

**CONNECTICUT VALLEY HOSPITAL
MEDICAL STAFF BY-LAWS
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CONNECTICUT VALLEY HOSPITAL MEDICAL STAFF BY-LAWS

PREAMBLE

The Medical Staff is responsible for the quality of total medical and psychiatric care of all patients at Connecticut Valley Hospital (hereinafter referred to as CVH). It accepts and discharges that responsibility, subject to the ethics and standards of care of the medical profession, to the statutes of the State of Connecticut, to the administrative authority of the Chief Executive Officer, and to the overall supervision and direction of the Commissioner of Mental Health and Addiction Services. The cooperative efforts of the Medical Staff, the Administration, and the Governing Body are necessary to fulfill the obligation of the CVH to its patients. Therefore, the physicians, Advanced Practice Registered Nurses, physician assistants, and dentists practicing at CVH hereby organize themselves into a Medical Staff in conformity with these By-Laws.

These By-Laws, which are developed and adopted by the Medical Staff, become effective when approved by the Governing Body. Neither the Medical Staff nor the Governing Body can amend them unilaterally.

Many Medical Staff Committees and Sub-Committees evaluate the quality and efficacy of patient care services. It is intended and understood that when engaged in such activities, each committee or subcommittee created or referred to, in or authorized by these By-laws or the By-laws of the Governing Body of Connecticut Valley Hospital, particularly when participating in a credentialing, re-credentialing, investigative or disciplinary matter, may at times serve as Medical Review Committees as defined in Section 19a of the Connecticut General Statutes, as amended from time to time. Proceedings of all of these Medical Review Committees, including minutes and other documents from meetings, shall be kept strictly confidential, as sub-committees of the Peer Review Committee.

ARTICLE I. DEFINITIONS

1. The term “Medical Staff” shall be interpreted to mean and include: (1) all fully licensed physicians and dentists permitted by Connecticut State Law and CVH to practice medicine or dentistry independently at the Hospital within the scope of their delineated clinical privileges; (2) Adjunct members; and (3) Advanced Practice Registered Nurses permitted by Connecticut State Law and CVH to practice medicine, and Physician Assistant members as defined in Article V. All Medical Staff members are subject to Medical Staff By-Laws and to review as part of the Hospital’s Performance Improvement Program.
2. The term “Governing Body” shall be defined in the Governing Body By-Laws.

The Medical Staff shall have membership at meetings of the Governing Body.

3. The “Chief Executive Officer” is appointed by the Commissioner of Mental Health and Addiction Services, chairs the Hospital’s Governing Body, and assures the establishment and effective management of administrative functions throughout the hospital. The Chief Executive Officer also serves as an ex-officio member of the Executive Committee of the Medical Staff.
4. The “Chief of Professional Services” is a psychiatrist who is responsible for overseeing the day-to-day clinical operations of the hospital and developing and overseeing the performance improvement activities for the hospital and serves as an ex-officio member of all Medical Staff Committees.
5. The “Chief of Staff” is a psychiatrist who serves as the liaison to the Governing Body and is responsible for ensuring the appropriateness of the performance improvement activities of the

Medical Staff. He/she in conjunction with the President of the Medical Staff enforces the Medical Staff Bylaws and Rules and Regulations and, along with the Chief of Professional Services, serves as an ex-officio member of all Medical Staff Committees.

6. There are two divisions of Connecticut Valley Hospital: the Addiction Services Division (ASD) and the General Psychiatry Division (GPD). Each division will have a "Division Medical Director" who shall be a psychiatrist with administrative leadership and clinical responsibility and will report directly to the Chief of Professional Services.
7. "Service Medical Directors" shall be psychiatrists with administrative leadership and clinical responsibilities for a specific clinical service(s) within a division and will report directly to the applicable Division Medical Director.
8. The Chief of Professional Services who in conjunction with the Director of Ambulatory Care Services oversees the performance of the general medical physicians, APRN's, physician assistants, consulting specialists, medical/surgical specialists, dentists, the Infection Prevention coordinators, and those clinicians and technicians who provide employee health, radiology and ancillary services to the hospital.
9. The term "Clinical Services Staff" shall be interpreted to include members of the disciplines of nursing, psychology, social work, pharmacy, rehabilitation therapy, and pastoral services. The services provided by the Clinical Services Staff on each unit are under the direction and review of the attending psychiatrist. The Clinical Services Staff may be authorized by the Medical Staff to provide clinical services within well-defined limits based on professional licensure, experience, competence, ability and judgment.

ARTICLE II. NAME

The name of this organization shall be the "Medical Staff of Connecticut Valley Hospital."

ARTICLE III. PURPOSE

The purpose of this organization shall be:

1. To ensure that the Medical Staff has a leadership role in organization performance improvement activities and actively participates in measuring, assessing, and improving the performance of the organization within which its members practice. This staff leadership and active participation takes place at various levels within the organization. The Medical Staff works with the hospital's Performance Improvement structures to identify, measure, assess and redesign processes required to meet established standards of practice, particularly in those areas of clinical care that are identified as high volume, high risk, or problem-prone. It communicates its findings, conclusions, recommendations, and corrective actions referable to performance improvement through its committee structure to the Governing Body and the committee of the Governing Body. Individual members are designated to perform the oversight activities of the Medical Staff at the treatment team level. In this capacity, they monitor and are aware of the performance improvement processes and patient satisfaction issues that impact upon the care provided by the treatment team.
2. To establish, enforce, and maintain high standards for medical practice, professional integrity, and ethics in the care of patients and in professional relations.
3. To establish, maintain and ensure a program of highest quality continuing medical education for the Medical Staff and to assist in educational programs for other clinical staff.
4. To provide a procedure for the appointment, reappointment and privileging of the Medical Staff.
5. To develop and adopt by-laws and rules and regulations which establish a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence, be self-governing and be accountable for the Governing Body.

6. To provide a mechanism for the resolution of conflicts within the Medical Staff. 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. Conflicts between the Medical Staff and the Executive Committee of the Medical Staff may be resolved through conflict management processes of a mutually agreed upon mediator.
7. To report periodically on its activities to the Governing Body of the Hospital.

ARTICLE IV. MEMBERSHIP

BURDEN OF ESTABLISHING QUALIFICATION FOR MEMBERSHIP

No physician, Advanced Practice Registered Nurse, physician assistant, or dentist shall be entitled to membership on the Medical Staff merely by virtue of the fact that he/she is duly licensed to practice his/her profession in this, or any other state, or that he/she is a member of some professional organization, or that he/she has had in the past, or presently has such privileges at another hospital. The burden of establishing professional competence, worthiness of character and adherence to professional ethics and conduct and evidence of physical and mental health shall rest with the applicant.

No applicant shall be refused membership on the basis of age, sex, race, creed, color, national origin, or any other criterion lacking professional justification.

SECTION 1 – QUALIFICATIONS

Subsection 1 – General Qualifications

Only those practitioners shall be deemed to possess basic qualifications for membership in the Medical Staff who:

1. Provide documentation of (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health. Such documentation must demonstrate to the satisfaction of the Medical Staff and the Governing Body that the applicant is professionally and ethically competent, and that patients treated by them can reasonably expect to receive the generally recognized high professional level of quality care.
2. Are determined by current practice and credential review (1) to adhere to current standards of practice of their respective professions, (2) to work cooperatively with others in the Hospital setting so as not to adversely affect patient care, (3) to participate in and properly discharge Medical Staff responsibilities, and (4) to maintain the clinical and ethical standards of any appropriate accrediting bodies.

Each individual must meet the qualifications established by the respective Connecticut State Examining Board.

Subsection 2 – Particular Qualifications

1. Physicians: A physician applicant for membership on the Medical Staff must hold an MD or DO degree issued by a medical or osteopathic school approved at the time of issuance of such degree by the appropriate Connecticut State Department, and must also hold a valid, current, license to independently practice medicine in Connecticut.
2. Dentists: A dentist applying for membership in the Medical Staff must hold a DDS or DMD degree issued by a dental school approved at the time of the issuance of such degree, by the

appropriate Connecticut State Department, and must also hold a valid, current, license to independently practice dentistry in Connecticut.

3. Advanced Practice Registered Nurses: An Advanced Practice Registered Nurse is an individual who, by virtue of specialized education and experience, performs acts of diagnosis and treatment of alterations in health status. The Advanced Practice Registered Nurse must maintain a “collaborative” agreement (a) mutually agreed upon relationship between an Advanced Practice Registered Nurse and a physician who is licensed to practice medicine in this state, and who is educated, trained or has relevant experience that is related to the work of such Advanced Practice Registered Nurse.
4. Physician Assistants: A Physician Assistant is an “individual functioning in a dependent relationship with a physician and licensed pursuant to Connecticut General Statutes (CGS) to provide patient services under the supervision, control, responsibility, and direction of a physician licensed in accordance with CGS.” (Chapter 370, Sec. 20-12 a-g)

The Physician Assistant must be a graduate of a scholastic/clinical training program accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation. Further, the Physician Assistant must be certified by the National Commission on Certification of Physician Assistants. A Physician Assistant applying for membership in the Medical Staff must have successfully completed a matriculated physician assistant program by a school approved at the time of the issuance of such degree by the appropriate Connecticut State Department and must hold a valid, current, license.

