by a designee.
- b. Meetings are open to the public unless otherwise designated by the Chairperson as executive (or closed) session meetings.
- c. Meetings of the Governing Body shall have an agenda prepared in advance and proper notice shall be provided to the members. Minutes shall be recorded and kept in a permanent file. A quorum

is defined as 60% of the committee's membership (including membership designees) being present to conduct the business at hand.

- d. The agenda of the Governing Body shall, with the guidance and consent of the CEO, include any pertinent issues brought before it including, but not limited to, the making of policy, the planning, implementation and coordination of services, the standards of quality of care, administrative and personnel issues, budget matters, and consideration of reports received. Issues for action of the Governing Body which have hospital-wide impact shall be acted upon by the Governing Body as a whole. Issues that are division specific shall be acted upon ordinarily by the Division Executive Committee.

2. **Committees of the Governing Body**

There shall be standing, special, or appellate review committees of the Governing Body. Such committees shall be designed and appointed by the CEO who shall appoint the Committee Chair. The CEO shall be an ex-officio member of all committees of the Governing Body. Whenever committees of the Governing Body deliberate issue(s) affecting the discharge of medical staff responsibilities, such committee(s) shall include members of the Medical Staff as a representative/attendee with a voice. Each committee meeting shall have an agenda, proper notice shall be provided to the members, and minutes of its meeting shall be submitted to the CEO for review and for the permanent file, including a listing of those present. To constitute a quorum for a committee of the Governing Body, 60% of the membership must be present to conduct the business at hand. Each committee, through its chair or co-chairs, distributes minutes of committee meetings to Governing Body members. Minutes are also posted to committee subfolder located in the Governing Body folder on the T-Drive. Performance Indicators are presented to Governing Body quarterly as applicable.

3. **Standing Committees**

a. **Operations Council**

This committee is chaired by the CEO. Membership shall consist of: the CEO, COO, COPS, the COS, the Director of Compliance and Performance Improvement, the Director of Staff Development, the Director of Fiscal Services and Plant Operations, the Director of Facility Operations/Safety Officer, the Director of Patient Care Services/Nurse Executive, the Director of Recovery and Consumer Affairs, Director of Clients Rights, the Facility Human Resources Director, The Director of Care Management/Community Provider Relations, the Director of Ambulatory Care Services, the two Division Directors, the Director of Accreditation and Regulatory Compliance, and the Directors of Social Work, Psychology, and Rehabilitation Services. Meetings occur weekly.

Responsibilities include:

1. to coordinate the day-to-day operations of the facility;
2. to ensure effective two way communication between the hospital staff and leadership as to the operating concerns of the facility;
3. to oversee new initiatives as they are implemented across the facility.;
4. to ensure that the facility remains in full compliance with the Joint Commission and CMS standards; and
5. to ensure that the workforce planning needs of the facility are met.

b. **Quality, Risk and Safety Committee**

This committee is chaired by the CEO. Membership shall consist of: the COO, COPS, COS, Director of Ambulatory Care Services, Director of Psychology, Director of Patient Care Services/Nurse Executive, Director of Compliance and Performance Improvement, Director of Accreditation and Regulatory Compliance, Division Directors, Division Medical

Directors, Director of Plant Operations & Safety Performance Improvement Managers, Director of Staff Development.

Responsibilities include:

1. to ensure a planned, systematic and hospital-wide approach to improving quality and safety, focusing on outcomes of treatment, care and services;
2. to oversee all risk management activities, including the status and effectiveness of reviews and corrective actions of the Division Review Committees and the Hospital Review Committee;
3. to monitor the hospital's incident and risk management processes to reduce or eliminate the risk of harm to patients, employees and visitors;
4. to ensure that divisions, disciplines and departments representing the scope of care and services across the hospital work collaboratively to minimize risk in the environment and plan and implement improvement activities;
5. to review and analyze aggregate hospital-wide incident and risk management data and identify individual and systematic patterns and trends;
6. to develop and implement corrective actions, including:
7. Investigation of identified patterns and trends;
8. Referral to various committees, teams and staff for corrective actions;
9. Assignment of a Performance Improvement Project/Team;
10. Implementation of systemic changes; and
11. Future monitoring needs and other follow-up activities.
12. to ensure the implementation and effectiveness of remedial actions as demonstrated by outcome data;
13. to review and revise risk management policies, procedures, and practices as indicated by hospital data;