SECTION 2 – RESPONSIBILITIES

The responsibilities of each member of the Medical Staff include but are not limited to:

1. Providing patients with optimal quality of care meeting generally recognized professional standards, including clinical standards of any appropriate accrediting body and achievable within available resources.
2. Abiding by the Medical Staff By-Laws, Rules and Regulations, and by all other and appropriate policies of the Hospital and the Department of Mental Health and Addiction Services. Failure to abide by any of the above may result in the revocation, suspension, or limitation of appointment.
3. Discharging in a responsible and cooperative manner responsibilities and assignments imposed upon the member by virtue of his or her membership, including committee assignments and chairmanships or other assigned functions for which the member is responsible by virtue of appointment or election.
4. Preparing and completing required records in a timely fashion. This responsibility includes but is not limited to the completion of the admission medical history and physical examination within twenty four hours of admission and at least annually. The specifics of this process are outlined in the Medical Staff Rules and Regulations.
5. Abiding by the current standards of practice of the professional association as applicable to his/her profession.
6. Participating in arrangements for coverage of patient services when required.
7. Participating in continuing education programs.

8. Discharging other such staff obligations as may be required.
9. Abiding by the policies of the Department of Mental Health and Addiction Services having to do with incompatible activity.
10. Regardless of staff status, or specific clinical privileges, in case of emergency, the staff member attending the patient will do all in his/her power to save the life of the patient. An emergency is defined as a condition wherein the life of the patient is in immediate danger, and in which delay in treatment would increase the danger.
11. Interacting on a professional basis with members of the staff, patients, and others and behaving in a professional and civil manner.

Section 3 – Ethics and Ethical Relationships

The principles of medical ethics of the American Medical Association as adopted by the American Psychiatric Association and the principles of ethics of the American Dental Association and the Connecticut State Employees Ethics Code shall govern the professional conduct of the members of the Medical Staff of CVH. The provisions of Commissioner's Policy Statement #40, "Private Practice/Outside Employment" of the Department of Mental Health and Addiction Services shall apply strictly to those individuals who wish to engage in private practice or in other employment outside of the Hospital. Such private practice or other employment shall in no way interfere with their discharge of hospital duty.

ARTICLE V. HISTORY AND PHYSICALS

1. The Admission History and Physical will be completed within 24 hours of admission. A patient who is unable and/or unwilling to cooperate with his/her Admission History and Physical shall still have a completed History and Physical done via direct observation of the patient and a review of all collateral information available. Components of the H&P not able to be examined or obtained will be noted in the appropriate sections of the form (no section of the form will be left blank.) All History and Physicals will have Diagnoses listed along with an Initial Plan of Care.

- 2.
3. The admission/annual medical history shall include (see form CVH-341):
Chief Complaint

Present Illness

Past Surgical History

Past Medical History

Gynecological History (if applicable)

Family History

Present Medications

Allergies and Adverse Drug Reactions

Life Style (e.g. tobacco, alcohol, and illicit drug usage)

Review of Systems (including major body systems and pain assessment)

Any information unobtainable will be documented as such.

4. The admission/annual medical physical examination shall include (see form CVH-341):

General Appearance

Vital Signs and Height/Weight/BMI

Skin

Head

Neck

Breasts

Lungs

Heart and circulatory system

Abdomen

Genitourinary and rectal

Extremities

Neurological examination

Any information unobtainable will be documented as such.

5. All patients shall receive an Annual History and Physical during the anniversary month of their admission (as defined by CVH policy).
6. All Admission/Annual History and Physical(s) shall outline assessments, additional diagnostic tests, consultations, and/or treatments for all non-psychiatric (medical) physical problems.
7. Pain assessments are completed in accordance with the Hospital's OP&P 2.5.
8. Chest X-rays will be performed based upon physical findings and/or clinical symptomatology. Chest X-rays are not part of Connecticut Valley Hospital's routine admission or annual medical assessments.

ARTICLE VI. ORGANIZATION OF THE MEDICAL STAFF

Section 1 – Categories of Medical Staff Membership

The Medical Staff shall consist of (1) Active members, (2) Adjunct members and (3) Advanced Practice Registered Nurses, and (4) Physician Assistant members.

1. Active Members: The Active members shall consist of physicians and dentists licensed to practice medicine or dentistry, respectively, in the State of Connecticut who are employed or contracted by the Department of Mental Health and Addiction Services to work at CVH. Only those physicians and dentists who work at least twenty (20) hours per week at the Hospital are eligible for Active membership, and such physicians and dentists shall have full voting privileges and may hold office in the Medical Staff organization.

2. Adjunct Members: The Adjunct members shall consist of the following categories:

- A. Associate Staff: The Associate Medical Staff shall consist of physicians and dentists who are licensed to practice medicine or dentistry in the State of Connecticut and who are contracted to work at CVH for a limited period of time (e.g., Temporary Worker Retirees, Durational Workers) or who work at the Hospital less than twenty (20) hours per week. They shall be eligible to serve on committees and to vote on matters before such committees. They shall be ineligible to hold office in the Medical Staff organization.
- B. Consulting Staff: The Consulting staff shall consist of physicians and dentists of recognized professional abilities who are engaged in specialized medical or dental practice. The duties of the Consulting Staff shall be to provide their services at the Hospital upon request of a member of the Medical Staff. The Consulting Staff shall not have voting privileges in the Medical Staff Organizations. They will not be required to serve on committees.

There are two categories of Consulting Staff, which are delineated by their clinical privileges as follows:

- i. Consultants privileged to provide consultation and treatment. These Consultants shall be privileged to provide consultation and treatment within the scope of their delineated clinical privileges, including writing orders and clinical findings in the patient's medical record.
 - ii. Consultants privileged to provide consultation only. These Consultants shall be privileged to provide consultation within the scope of their delineated clinical privileges but shall document on a consultation form or separate consultation report and shall not write orders.
- C. Night and Weekend Duty Staff: The Night and Weekend Duty Staff shall consist of physicians employed by the Department of Mental Health and Addiction Services to provide after hours, holiday and weekend medical and psychiatric services at CVH. Physicians in this category shall not have voting privileges or be eligible to serve on committees.
3. Advanced Practice Registered Nurse Members: The Advanced Practice Registered Nurse members shall consist of Advanced Practice Registered Nurses licensed in the State of Connecticut and employed by the Department of Health and Addiction Services to work at CVH as an Advanced Registered Practice Nurse and provide direct clinical care. Only Advanced Practice Registered Nurses who work at least twenty (20) hours per week at the Hospital are eligible for membership, shall have voting privileges in committees and at Medical Staff meetings are eligible to hold Medical Staff office.
4. Physician Assistant Members: The Physician Assistant members shall consist of Physician Assistants licensed in the State of Connecticut and employed by the Department of Health and Addiction Services to work at CVH as a Physician Assistant. Only Physician Assistants who work at least twenty (20) hours per week at the Hospital are eligible for membership, shall have voting privileges in committees and at Medical Staff meetings and are eligible to hold Medical Staff office.

ARTICLE VII. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1 – Mechanism for Appointment to the Medical Staff

Appointment to the Medical Staff is made through the specific mechanism described as follows:

Each applicant for Medical Staff membership completes an application that asks for information specified in the Medical Staff By-Laws. The following professional criteria shall be uniformly applied to all applicants and shall constitute the basis for granting initial or continuing staff membership and are designed to assure the Medical Staff and the Governing Body that patients will receive quality care.

1. The application form requires information concerning the following professional criteria:
 - A. Current licensure
 - B. Relevant training and/or experience including CPR certification.
 - C. Current competence
 - D. Health status of the applicant
 - E. Involvement in any professional liability action
 - F. Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration
 - G. Pending challenges, sanctions or exclusion from being a participating provider with the Centers for Medicare and Medicaid Services (CMS)
 - H. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital

The application shall require detailed information concerning the applicant's professional qualifications. It shall request the names of at least three peer references, at least one of which is by a professional who holds the same category of license as the applicant, who have had experience in observing and working with the applicant and who can provide adequate testimony pertaining to the applicant's current competence and ethical character. Any exception to this requirement must be approved by the Executive Committee of the Medical Staff.

2. The applicant shall submit a request for specific privileges with the application for membership.
3. The applicant shall have the burden of producing adequate information for a proper evaluation of competency, character, ethics, and other qualification and for resolving any doubt about such qualifications.
4. Material falsification, either through omission or commission, on the application will result in automatic termination of the application process. The applicant will have the opportunity to discuss the issue with the Chief Executive Officer, or his/her designee, and the Chair of the Credentialing and Privileging Committee.
5. The Hospital and its Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 by reporting adverse actions and obtaining necessary information from the National Practitioner Data Bank.
6. The completed application shall be submitted to the appropriate Credentialing and Privileging Committee, which, after collecting the references and other materials deemed pertinent, shall consider the application.
7. The Credentialing and Privileging Committee shall review the application no later than one month from the time of receipt of all required materials. The Credentialing and Privileging Committee shall either recommend approval or rejection of the application to the Executive Committee of the Medical Staff. If approved, the application shall then be submitted by the Executive Committee to the Governing Body for further consideration and granting of Medical Staff membership or rejection thereof. Privileges will be granted by the Governing Body in accordance with the Governing Body By-Laws and within a reasonable period of time.