14. to incorporate root cause analysis findings into safety and performance improvement activities to effectively reduce factors that contribute to unanticipated adverse events and/or outcomes;
15. to review recommendations from the management of Environment of Care (EC) Committee and implement measures to improve safety; and
16. to monitor the status of managing risks identified on the hospital's Environmental Hazards Risk Assessment.

c. **Hospital Review Committee (HRC)**

This committee is chaired by the COS and functions under the auspices of the Quality, Risk and Safety Committee. Membership shall consist of: the CEO, COO, COPS, Director of Ambulatory Care Services, Director of Patient Care Services/Nurse Executive, Director of Psychology, the Behavioral Intervention Service Director, ; the GPD Division Director; the Director of Rehabilitation Therapy Services, and Director of Compliance and Performance Improvement.

Responsibilities shall include:

1. to review all patients who (a) meet threshold for triggers; (b) are placed on the high-risk list for a second time in a six-month period, or (c) remain on the high-risk list for six consecutive months for the same reason as defined in the hospital's Risk Management procedure.
2. to provide recommendations, with rationale, to the Interdisciplinary Treatment Teams based on clinical review of each individual who meets threshold for triggers for further assessments and/or interventions;
3. to consider the need for additional psychology services including assessments and the development and implementation of specific behavioral, psychosocial and cognitive rehabilitation interventions;
4. to provide oversight and consultation to Interdisciplinary

Treatment Teams in the management of patients on the high-risk list for behavioral, psychiatric, and medical conditions; and

5. to hold regular bi-weekly meetings;
6. to maintain and forward meeting minutes, including conclusion and recommendations to the Quality, Risk and Safety Committee following each meeting.

d. **Investigation Review Committee (IRC)**

This committee is chaired by the Director of Patient Care Services/Nurse Executive and functions under the auspices of the Quality, Risk and Safety Committee. Membership shall consist of: the CEO, COO, COPS, Division Directors, Facility Human Resources Director, Facility Labor Relations Representative, Director of Compliance and Performance Improvement, Director of Patient Rights, appropriate Discipline Director(s) for alleged perpetrator(s) of abuse, neglect or exploitation under investigation. Two clinical staff (e.g. COPS, Discipline Director), one representative from Performance Improvement, and two additional members will be present for all IRC meetings.

Responsibilities shall include:

1. to review all investigations concerning abuse, neglect or exploitation to determine if they were conducted according to the Investigations Manual guidelines and appropriate corrective actions were taken in response to investigation findings;
2. to identify and track disciplinary and programmatic corrective actions to ensure effective and timely implementation;
3. to track the timeliness of reports in the IRC minutes.

e. **Environment of Care (EC)**

This committee is chaired by the Director of Facility Operations/Safety Officer and functions as a subcommittee of the Quality, Risk, and Safety Committee. Membership shall consist of: representatives from the divisions, departments, the Director of Accreditation and Regulatory

Compliance, and the Affirmative Action Officer. Division Representatives are either chairs or members of the division-based EC Committees. Meetings are held monthly, but may meet more frequently at the discretion of the chairperson.