8. By applying for membership to the Medical Staff, each applicant signifies his/her willingness to appear for an interview in regard to the application. The applicant further authorizes CVH to contact staff of other facilities to request information bearing on competency, character, and ethical qualifications; consents to inspection of all records and documents that may be material to any valuation of professional qualifications; consents to inspection of all records and documents that may be material to an evaluation of professional qualifications and competency to carry out clinical privileges requested as well as all moral and ethical qualifications for Medical Staff membership; releases from any liability all individuals and organizations who provide information to this facility in good faith and without malice concerning the applicant's competency, ethics, character and other qualifications for Medical Staff appointment and clinical privileges. The application form contains a statement that fully informs the applicant of the scope and extent of these authorizations, releases, and consent provisions.
9. The applicant shall receive a copy of the By-Laws, Rules and Regulations of the Medical Staff of CVH, and shall sign an agreement that, if appointed and granted clinical privileges, he/she will abide by the Medical Staff By-Laws, Rules and Regulations, CVH Operational Policies and Procedures and all DMHAS Work Rules and Commissioner Policy Statements. The applicant will further agree to accept the professional obligations therein reflected along with accepting clinical privileges. Failure to abide to the fore mentioned may result in action by the Medical Staff which may include referral for a Peer Review, referral to the appropriate Medical Director, or referral to Human Resources for other action.
10. A Medical Staff member with a temporary license shall be required to secure a permanent license not later than one year from the date of initial appointment. Failure to secure such license shall result in termination of membership and privileges. This is explained to the physician at the time of appointment. A Medical Staff member with a permanent license shall be eligible for appointment for a further eighteen (18) months for a total of not more than two (2) years.
11. Each member shall have delineated clinical privileges that allow the provision of patient care services independently within the scope of privileges granted. Status as a manager, or as a member of the Governing Body shall not, in and of itself, exclude a full membership or office on the Medical Staff at CVH.
12. A separate credentialing and privileging file shall be maintained for each staff member.
13. A period, generally to be up to six months, of Focused Professional Practice Evaluation will be implemented for all initially requested privileges. The period may be extended if further observation and/or supervision is warranted. The responsible Medical Director will carry out the evaluation using the standards of the Ongoing Professional Practice Evaluation (see Section 2 below) and may include chart reviews or observational proctoring. The results of the evaluation will be communicated to the individual practitioner and to the Credentialing & Privileging Committee at the end of six months, or earlier if indicated.

Section 2 – Mechanism for Reappointment to the Medical Staff

Each member shall be considered for reappointment to the Medical Staff every two (2) years.

Subsection 1:

1. Prior to the expiration date of an appointment, each member shall submit to the Credentialing and Privileging Committee and completed application form. The reapplication will also include a request for renewal and modification of privileges. Whenever possible, response to the application will be made by the Governing Body on or before the reappointment date.

2. Each recommendation concerning reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon each members' current professional competence and clinical judgment in the treatment of patients; the results of quality improvement activities, ethics and conduct; attendance at Medical Staff Committee meetings; compliance with CVH policies and the Medical Staff Rules and Regulations; relations with other practitioners. Such periodic appraisals shall include consideration of physical and mental capabilities. Consideration will be given to the applicant's involvement in previous or current liability claims; previously successful or currently pending challenges to any licensure or registration or voluntary relinquishment of such licensure or registrations; voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at CVH or another hospital. Three peer recommendations are required.
3. An Ongoing Professional Practice Evaluation is conducted for every member of the Medical Staff. This ongoing evaluation is carried out by the Medical Director responsible for supervising each practitioner, and in the case of the Medical Directors, it is carried out by the Chief of Professional Services.

It includes the following areas of general competencies:

- Clinical Skills / Competence and Patient Care
- Medical / Clinical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice

The result of each ongoing evaluation, and whether it justifies the continuation, revision, or revocation of privileges is communicated to the Credentialing & Privileging Committee at least every six months. These evaluations are based on monitoring data that may include but not be limited to peer reviews and performance improvement reviews. Examples include reviews of quality and timeliness of documentation and practice performed in death reviews, drug/medical utilization reviews, admission psychiatric evaluations, treatment plans including chart and observational reviews, progress notes, restraint and seclusion, medication practices, and discharge summaries. For Ambulatory Care, the reviews may also include quality of history and physical examinations, preventative health care, and treatment of chronic medical conditions as indicated. Participation and attendance in Medical Staff committees are important and will also be considered.

The data is provided to the individual practitioner and to his/her supervisor. Aggregate data is provided to the Credentialing and Privileging Committee by the supervisor. Individual practitioners may submit a written response to his/her file in the event of disagreement.

Additionally, an agency-wide Human Resources Competency Based Performance Appraisal or Performance Assessment and Recognition System is completed on a yearly basis and is reviewed at the time of all reappointment and privileging decisions.

4. A member seeking a change of status or modification of privileges may submit such a request at any time. A change in privileges would initiate a Focused Professional Performance Evaluation (FPPE).
5. If at any time, concerns are raised relative to a practitioner's current clinical competence, practice behavior and/or ability to perform any of his/her privileges, a period of focused evaluation may be indicated. Examples include, but are not limited to: (1) information obtained from ongoing evaluation/peer review activities; (2) other evidence suggesting that a practitioner's performance does not fall within the accepted practice guidelines or standards of care; and (3) staff or patient/family complaints. A focused review may be triggered by a specific or single incident, a sentinel /adverse event,

evidence of trends in clinical practice, or other circumstances indicating that patient safety may be compromised.

Such matters shall be brought to the Chief of Professional Services, the President of the Medical Staff or a Medical Director or a representative of the Executive Committee of the Medical Staff (ECMS). After consideration of the facts available, the ECMS shall designate an individual (generally a Medical Director) to conduct a focused evaluation as appropriate.

Focused evaluation may include, but is not limited to, one or more of the following:

- Retrospective or prospective chart review
- Monitoring of clinical practice patterns
- Proctoring
- External Peer Review
- Discussion with other individuals involved in the care of the practitioner's patients relative to the substance of the focused review.

External peer review will be solicited when the ECMS determines that an internal review would not be fair and objective when, for example, (1) the case(s) under review is/are not performed by any other member of the Medical Staff; (2) when there is concern regarding relationships between the practitioner in question and the other practitioners on the Medical Staff who would be considered appropriate peers; or (3) other circumstances exist that could compromise the review.

The period of focused review is time limited. The duration and type of monitoring required will be dependent upon the nature/severity of the situation under evaluation, the type of privilege(s) in question and the practitioner's overall activity level. The affected practitioner and his/her Medical Director are informed of the duration of the review as well as the mechanisms that will be employed during the review.

The initial review period may be extended at the discretion of the ECMS or its appropriate designee based upon the extent to which sufficient information to evaluate the practitioner's performance has been obtained. Similarly, the initial method of evaluation may be expanded or supplemented with other methods as needed during the initial and any subsequent review periods.

Upon completion of the focused evaluation, significant findings shall be reported to the ECMS. The ECMS shall evaluate the results of the evaluation and make a recommendation. Recommendations may include, but are not limited to, the following:

- No further action
- Issuing a verbal warning or letter of reprimand or admonition;
- Referral for formal peer review.

Subsection 2:

In any case where the Executive Committee of the Medical Staff does not recommend reappointment or in any case where reduction of clinical privileges is recommended, notice thereof shall promptly be given by the President of the Medical Staff to the individual concerned, and the latter shall be entitled to the procedures that are provided for in Article VIII of these By-Laws.

Should a member of the Medical Staff be on an extended sick leave just prior to the time when his/her privileges expire, the Credentialing and Privileging Committee will review any submitted application but hold action until the physician is ready to return to work.

Subsection 3:

The Governing Body shall in no case refuse to reappoint or cancel an appointment previously made, without conferring with the Executive Committee of the Medical Staff.

Members of the Medical Staff who are employees of the State of Connecticut shall be subject to suspension, revocation, or denial of privileges, or termination from employment only for cause and shall be entitled to the procedures outlined in the Connecticut General Statutes, Section on State Personnel Policies, and in Article VIII of these By-Laws, unless otherwise provided in these By-Laws.

ARTICLE VIII. CREDENTIALING AND PRIVILEGING

Section 1 – Clinical Privileges

All physicians/dentists, holding unrestricted licenses in Connecticut and permitted by law and by CVH to provide patient care services independently within the facility, shall have delineated clinical privileges, i.e., each such physician/dentist shall have written permission to order and/or provide, without direction or supervision, certain specific medical or other patient care services within well-defined limits. Each application for appointment and reappointment shall contain a request for specific clinical privileges. Granting and renewal of such clinical privileges shall be recommended by the Executive Committee of the Medical Staff to the Governing Body and shall be based upon a careful review of the individual's credentials and performance by the Credentialing and Privileging Committee.