Responsibilities shall include:

1. to develop hospital-wide procedures based on Joint Commission Standards and other regulatory entities for review by the Governing Body;
2. to establish functional work teams that develop procedures for review of each management plan and monitoring activities to comply with applicable standards and regulations;
3. to review hospital safety procedures;
4. to review the results of surveillance activities and monitor the correction of deficiencies and Hot Spots;
5. to review data collected by Divisional EC Committees that relates to the Environment of Care;
6. to conduct the hospital's Environmental Hazards Risk Assessment identifying potential risks, prioritizing identified risks and recommending ways in which to manage risks for review and approval by the Quality, Risk, and Safety Committee;
7. to regularly report to the Quality, Risk, and Safety Committee on the status of managing risks identified on the hospital's Environmental Hazards Risk Assessment;
8. to plan, implement and review semi-annual disaster drills; and
9. to advise the Quality, Risk and Safety Committee of the Environment of Care issues that require further resources or higher jurisdiction for resolution.

f. **Clinical Management Committee**

This committee is co-chaired by the COO and the COPS. Membership shall consist of: the COS, the Director of Patient Care Services/Nurse Executive, the Director of Psychology, the Director of Social Work, the

Director of Rehabilitation Services, the Division Directors, the Director of Health Information Management, the Director of Ambulatory Care Services, the Director of Accreditation and Regulatory Compliance and Director of Compliance and Performance Improvement.

Responsibilities include:

1. to oversee the development and communication of Standards of Practice and to establish monitors to assure that professional staff of the various disciplines (employed and contracted) are providing competent clinical care that meets or exceeds community standards;
2. to oversee the quality, appropriateness and integration of treatment services in providing patient care;
3. to oversee discipline quality improvement plans and key indicators;
4. to promote collaboration and input among disciplines around key clinical issues;
5. to ensure standardization of clinical documentation processes;
6. to review clinical programs for appropriate utilization of evidence-based best practices and to ensure that needs and expectations of patients and staff are being fulfilled.

g. **Continuing Medical Education Committee**

The committee shall be chaired by the Chief of Staff, as a joint committee of the Governing Body and the Medical Staff. Membership shall consist of: the Director of Staff Development; the CME Coordinator, representatives from the Professional Disciplines (Nursing, Psychology, Social Work), Pharmacy and Ambulatory Care Services. Meetings occur quarterly, at a minimum of four (4) meetings per year. Additional meetings will be called as needed.

Responsibilities shall include:

1. to assess the education, training and competencies required of Medical Staff and professional hospital staff based on the

qualifications, competencies and staffing necessary to provide specialized services;

2. to identify educational needs and recommend appropriate Continuing Medical Education (CME) and other educational offerings;
3. to regularly monitor and evaluate the quality and appropriateness of Medical educational offerings, staff competence patterns and trends so as to identify and respond to staff learning needs;
4. to maintain accreditation as a provider of CME by the Connecticut State Medical Society; and

h. **Ethics Committee**

The committee is chaired by the COS. Membership shall consist of: representatives from the Professional Disciplines, Divisions, Medical Staff, a representative from Patient Advocacy and Grievance, the Compliance Department, Fiscal Services and Plant Operations, Ambulatory Care Services, and Rehabilitation Services. Meetings are held monthly, but may convene more frequently at the discretion of the chairs.

Responsibilities include:

1. to provide a forum and a process in which treatment teams and individuals (patients, families, clinicians, community members and others) can explore ethical issues and concerns;
2. to provide case consultations to help focus ethical questions and formulate strategies for consideration;
3. to assist clinical teams with questions and concerns regarding such Patient's Rights issues as conservatorship, capacity to give informed consent, and emergency and involuntary medication;
4. to develop in-service modules and learning experiences that inform the hospital staff about the ethical aspects of patient care;
5. to review hospital policies and procedures relating to the ethical aspects of patient care including, but not limited to, end of life

issues, advance directives, withdrawal of life-sustaining treatments, pain management and organ donation; and

6. to advise the hospital leaders on issues involving organizational ethics such as conflict of interest. The committee may initiate suggestions for policy additions or changes, mindful of its major role of being advocating for patients and of improving organizational performance.

i. **Hospital Compliance Committee**

The Hospital Compliance Committee is chaired by the Director of Compliance and Performance Improvement. Membership shall consist of: CEO, COO, the Director of Fiscal Services and Plant Operations, the Director of Accreditation and Regulatory Compliance, the Division Directors, the Director of Health Information Management (HIM), the COS, the Director of Admissions and UM; a Utilization Review Nurse Coordinators, the Director of Patient Care Services/Nurse Executive, the IT Director, and a representative from Human Resources. The Hospital Compliance Committee will meet bi-monthly or a minimum of six times annually and provide a semi-annual report to the Governing Body.

Responsibilities include:

1. to implement monitoring, auditing and other evaluative techniques to identify and/or investigate potential risk areas for the hospital. This includes, but is not limited to, claims and billing operations to reduce the risk of the hospital submitting false or inaccurate claims to federal or private payors and the Periodic Performance Review required for accreditation;
2. to implement systems to promote the prevention, detection and resolution of instances of conduct or performance that do not conform to federal and state law, accreditation requirements, health care regulations and federal, state and private health plan program requirements;

3. to ensure the hospital's commitment to compliance is integrated in all policies and procedures;
4. to develop and implement training programs for employees to communicate essential elements of the hospital Compliance Program; and
5. to implement a methodology that encourages employees to report potential compliance problems without fear of reprisal.

j. **Utilization Management Committee (UM)**

This committee is co-chaired by the Chief of Professional Services and the Director of Community Provider Relations. Membership shall consist of: Director of Admissions and Utilization Management, a Medical Director or Service Medical Director from each hospital division, the Division Director or designee from each hospital division, and the Director of Social Work.

Responsibilities shall include:

1. Oversight of the hospital's Utilization Review Plan, which meets standards established by the Joint Commission, CMS, responsible peer review organizations and other external regulatory bodies;
2. Identification of necessary data and development of reports needed to understand and monitor utilization activity at CVH;
3. Review of data on admissions, discharges and lengths of stay to ensure effective use of hospital resources;
4. Review of data on concurrent or continued stay reviews to ensure that individuals are benefiting from and continue to require treatment at a hospital level of care;
5. Review of readmission data to monitor for trends that would indicate reasons for concern;
6. Study and attempt to remedy any identified over or under utilization of inpatient beds;

Meetings will be held, at a minimum quarterly.

k. **Ad-Hoc Committees**

1. The Governing Body can direct the establishment of Ad-Hoc Committees to accomplish certain objectives as warranted.

Article V Organized Medical Staff

A. Authority

CVH shall have an organized medical staff in accordance with the Medical Staff standards set forth in the most current The Joint Commission (TJC) Manual for hospitals and approved by the Governing Body. The Medical Staff of CVH shall have overall responsibility for the total clinical care of patients at CVH and shall account therefore to the Governing Body. There shall be a mechanism to assure that all individuals with clinical privileges or credentials provide their services within the scope of their clinical practice.

B. By-Laws

The Chair of the Governing Body of CVH shall assure that the Medical Staff develop and adopt By-Laws and rules and regulations that are consistent with the Governing Body By-Laws; Department of Mental Health and Addiction Services policies; federal and state statutory and regulatory requirements; the current Joint Commission standards; and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation. The Medical Staff By-Laws shall provide for procedures by which the Medical Staff is organized, including the selection of officers, in order to establish leadership and a functional structure to accomplish its tasks. Such by-laws and rules and regulations shall be reviewed at least every two years by the Medical Staff, and revisions and/or amendments adopted as appropriate. By-Laws revisions, or amendments adopted by the Medical Staff shall be subjected to, and effective upon, approval of the Governing Body. Approval shall be promptly provided unless specific reason is given for withholding approval.

Article VI Discipline Chairs and Associate Chairs

Each professional discipline will have a chairperson appointed by the CEO to take responsibility for establishing standards of practice for their respective disciplines and monitoring professional activities in accordance with accepted performance

improvement practices and policies.