Physician consultants, optometrists, podiatrists, and other non-physician consultants will have delineated clinical privileges.

Only such clinical privileges as have been granted by the Governing Body, in accordance with these By-Laws, shall be conferred on the practitioner.

Section 2 – Emergency Privileges

In the case of emergency, any member of the Medical Staff, regardless of Medical Staff status or privileges, shall be permitted to do everything possible to save the life of a patient, using every facility of the community necessary, including calling for any necessary or desirable consultation. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 3 – Disaster Privileges

As part of the Hospital's overall emergency preparedness plan, and only when the Hospital has activated the *Emergency Operations Plan*, volunteer physicians and licensed independent practitioners, whose services are required and who are not current members of the Medical Staff, may be privileged by the Chief Executive Officer or designee, upon recommendation by the President of the Medical Staff or Chief of Professional Services. These practitioners will be supervised by the Chief of Professional Services through the Division Medical Directors. All practitioners with disaster privileges will be mentored and supervised through direct supervision and chart review in order to evaluate each practitioner's professional performance.

When the *Emergency Operations Plan* is activated and during the immediate disaster period, privileges may be granted upon presentation of a current government issued identification card and one or more of the following:

- Current picture hospital/health organization identification card

- Current license to practice as a independent practitioner in the State of Connecticut
- Identification that the individual is a member of a Disaster Medical Assistance Team, Medical Reserve Corp (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or has been granted authority to render patient care in disasters by a federal, state or municipal entity
- Confirmation by a current Medical Staff member of the volunteer's ability to act as a practitioner during a disaster

A Hospital issued Disaster Volunteer badge will serve as the volunteer's identification during the disaster.

Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from when the practitioner was granted disaster privileges. In the extraordinary circumstance that primary verification of licensure cannot be completed within 72 hours, it will be done as soon as possible. If primary verification of licensure is unable to be completed within 72 hours the following documentation will be required: the Chief Executive Office or Chief of Professional Services must possess documentation of the following: why primary verification could not be performed in the required timeframe, evidence of demonstrated ability to continue to provide adequate care, treatment and services and what attempts have/will be done to rectify the situation. If able to convene, within 72 hours, the Governing Body makes a determination (based on all information obtained regarding the professional practice of the practitioner and the status of the disaster event) to continue or terminate the granted disaster privileges.

Section 4 – Interim Clinical Privileges

When necessary for important patient care needs, interim clinical privileges may be granted by the Chief Executive Officer (or designee) at the request of the President of the Medical Staff (or designee), and based on the recommendation of the Chair of the Credentialing and Privileging Committee (or designee) for up to one hundred and twenty (120) days. The interim privileges may be granted only upon verification of the following:

- Current licensure
- Current competence

Interim privileges may also be granted in the case of a new applicant with a complete application that raises no concerns and is awaiting review and approval of the Medical Staff Executive Committee and the Governing Body. In this case, interim (temporary) privileges may be granted only upon verification of the following:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- A query and evaluation of the NPDB (National Practitioner Data Bank) information
- A query of the Office of Inspector General for any pending or current adverse actions
- A complete application
- A current government issued photo identification
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
- Other criteria required by the organized Medical Staff By-Laws

Section 5 – Advanced Practice Registered Nurse Credentialing

The Advanced Practice Registered Nurse will be credentialed to perform designated clinical activities within the context of a collaborative agreement with a licensed physician who is an Active Member of the Medical Staff. Advanced Practice Nurses do not require co-signatures.

Section 6 – Physician Assistant Credentialing

The Physician Assistant will be credentialed to perform designated clinical activities under the supervision of a licensed supervising physician who is an Active Member of the Medical Staff. These responsibilities are enumerated in Operational Policy and Procedure “Ambulatory Care Services: Physician Assistants.” The Physician Assistant requires co-signatures on Schedule II and III medications within 24 hours of prescribing.

Section 7 – Resignation

1. A Medical Staff member wishing to resign shall submit a letter of resignation addressed to the President of the Medical Staff (or their designee), no less than thirty (30) days prior to his/her desired date of departure. This letter is shared with the Chair of Credentialing and Privileging Committee.
2. The President shall present such a letter to the Executive Committee of the Medical Staff for recommendation on the status of the resignation: accepted in good standing, accepted in conditional standing or accepted not in good standing. The recommendation of the Executive Committee of the Medical Staff will be forwarded to the Chief Executive Officer, or designee, for Governing Body review and final determination of acceptance and status of resignation.
3. For any Medical Staff credentialed and privileged clinician who is terminated from Connecticut Valley Hospital service secondary to a disciplinary action through the Labor Relations Division of the Human Resources Department; the Executive Committee of the Medical Staff will recommend to the Governing Body that the clinician’s privileges be terminated.

ARTICLE IX. CORRECTIVE ACTION AND APPEAL MECHANISMS

Section 1 – Standard of Professional Conduct

Subsection 1:

Standards of professional conduct shall conform to the prevailing national standards of the relevant specialty and shall be the measurement by which all Medical Staff are evaluated.

Subsection 2: Procedures

1. Whenever the activities or professional conduct of any Medical Staff member are considered to be lower than the standards or best interests of the Medical Staff, contrary to good patient care and safety, or to be disruptive to the operations of the Hospital, an investigation against such practitioner may be requested by any member of the Hospital Staff. All requests for investigation must be submitted to the Executive Committee of the Medical Staff in writing and shall be supported by reference to the specific activities or conduct, which constitute grounds for the request. A Focused Professional Practice Evaluation may be initiated or a more formal and extensive Peer Review may be warranted. If the Executive Committee of the Medical Staff deems it necessary, the Medical Peer Review Committee, as described in Article X, will conduct the review.
2. The President of the Medical Staff shall notify the member of the general nature of the complaint against him/her and of his/her rights under the By-Laws of the Medical Staff.

Section 2 – Discipline and Summary Suspension

Medical staff appointments may be, revoked, suspended or limited for due cause, including but not limited to physical or mental disability, failure to provide evidence of satisfactory health status, including evidence of mandatory vaccinations if required by state or federal agencies, impairment regardless of cause, failure to

provide adequate patient care, exceeding the scope of delineated privileges, prescribing controlled substances without the required state and federal authority, or failure to abide by these Bylaws or the Rules and Regulations of the Medical Staff or the Operational Policies and Procedures of Connecticut Valley Hospital. Based on these due causes or recommendations of the Peer Review Committee, the Executive Committee of the Medical Staff has the right to revoke, limit, or suspend a medical staff appointment.

The Chief Executive Officer, Chief of Professional Services, Chief of Staff and/or the Medical Directors shall each have the authority to summarily suspend all or any portion of the clinical privileges of a practitioner and/or revoke, suspend, or limit medical staff appointments in advance of any proceedings contained in Article VIII, Section 4., whenever action must be taken immediately in the best interest of the health and safety of patients or patient care at the Hospital. A summary suspension is effective immediately upon imposition. Immediately following summary suspension, the President of the Medical Staff shall be notified, and he/she will convene a special meeting of the Executive Committee of the Medical Staff within two business days to review the matter under consideration, and to make a determination as to whether the suspension should be continued, modified or ended. Whenever the summary suspension is modified or continued, a Peer Review Committee shall be appointed within (1) business day to review the matter. The Executive Committee of the Medical Staff may also initiate any other fact-finding investigations it deems necessary. The Executive Committee of the Medical Staff shall convene again within twenty-one (21) calendar days of the commencement of the summary suspension to consider information from the Peer Review or any other information pertinent to the case under scrutiny. A summary suspension may be continued up to a maximum of twenty-one (21) additional days only with the approval of the Executive Committee. The Medical Staff member shall be entitled to review in accordance with the procedures contained in Section 4 of this Article.

Section 3 – Automatic Suspension

Action by the Connecticut State Licensing entity revoking or suspending a practitioner's license or placing him/her on probation or the voluntary relinquishment of a license to practice in Connecticut shall result in the automatic revocation of the practitioner's Hospital privileges and Medical Staff membership. Agreement with a governmental entity not to exercise a license to practice, or license or permit to prescribe controlled substances, or notice of exclusion/disbarment from participation in the Medicare, Medicaid or other federal health care program shall be cause for automatic suspension of Hospital privileges and Medical Staff membership. Under these circumstances, provisions relating to hearings and appeals do not apply. None of the above sections shall preclude a Medical Staff member from exercising his/her appeal rights under the present collective bargaining agreements and his/her legal and statutory rights.

In the event a Medical Staff member is or becomes the subject of a voluntary or involuntary consent agreement or consent order by or with a private or governmental entity not to exercise some licensed activities, the Medical Staff member must supply a copy of the agreement or order to the Chief of Staff. Clinical privileges will be adjusted as necessary or as required under the agreement or order.