Those discipline chairs with other centralized functions (those not assigned to a division), will designate associate chairs for each Division to ensure that professional discipline practices are uniform across divisions. Discipline Chairs and Associate Chairs are responsible for professional supervision of their subordinate staff in the respective divisions.

Article VII Quality of Patient Care

The CEO of CVH shall require the Medical Staff, each division, each department, and each office in the hospital to implement mechanisms for monitoring and evaluating the quality of patient care and services, for identifying and resolving problems in patient care and services, and for identifying opportunities to improve patient care and organizational performance. The CEO shall require each discipline to implement mechanisms to monitor the performance of persons providing care. The results of these activities shall be reported, as appropriate, to the Office of the Commissioner. Review and action on these items shall ordinarily be accomplished through oversight by the Governing Body of CVH. Items appropriate for action at a higher level may be forwarded to the Medical Director at the Office of the Commissioner.

A. Performance Improvement and Uniformity of Care

As guided by TJC standards and CMS Conditions of Participation for improving organizational performance, the Governing Body of CVH shall establish, implement and maintain systems designed to assess and improve the quality of patient care and organizational performance. Such systems shall be implemented recognizing that quality care involves integration of services across programs and over time. Furthermore, mechanisms shall be established to assure that each person served by CVH will receive, as appropriate for each condition, the same level of care without regard to race, color, religion, age, national origin, sex, sexual preference, physical disability or inability to pay/social status.

B. Use of Information Systems and Performance Indicators

Quality improvement activities throughout CVH shall be integrated using information management systems that permit comparison and analysis of empirical data and performance indicators across programs and divisions.

C. Performance Improvement Plans and Periodic Reports

As directed by the CEO, each Division and Department shall develop and implement plans and produce periodic reports regarding performance improvement activities. These plans and reports shall be submitted to the Governing Body quarterly. The Governing Body shall review the plans and reports, provide comment to the Division or Department and, through the CEO, bring such matters to the Office of the Commissioner as deemed appropriate or as directed by the Commissioner or his Deputies.

D. Competence to Provide Quality Patient Care

Each professional Discipline of CVH shall develop, implement and maintain systems designed to assure that each individual who provides patient care services is competent and/or credentialed to provide such services and has current licensure and/or certification, if applicable. Such systems shall include, but not be limited to, establishment and adherence to standards of care and performance assessment processes; supervision and evaluation of staff; and use of continuing education to provide ongoing training.

Article VIII Patient Rights and Patient Education

CVH shall maintain a Patients' Rights Program consistent with the Patients' Rights Standards as set forth in the Department of Mental Health and Addiction Services Patients' Rights Manual and the Commissioner's Policy Statement. The Director of Client Rights shall be responsible for the Patient's Rights Program at CVH. The Patients' Rights program shall recognize and identify the rights of patients as an integral part of the treatment process. Every patient is entitled to receive humane and dignified treatment at all times, with full respect for his/her personal dignity and right to privacy.

The CEO of CVH shall foster a patient environment of humane and dignified treatment at all times that respects the rights of patients and recognizes that each patient is an individual with unique health care needs who must be treated with a specialized treatment plan suited to his/her disorder.

The CEO of CVH shall ensure the following:

1. that patients be given opportunities for self-determination;
2. that environments be established that promote patient empowerment;
3. that the Hospital has a patient grievance procedure; and
4. that consumer organizations are encouraged and permitted to provide education and advocacy to patients.

Article IX Conflict of Interest

- A.** CVH is fully owned and controlled by the State of Connecticut, except where programs and/or services are contracted from individuals, private organizations, private non-profit organizations, municipalities, or other entities of state government. Such Department of Mental Health and Addiction Services contracts with individuals or organizations are a matter of public record.
- B.** No member of the Governing Body or any employee of the Department of Mental Health and Addiction Services may receive financial benefit from the operation of the Department of Mental Health except for lawful compensation for services provided to the state.
- C.** The authority or position of the Governing Body or confidential information about CVH may not be used for private purposes except as provided by law.
- D.** The CEO shall require prompt investigation of apparent conflict of interest within CVH and shall refer pertinent cases to the Office of the Commissioner for possible evaluation by the State of Connecticut Ethics Commission and/or the Attorney General.

Article X Mechanisms for Resolving Conflicts

There are mechanisms designed for resolving conflicts among leaders and individuals under their leadership. The Medical Staff has a mechanism to resolve conflicts within the Medical Staff By-Laws. Conflicts between the Medical Staff and Governing Body may be resolved through referral and/or appeal to the Medical Director of the Department of Mental Health and Addiction Services. Administrative and Managerial Staff resolve conflict in accordance with grievance procedures outlined in the State of Connecticut Personnel Regulations. Clinical and other staff conflict resolution procedures are outlined in their respective Collective Bargaining Agreements. All issues related to patient care are arbitrated by the CEO and COPS. The effectiveness of these mechanisms are periodically reviewed and modified to improve their effectiveness as needed.

Article XI Performance of the Governing Body

- A.** Each member of the Governing Body shall be required annually to identify and to implement performance objectives in the individual member's area of authority and responsibility. Such performance objectives shall be based upon annual departmental objectives set by the Commissioner. The Commissioner shall annually evaluate the relevant performance of the CEO.

- B.** The Governing Body shall regularly monitor the quality of patient care and the efficiency and effectiveness of administration throughout CVH for indications as to its own performance.

- C.** The Governing Body shall regularly monitor standards and parameters of mental health care within Connecticut in order to benchmark or compare with relevant parameters in other jurisdictions for indications as to its own performance.

- D.** The Governing Body may request an independent outside consultant or group to evaluate its performance in one or more respects.

- E.** The Governing Body may request the State Board of Mental Health and/or other

advisory bodies to evaluate its performance in one or more respects.

- F.** The Governing Body may meet for the specific purpose of considering its own performance in one or more respects.
- G.** The Commissioner of Mental Health and Addiction Services regularly reviews aspects of the performance of the Governing Body. He/she may reach conclusions, make recommendations or take appropriate actions.

Article XII Orientation and Education of the Governing Body

New members of the Governing Body shall have a thorough orientation to the Connecticut Department of Mental Health and Addiction Services, to CVH, and to the rights and duties of a member. The Chairperson of the Governing Body or designee shall provide an overview of the functioning of the Governing Body. The new member shall be provided with a copy of these By-Laws, and access to all laws pertaining to mental health and the Department of Mental Health and Addiction Services, as well as all pertinent policies, procedures, rules, and regulations approved by the Governing Body of CVH. The new member shall also have a copy of the most recent annual report and any other information deemed appropriate by the Chairperson. Key staff members shall meet with the new member to describe current operations and future plans and goals. Tours of the Hospital with appropriate staff briefings shall be carried out.

An orientation to the responsibility of the Governing Body for quality of care and to the hospital's performance improvement programs shall be provided. Each member of the Governing Body shall participate in ongoing education programs appropriate to the member's duties, training, and professional identity.

The Chairperson shall be responsible for assessing the educational needs of the Governing Body as a whole and for making recommendations or taking steps to meet those needs.

Article XIII Adoption and Amendment of Governing Body By-Laws

The Governing Body shall, after consideration and review, adopt these By-Laws by an affirmative vote of at least two-thirds of the members of the Governing Body subject to approval by the Commissioner of DMHAS. Thereafter, these By-Laws may be amended, repealed or altered in whole or in part, by an affirmative vote of at least two-thirds of the members of the Governing Body subject to approval by the Commissioner of DMHAS. Any such action concerning the Governing Body By-Laws may take place at any meeting, regular or special, where such action has been announced.

Helene Vartelas

*Helene Vartelas, MSN, Chief Executive Officer (CEO)
Chair, Governing Body*

Approved at Governing Body: January 25, 2018

Revised: January 25, 2018;