Section 4 – Hearing and Appeals Process

1. Right to Hearing and Appellate Review
 - A. Except as otherwise provided in these By-laws, there is a right to a hearing before the Hearing Committee of the Executive Committee of the Medical Staff and to an appellate review by the Governing Body for the following recommendations of corrective action or summary suspension:
 - No further action
 - Issuing a verbal warning or letter of reprimand or admonition;
 - Imposing terms of probation, or requirements of consultation, monitoring, or supervision;
 - Modifying, suspending, or terminating clinical privileges;
 - Reducing Medical Staff category or limiting certain Medical Staff prerogatives;

- Suspending, limiting, or terminating Medical Staff appointment; and/or
- Other appropriate measures.

2. Notices to and Requests from Appellants

- A. Whenever an appellant is entitled to a hearing or to appellate review, he/she promptly shall be advised of such right by certified mail, return receipt requested. Where relevant, the appellant should be advised of his/her Medical Staff status pending further action, or be provided with the basis for the adverse decision so that he/she may prepare for a hearing or appeal. The notice of hearing shall contain a concise statement of the practitioner's alleged acts or omissions, a list of the specific representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. Hearings should be scheduled as soon as reasonably possible after the receipt of a request by the appellant. The hearing date shall not be less than thirty (30) nor more than sixty (60) days from the date of the receipt of the request for hearing. The hearing date may be earlier than thirty (30) days from the date of request for hearing if so requested by Appellant and agreed to by the Hearing Committee. The appellant should be consulted in regard to all scheduling matters.
- B. Any appellant who has received notice of his/her right to a hearing or to appellate review of a decision shall request such hearing or appellate review in writing, by certified mail, return receipt requested, addressed to the Chief of Staff or shall be deemed to have waived the right to such hearing or appellate review. Such request shall be made within fifteen (15) business days of the date the notice was mailed.
- C. If the hearing has been requested on a timely basis, the appellant will be provided with a notice by certified mail, return receipt requested, setting forth the place, time and date of the hearing. The Chief of Staff is responsible for scheduling and arranging for the hearing and notifying the appellant. At least fourteen (14) days prior to the hearing date, the Chair of the Peer Review Investigating Subcommittee shall provide the appellant by certified mail, return receipt requested with a list of witnesses and documents, if any, to the extent reasonably possible, expected to testify or be presented at the hearing. At least fourteen (14) days prior to the hearing date, the appellant shall provide the Chair of the Peer Review Investigating Subcommittee by certified mail, return receipt requested, with a list of the witnesses and documents, if any, expected to testify or be presented at the hearing on behalf of the appellant.
- D. If the member of the medical staff accepts the Executive Committee recommendation for corrective action, then the recommendation shall be implemented by the Governing Body.

3. The Hearing Committee

- A. The Hearing Committee shall be a three-person sub-committee of the Executive Committee of the Medical Staff appointed by the President of the Medical Staff, and one of the members so appointed shall be designated by the President of the Medical Staff as Chairperson of the Hearing Committee. Any member of the Medical Staff who initiates a complaint or actively participated in the consideration of the matter leading up to the recommendation or action or is personally related to the appellant shall not be a member of the Hearing Committee or participate in the deliberations of the Executive Committee on this issue. Merely voting on the recommendations of the Peer Review Investigating Committee does not constitute active participation.

4. Conduct of Hearing

- A. The hearing shall be conducted fairly, but is to be informal and not restricted to judicial rules of evidence. All reasonably relevant information should be heard or accepted in evidence as exhibits. The Chairman of the Hearing Committee shall preside over the hearing and rule upon matters of procedure, assure that all participants have reasonable opportunity to present information, maintain decorum, and be responsible for the preservation of exhibits.
- B. An accurate record shall be made by means of a recording device. The appellant will be notified of the recording and will be asked for written consent to record proceedings. If the appellant refuses to sign for recording, recording will proceed unless the appellant agrees to pay for stenographic transcript by a court stenographer. If available, in whole or in part, a copy of the stenographic or recorded record of the hearing will be provided to the appellant upon request. The appellant is responsible for any costs associated with duplication.
- C. The chair of the Peer Review Investigating Subcommittee making the recommendation for corrective action, will present information in support of its decision and recommendations. Such representatives shall have the right to call and examine witnesses, present written evidence, cross-examine witnesses, and, at his/her discretion, make opening remarks and a closing statement.

5. Rights of the Appellant

- A. The appellant shall have the following rights:
 - i. To present all relevant information.
 - ii. To call and examine witnesses on his/her behalf and cross-examine witnesses produced by the Chair of the Peer Review Investigating Subcommittee.
 - iii. To be represented by a member of the Medical Staff in good standing, or by a member of a professional society, or by an attorney; provided, however, that if the appellant is to be represented, he/she shall provide reasonable notice to the Chairman of the Hearing Committee and the Chair of the Peer Review Investigating Subcommittee.
 - iv. To make, at his/her discretion, opening and closing statements, and to submit a written statement at the close of the hearing.
- B. If the appellant fails to appear at the hearing, he/she shall be deemed to have waived rights to the hearing and to have accepted the adverse recommendation or decision involved and the same shall thereupon become and/or remain in effect. However, the Hearing Committee, for good cause, may, in its sole discretion, continue the hearing. Good cause shall not include any circumstances reasonably avoidable.
- C. At its discretion, the Hearing Committee may call its own witnesses or obtain expert assistance in connection with any matter pending before it. Any written reports by such experts shall be provided to all parties at the hearing. The Hearing Committee may be represented by an attorney and may receive advice from their attorney at any phase of the hearing.
- D. Both sides are required to prepare their cases so that a hearing shall be concluded after a maximum of twelve hours of hearing extended over no more than three hearing sessions.

Under extraordinary circumstances, the Hearing Committee in its sole discretion may depart from this requirement; however, a hearing will not be extended due to delay, repetition, or lack of appropriate deportment during the presentation.

Upon the conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may, thereupon, at a time convenient to its members conduct its deliberations outside of the presence of the Peer Review Investigating Subcommittee and the appellant for whom the hearing was convened.

- E. Within thirty (30) days of the close of the hearing, the Hearing Committee shall prepare a written opinion setting forth its findings and recommendations, including a statement of the basis for the recommendations. The written opinion shall be forwarded, together with exhibits and, if available in whole or in part, the hearing record (including a copy of the recorded record of the hearing), to the President of the Medical Staff. The Executive Committee may confirm, modify, or reject the written opinion of the Hearing Committee including modifying the opinion to include education, observation, supervision, or termination of privileges of the appellant. Within twenty one (21) days of receiving the written opinion of the Hearing Committee, the President of the Medical Staff will inform the appellant of a meeting with the Executive Committee of the Medical Staff by certified mail, return receipt requested. The appellant shall appear before the Executive Committee of the Medical Staff, with counsel, if counsel is used, to hear the opinion. A copy of the written opinion will be provided to the appellant, at the time of this appearance which he/she will sign upon receipt, based upon the written opinion, the President and Executive Committee of the Medical Staff will recommend to the Governing Body for approval, appropriate corrective action against the member, if any.
- F. If the appellant accepts the decision of the Executive Committee of the Medical Staff, the case shall be deemed closed and no further hearings shall occur.
- G. The foregoing procedures for a hearing are intended as guidelines for ensuring the appellant a fair hearing and are not to be construed as establishing any rigid format for the hearing or action by the Hearing Committee.

6. Appellate Review

- A. Subsequent to an unfavorable recommendation by the Executive Committee of the Medical Staff, the appellant is entitled to appellate review by the Governing Body. He/she shall notify the Chief Executive Officer of this request by certified mail, return receipt requested, within fifteen (15) business days of receipt of the opinion by the Executive Committee of the Medical Staff. The Governing Body shall determine the procedure to be followed for the appeal. At its discretion, the Governing Body, or its designee, may elect to mediate the appeal, conduct further investigation and/or act on the appeal. The Governing Body may affirm, modify, or reverse the decision of the Executive Committee. Such decision will be mailed to the appellant by certified mail, return receipt requested.
- B. Upon request for appellate review, the appellant shall be entitled, upon request, to copies of any documents in the record of the Hearing Committee, and, if available in whole or in part, a copy of the stenographic or recorded record of the hearing.
- C. The decision of the Governing Body will be final.

ARTICLE X. MEDICAL STAFF HEALTH

1. A health care organization is obligated to protect patients from harm. In this regard, the organized Medical Staff of Connecticut Valley Hospital is responsible for the design of processes that:
 - Provide education about Medical Staff physical and mental health issues, including the recognition of impairment.
 - Provide education regarding health maintenance.
 - Facilitate referral for confidential assessment, diagnosis, treatment, and rehabilitation, when warranted, of the practitioners who suffer from a potentially impairing condition, or who appear at risk of providing unsafe treatment.
 - The purpose of these processes is to provide assistance and rehabilitation, separate and distinct from Medical Staff or administrative disciplinary processes, in order to aid the practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients.
2. Responsibility for the design and implementation of educational activities related to practitioner health and early recognition of practitioner impairment shall be delegated to the Committee on Medical Staff Health (see Article XII, Section 10).
3. Responsibility regarding the formal referral of a practitioner who may be impaired as a result of mental or physical illness or abuse or excessive use of drugs, including alcohol, narcotics or prescribed medications, is delegated to the Chief of Professional Services (or a designated Medical Director in the absence of the Chief of Professional Services). If the Chief of Professional Services, or designee, determines that a practitioner may be impaired and that the impairment may adversely affect the practitioner's ability to provide safe and appropriate treatment, the Chief of Professional Services shall refer the practitioner to the HAVEN Program.

The HAVEN Program will be utilized as the assessment and treatment resource. Strict confidentiality of the practitioner seeking referral or referred for assistance will be maintained, except as limited by state and federal law, ethical obligation, or when the safety of a patient is threatened. The Chief of Professional Services will inform appropriate Hospital administrative leaders, including the appropriate Division Director or Director of Ambulatory Care Services, the appropriate Medical Director(s), of the practitioner's referral and progress in treatment (if instituted) on a need to know basis, but all persons involved must maintain strict confidentiality around the referral. A confidential file on the matter will be maintained in the Medical Staff Office.

A practitioner may institute a self-referral in consultation with the Chief of Staff and/or the Chief of Professional Services. In addition, a practitioner may be referred by any member of the Medical Staff, including his/her Medical Director, or by Hospital Administration, in collaboration with the Chief of Professional Services.

4. The HAVEN Program will assume responsibility for the evaluation of the individual in question, the determination of impairment, if any, recommendations for treatment and/or rehabilitation, if warranted; and for the provision of any necessary information to the Chief of Professional Services in order for the Chief of Professional Services to protect patients at Connecticut Valley Hospital from harm and provide appropriate monitoring of the affected practitioner.
5. The Chief of Professional Services may delegate the ongoing monitoring of the affected practitioner and the continued maintenance of patient safety (until the assessment or rehabilitation process is complete) to a Medical Director.
6. The practitioner in question shall be asked to sign a written agreement, addressing the following conditions:

- To authorize the Chief of Professional Services to provide whatever information may be requested by the HAVEN Program;
 - To comply with any terms or conditions established by the HAVEN Program;
 - To cooperate fully with the HAVEN Program, authorizing the release of such information deemed necessary for a full credible assessment, or required by law;
 - To enter into a rehabilitation program as recommended by the HAVEN Program; and
 - To comply with whatever is required in order to successfully complete the rehabilitation program.
7. In the event that the practitioner refuses to accept a referral to the HAVEN Program, or in the event that the HAVEN Program notifies the Chief of Professional Services that the practitioner is not cooperating with the assessment or complying with the rehabilitation program, the Chief of Professional Services will notify the Executive Committee of the Medical Staff, and the practitioner will no longer be entitled to the benefit of any of the provisions of this section and shall be fully subject to action under any other relevant provision of those By-Laws, including, but not limited to, Article VIII (Corrective Action and Appeal Mechanisms).
 8. A practitioner who has agreed to enter a rehabilitation program may be placed on a medical leave of absence. The terms and conditions of such medical leave of absence shall be in accordance with Hospital and Department of Mental Health and Addiction Services personnel policies and any relevant provisions of the collective bargaining agreement.

ARTICLE XI. PEER REVIEW

Section 1 – Purpose and Process

1. The Peer Review Committee shall oversee, coordinate and evaluate peer review activities throughout Connecticut Valley Hospital, including activities conducted by the Medical Staff evaluating the quality and efficiency of services ordered or performed. As needed the Committee shall request and receive reports from any hospital entity with information pertinent to the investigation.
2. The Peer Review Committee or subcommittees thereof shall be responsible for performing case reviews and recommending corrective action for identified problems regarding clinical competence and may make recommendations for further activities by departments and services. In addition, the Committee shall coordinate peer review activities undertaken by and may work jointly in such peer review activities with the Executive Committee of the Medical Staff, the various Medical Staff committees, or any Performance Improvement committees within Connecticut Valley Hospital.
3. As appropriate, the Committee may act through subcommittees or committee members and may retain consultants or experts as needed for a particular task or review.
4. Any member who is the subject of a peer review shall be excused from any deliberations of the Committee. The Committee's deliberations shall be protected and regulated by CGS 19a-17b and any other pertinent state or federal statutes protecting medical staff peer review. The Committee's proceedings will be confidential and privileged as defined in that statute.
5. The conclusions of the Committee's deliberations, a statement of the method of the review process, the findings, and any recommendations shall be forwarded to the Executive Committee of the Medical Staff through the President of the Medical Staff. The President (or designee) shall inform the person reviewed of the findings and recommendations.

7. The definition of a peer is any credentialed member of the Medical staff with a M.D., D.O., D.P.M., D.D.S., D.M.D., O.D., APRN or PA degree. The Connecticut Department of Mental Health and Addiction Services Medical Director will be a permanent “ex-officio” member of the Peer Review Committee.

Section 2 – Types of Peer Reviews

1. The Peer Review Committee shall be responsible for the following types of reviews and any other reviews as deemed appropriate by the Executive Committee of the Medical Staff:
 - Focused Professional Performance Evaluation (FPPE)
 - Death Reviews.
 - Critical Incident Reviews
 - Formal Peer Reviews.
2. Focused Professional Performance Evaluations (FPPE) are outlined in Article VII, Section 2.
3. Death Reviews: In the cases of the death of a patient, a special Peer Review Subcommittee shall be convened by the Chairperson of the Peer Review Committee within thirty (30) days of notification and shall report its findings to the Executive Committee. It shall consist of at least three (3) members, at least one of whom shall be a general medical physician. The subcommittee shall review the standard of care provided for patients who die at Connecticut Valley Hospital or who die within fourteen (14) days after discharge from Connecticut Valley Hospital (in those instances in which the hospital becomes aware of the patient’s death). The purpose of such review will be an analysis of the quality and appropriateness of care rendered at Connecticut Valley Hospital. The Executive Committee of the Medical Staff shall determine whether findings from any individual case should be presented to the Medical Staff for educational purposes. Under other circumstances beyond this time frame, death reviews will be considered on a case by case basis.
4. Critical Incident Reviews: Critical Incident Reviews shall be conducted under the auspices of the Chief of Professional Services and/or his/her designee, as subcommittees of the Peer Review Committee of the Medical Staff. When convened for the purpose of conducting a Critical Incident Review, this subcommittee will follow the Connecticut Valley Hospital Operational Policy and Procedure Manual, Section II, Policy 6, Procedure 5.3, “Critical Incident Review Process.” Each convocation of the subcommittee shall be construed to meet the definitions of “Peer Review” and “Medical Review Committee” in the General Statutes of Connecticut, Title 19 “Public Health and Safety,” Chapter 368a, Section 19a-17b. The Physician CIR Manager is responsible for assuring that any question regarding the competency of a member of the Medical Staff or other licensed professional be referred to the Executive Committee of the Medical Staff or appropriate Discipline Executive Committee for consideration.
5. Formal Peer Reviews instituted by the Executive Committee of the Medical Staff on request of a member of the Medical Staff: Any member of the Hospital staff may request a peer review in writing whenever there is reason to believe that the medical care rendered by a member warrants a review. Such a request shall be made in writing and sent to the President of the Medical Staff. The Executive Committee shall review the request and shall order the review deemed necessary. For a Formal Peer Review, the President shall inform the Chairperson of the Peer Review Committee, who, in consultation with the Executive Committee, shall appoint an investigating subcommittee consisting of at least (3) three members of the Active Medical Staff, including himself/herself, one of whom must be from within the same division as the member being investigated. The time frame in which a particular peer review will be conducted will be

determined on a case by case basis by the chair of the peer review committee based on the individual circumstances of each case.

The President of the Medical Staff shall notify the member of the general nature of the complaint as per Article VIII, Section 1, Subsection 2.2. The investigating subcommittee shall review the facts underlying the request, review documents and interview relevant people, and afford the member an opportunity for an interview with the subcommittee. At such interview, the affected member shall be invited to discuss the complaint and explain or refute the concerns. This interview is not a hearing. The affected member would have fourteen (14) days to submit relevant written evidence to the investigating subcommittee. Within thirty (30) days of the date of the interview with the affected member, the subcommittee shall complete a report including recommendations whether any corrective action is necessary and what action is recommended. The report will be sent to the President of the Medical Staff and will include a summary of information obtained, copies of any written evidence considered and a summary of the interview, if held. If there is a recommendation of corrective action, the report and the recommendations shall be forwarded to the President of the Medical Staff who shall proceed in accordance with Article VIII. If there is no recommendation of corrective action, the matter will be closed.

Section 3 – Meetings

The Peer Review Committee shall meet as often as needed. A summary report of the committee's activities (peer reviews, death reviews, and critical incident reviews) shall be sent quarterly to the Executive Committee of the Medical Staff for assessment and any action necessary.

ARTICLE XII. OFFICERS

Section 1 – Officers of the Medical Staff

The officers of the Medical Staff shall be: President and President-elect.

Section 2 – Qualifications of Officers

Officers must be members of the Medical Staff at the time of nomination and election, and must remain members in good standing during their term of office. Failure to retain such status shall immediately create a vacancy in the office. If the President loses his/her standing, the President-elect will complete the term of the President and then continue for the next full term. If the President-elect loses his/her standing or assumes the Presidency early, a special election will be held to fill the vacancy at the next available meeting of the full Medical Staff. If the Medical Staff decides by a two-thirds vote that an officer no longer represents its best interest, that officer shall be removed and the actions outlined above in this section will be initiated.

Section 3 – Selection of Officers of the Medical Staff

1. The President of the Medical Staff will remain in office for one year commencing with the October election. The President-elect will serve one year as President-elect and then one year as President. The President-elect shall become President following elections for a new President-elect at the October meeting of the Total Medical Staff.
2. Nominations for position of President-elect shall be made from the floor.
3. When more than one candidate for President-elect is nominated and no candidate receives a majority of the vote, successive balloting shall decide the election by omitting the candidate with the least number of votes after each successive balloting until one candidate receives a simple majority of voting members present. Voting is by secret ballot.

Section 4 – Duties of Officers

1. President: The President shall preside over the Medical Staff and shall:
 - A. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the hospital.
 - B. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
 - C. Serve as Chair of the Executive Committee of the Medical Staff and be an ex-officio member of all Medical Staff Committees.
 - D. Serve as a representative of the Medical Staff on the Governing Body. Represent the view, policies, needs and concerns of the Medical Staff to the Chief Executive Officer and the Governing Body.
 - E. In conjunction with the Chief of Staff, he/she will be responsible for the enforcement of the Medical Staff By-Laws, Rules and Regulations; for the implementation of sanctions where these are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
 - F. Appoint, in consultation with the Executive Committee, Medical Staff members and chairpersons to all Medical Staff Committees, except the Executive Committee, and shall recommend to the Chief Executive Officer, Medical Staff representatives as candidates for non-Medical Staff Committees, and shall approve recommendations for non-Medical Staff members serving on Medical Staff Committees.
 - G. In the absence of the Chief of Staff, he/she receives and interprets the policies of the Chief Executive Officer to the Medical Staff and reports to the Chief Executive Officer on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to patient care.
 - H. Ensure the Medical Staff's participation in Performance Improvement activities.
2. President-Elect:
 - A. In the absence of the President, the President-elect shall assume the responsibilities of the President of the Medical Staff. The President-elect shall serve as Vice-President of the Medical Staff.
 - B. The President-elect shall serve, with the President of the Medical Staff, as representative of the Medical Staff to the Governing Body of the Hospital.

Section 4 –Removal of Officers

The Medical Staff by a 2/3 majority vote may remove any Medical Staff officer for conduct detrimental to the interests of the hospital and the Medical Staff, failure to maintain the qualifications listed in Article IV, Section 1, or if the officer is suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of that office, providing that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten days prior to the date of the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

Section 5- Removal of the Authority of the Executive Committee

1. The Total Medical Staff can remove the authority of the Executive Committee of the Medical Staff if it believes that the Executive Committee of the Medical Staff is not providing adequate representation.
2. Individual members of the Total Medical Staff shall provide requests in writing to remove the authority of the Executive Committee of the Medical Staff. These requests shall be sent to the Chief Executive Officer, Chief of Professional Services, or the Chief of Staff.
3. If 10% of the Active Medical Staff members submit such requests, the removal of the authority of the Executive Committee of the Medical Staff shall undergo voting by the Total Medical Staff.
4. Vote of the Total Medical Staff with two-thirds majority of the quorum is required for removal of the authority of the Executive Committee of the Medical Staff.
5. Voting must be conducted only at a Total Medical Staff Meeting with sufficient numbers to meet the bylaws required quorum.

ARTICLE XIII. STANDING COMMITTEES OF MEDICAL STAFF

The committees described in this Article shall be Standing Committees of the Medical Staff unless otherwise specified. Special or ad hoc committees may be created by the President of the Medical Staff or Executive Committee to perform specified tasks.

All Chairpersons of Standing Committees of the Medical Staff shall be members of the Medical Staff, except that a physician or non-physician may serve as Co-Chair along with an Active member of the Medical Staff as Chairperson. Unless otherwise specified in these By-Laws, members and Chairs of all committees shall be appointed for a two-year term by the President of the Medical Staff in consultation with the Executive Committee. Committee members and Chairpersons may be removed by the President of the Medical Staff in consultation with the Executive Committee of the Medical Staff.

Section 1 – Executive Committee

1. Only Active members, APRNs and PAs of the Medical Staff shall be eligible for membership on the Executive Committee. The Executive Committee shall consist of the officers and immediate past President of the Medical Staff; three elected delegates at large; and four ex-officio voting members consisting of Chief of Professional Services, a Medical Director from the Division of General Psychiatry and the Addiction Services Division. If an ex-officio member is also an officer or immediate Past-President of the Medical Staff, the number of delegates will be correspondingly increased so that the total membership remains twelve. The President of the Medical Staff shall be the Chairperson of the Executive Committee. The Chief Executive Officer or his/her designee may attend each Executive Committee meeting on an ex-officio basis without vote.

The Medical Director members shall serve for a two-year term commencing with the October elections. They shall be elected at the October meeting of the Medical Staff by the voting members of their respective divisions. Election protocol will be similar to that of the President-elect. Each Medical Director member shall be elected in a separate election and will need a simple majority of voting members from that division present to win the election. Members of the Medical Staff who are not assigned to a particular division shall not have voting privileges for Medical Director representation.

The delegates at large will have a two-year term commencing with the October election. Two delegates will be elected each year during the October meeting of the Medical Staff to create in any given year two experienced delegates and two new delegates. Election protocol will be similar to that of the President-elect. Each delegate

will be elected in a separate election and will need a simple majority of voting members present to win the election.

The Executive Committee of the Medical Staff may invite other individuals necessary to conduct its business to attend its meetings. Such individuals shall not have voting privileges.

2. The Executive Committee of the Medical Staff is empowered to act for the Medical Staff in the intervals between Medical Staff meetings and is responsible for making recommendations to the Chief Executive Officer and to the Governing Body. Such recommendations and actions shall include, but are not limited to, the following:
 - A. The structure of the Medical Staff;
 - B. The mechanism used to review credentials and to delineate individual clinical privileges;
 - C. Recommendation for individual Medical Staff appointment, reappointment, and termination;
 - D. The granting, renewal, and revision of specific clinical privileges for each eligible individual;
 - E. The mechanism by which membership on the Medical Staff may be terminated;
 - F. The mechanism for fair hearing procedures;
 - G. Questions pertaining to clinical practice;
 - H. Reasonable steps to insure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of, and/or participation in Medical Staff corrective or review measures when warranted;
 - I. The Executive Committee receives and acts on reports and recommendations from Medical Staff committees;
 - J. When appropriate, the Executive Committee shall recommend educational activities for each individual with delineated clinical privileges that:
 - i. relate in part to the privileges granted;
 - ii. are related to the type and nature of care offered by the Hospital;
 - iii. are related to the findings of improvement of performance activities;
 - iv. consider the expressed educational needs of individual members of the Medical Staff;
 - v. are documented and considered at time of reappraisal and in the renewal or revision of individual clinical privileges;
 - K. Recommending amendments to the By-Laws, and revisions to the Rules and Regulations, as changes in Medical Staff structure, policies and procedures and Hospital structure occur;
 - L. Reviewing the By-Laws and the Rules and Regulations, making appropriate changes at least every two years;
 - M. Reviewing the credentialing process of each of the professional disciplines (Nursing, Social Work, Psychology and Rehabilitation) which permits clinical services staff to provide specified patient care services within their scope of practice; and
 - N. Reporting on its activities and the activities of the various Medical Staff committees to the Governing Body on a quarterly basis.
3. Meetings: The Executive Committee shall meet at least monthly and shall be empowered to act for the Medical Staff in the intervals between Medical Staff monthly meetings.

Section 2 – Pharmacy, Nutrition and Therapeutics Committee

1. Composition: The Pharmacy, Nutrition, and Therapeutics Committee shall consist of at least one psychiatrist from each division, a physician from Ambulatory Care Services, a dentist, dietician, the Director of Pharmacy, and a Chief of Patient Care Services or his/her designee. Members appointed in accordance with these By-Laws shall have the right to vote.

2. Duties: The Pharmacy, Nutrition, and Therapeutics Committee shall:
 - A. Review drug utilization practice in the Hospital.
 - B. Develop guidelines for the use of drugs including policies and procedures relating to selection, distribution, handling, use and administration of drugs.
 - C. Serve as an advisory group to the Medical Staff and the pharmacy on matters pertaining to the choice of available drugs, including the contents of the emergency cart.
 - D. Develop, maintain, and review periodically a formulary or drug list for use in the Hospital.
 - E. Work to limit unnecessary duplication and expense in stocking drugs and drug combinations.
 - F. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
 - G. Evaluate and approve protocols concerned with the use of investigational drugs.
 - H. Review all significant adverse drug reactions and recommend necessary actions.
 - I. Review reports, findings and conclusions, including Performance Improvement activities of this committee and submit them to the Executive Committee of the Medical Staff on a quarterly basis for further deliberation and action.
 - J. Review and approve any new therapeutic medical devices or equipment proposed for use in the Hospital.
 - K. Monitor performance of drug usage evaluation under the Pharmacy contract as a criteria based, ongoing, planned and systematic process of monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs; to help assure that the drugs are provided appropriately, safely and effectively.
 - L. Monitor and evaluate selected drugs as part of the Medical Staff's Performance Improvement activities.
 - M. Maintain a permanent record of its proceedings, findings, recommendations and actions taken.
 - N. Collaborate with Dietary Services and other disciplines in developing and maintaining standardized approaches to nutrition care. Develop and maintain a nutrition care manual. Review the Hospital's Hazard Analysis and Critical Control Point (HACCP) plan, on the handling of food, enteral tube feeding, and water; and periodically survey the food and enteral tube feeding handling process; and address any inconsistencies.
4. Meetings: The Pharmacy, Nutrition and Therapeutics Committee shall meet at least quarterly.

Section 3 – Infection Prevention Committee

1. Composition: The Chairperson shall be an Ambulatory Care physician with a designated Infection Prevention Practitioner serving as Co-Chairperson. The Committee shall consist of physicians, a dentist, nurse(s), and Infection Prevention Coordinator from each division, and a representative of each of the following as appropriate: Dietary, Housekeeping, Maintenance, Pharmacy, Laboratory Services, Physical Therapy, Central Supply, Laundry, and Administration. It shall be responsible to the Executive Committee of the Medical Staff. Members appointed in accordance with these By-Laws shall have the right to vote.
- 2.
3. Duties: The Infection Prevention Committee shall:
 - A. Develop a hospital-wide Infection Prevention manual and program and maintain surveillance over the program.
 - B. Develop a system for identifying, reporting and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities.

- C. Develop and implement a preventive and corrective program designed to minimize infection hazards including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
 - D. Develop written policies defining special indications for isolation requirements.
 - E. Act upon recommendations related to Infection Prevention received from the Physician **Chair**, the Executive Committee and other committees.
 - F. Maintain a permanent record of its proceedings, findings, recommendations and actions.
 - G. Submit a report of its findings, recommendations and actions to the Executive Committee of the Medical Staff in a quarterly report.
4. Meetings: The Infection Prevention Committee shall meet monthly at the call of its Chairperson.

Section 4 – Medical Record Committee

- 1. Composition: The Medical Record Committee shall be chaired by a member of the Medical Staff and consist of at least one physician from each Division, and representatives from Performance Improvement, Nursing, Social Work, Psychology, Rehabilitation Services, the Medical Record Director, and other services/disciplines as appropriate. Members appointed in accordance with these By-Laws shall have the right to vote. Committee members who do not have contact with the Medical record but are needed to facilitate the Committee's work can be added as non-voting members.
- 2. Duties: The Medical Record Committee shall:
 - A. Evaluate and improve the quality of the medical record.
 - B. Develop and implement changes to the medical record.
 - C. Assure compliance with hospital requirements including timeliness, accuracy, and legibility of the medical record.
 - D. Report its findings and conclusions, including the quality performance activities on a quarterly basis, to the Executive Committee of the Medical Staff for further deliberation and action.
 - E. Maintain a record of its conclusions, recommendations, and actions taken. Results of action taken will be retained for a period of five (5) years as required by General Schedule IV, Retention/Disposition of Health Information Management Records and Case Files of Connecticut State Facilities.
- 3. Meetings: The Medical Record Committee shall meet at least quarterly or more often as called by the Chairperson.

Section 5 – Continuing Medical Education Committee

- 1. Composition: A physician shall be the Chairperson of this Committee. Other members shall include the Medical Staff Academic Director, the Chief of Professional Services, a Performance Improvement representative, a representative from the Office of Staff Development, and a physician representative from each division. Representation of other disciplines may be appointed by the Executive Committee of the Medical Staff.
- 2. Duties: The Continuing medical Education Committee shall:
 - A. Identify educational needs of all Medical Staff members and recommend appropriate educational activities.

- B. Respond to Performance Improvement findings when the corrective action for identified problems, opportunities to improve patient care and/or staff performance is educational in nature.
 - C. Encourage participation of members of the Medical Staff with delineated clinical privileges in those continuing medical education activities that are related to the privileges granted and to the expressed educational needs of the individual practitioners.
 - D. Insure that library and information services are available to meet the educational needs of the staff and to assure that current reference material, books and basic health care journals are available.
 - E. Report its findings and conclusions on a quarterly basis to the Executive Committee of the Medical Staff for further deliberation and action.
 - F. Maintain a permanent record of its proceedings, findings, and recommendations.
3. Meetings: The Committee shall meet at least quarterly and more frequently if deemed necessary by the Chairperson. Minutes shall be recorded.

Section 6 – Research Committee

- 1. Composition: The Chairperson shall be a psychiatrist. Members shall include physicians from each Division, a representative from Nursing, Social Work Psychology, Medical Services, Director of Health Information Services, and a patient advocate. Additional members may be appointed from either within or outside of the Hospital as needed for any particular review to assure appropriate evaluation of any proposal.
- 2. Duties: The Research Committee shall:
 - G. Monitor and evaluate the quality and appropriateness of any research activities undertaken at the Hospital.
 - H. Approve, review and critique the scientific methodology of all research proposals to be done at the Hospital.
 - I. Report its activities and findings on a quarterly basis to the Executive Committee of the Medical Staff.
- 3. Meetings: The Committee shall meet on the call of the Chairperson as needed.

Section 7 – Credentialing and Privileging Committee

- 1. Composition: The Credentialing and Privileging Committee shall consist of the appointed chair, the Chief of Staff and Chief of Professional Services as ex-officio members, at least one psychiatrist from each division and two physicians from Ambulatory Care Services. The Executive Committee may appoint additional physician or non-physician members if it deems this necessary.
- 2. Duties: The Credentialing and Privileging Committee shall:
 - A. Gather, authenticate and evaluate all necessary information to assure that an applicant possesses the necessary qualifications for an appointment and reappointment to the Medical Staff and is appropriately trained, maintaining competence and capable of carrying out any privileges granted to him/her.
 - B. Revise any forms and procedures in this process to comply with any changes in Medical Staff By-Laws, information sources, and State Statutes.
 - C. Provide to the Executive Committee of the Medical Staff with recommendations regarding the credentials and privileges of any application, or Medical Staff member, applying for or reapplying for Medical Staff membership, privileges, or delineated clinical activities

- D. Have available for the Executive Committee's inspection any and all documentation to support its recommendations.
 - E. Maintain a permanent record of its proceedings, findings, and recommendations.
 - F. Present a quarterly report summarizing its activities to the Executive Committee of the Medical Staff.
3. Meetings: The Committee will meet at least quarterly and more frequently if necessary.

Section 8 – Peer Review Committee

- 1. Composition: The Peer Review Committee shall consist of the appointed Chair, and the Chief of Staff. Medical Directors become members in the context of chairing Critical Incidents Reviews. Members of the Medical Staff are appointed, according to the Medical Staff By-laws (see Article X, Section 2) to serve on Death Reviews and Peer Reviews. Additionally the Chief of Professional Services may present administrative issues as they relate to standards of practice and care.
- 2. Duties: The Peer Review Committee shall:
 - A. Oversee, coordinate, and evaluate peer review activities of the Medical Staff including but not limited to death reviews, peer reviews, Focused Professional Performance Evaluations, and critical incident reviews.
 - B. Take responsibility for performing case reviews and recommending corrective action for identified problems regarding clinical competence.
 - C. Make recommendations for further activities by departments and services designed to promote quality and maintain the highest caliber of clinical care and professional conduct.
 - D. Present a summary report of its activities on a quarterly basis to the Executive Committee of the Medical Staff.
- 3. Meetings: The Committee shall meet on the call of the Chairperson as needed, but at least quarterly.

Section 9 – Committee on Medical Staff Health

- 1. Composition: The Committee on Medical Staff Health shall consist of four Members of the Medical Staff appointed for a five-year term by the President of the Medical Staff, in consultations with the Executive Committee of the Medical Staff. There shall be one member from each Division of the Hospital and one member from Ambulatory Care Services.
- 2. Duties: The Committee on Medical Staff Health shall:
 - A. Educate the Medical Staff (in coordination with the Continuing Medical Education Committee) and other Hospital staff about illness, impairment recognition, and treatment specific to physicians.
 - B. Educate the Medical Staff and other Hospital Staff on the appropriate mechanisms for physician referral.
- 3. Meetings: The Chair shall call regular quarterly meetings, or more often as needed.

ARTICLE XIV. MEDICAL STAFF MEETINGS

- 1. General Meetings: There shall be at least ten (10) meetings per year. The Medical Staff shall receive Performance Improvement reports at least quarterly.

2. Special Meetings: The Chief of Staff; the President of the Medical Staff; Members by petition to the Executive Committee and if supported in writing by at least twenty-five percent (25%) of the Active Members, may call a special meeting at any time. Written or telephone notice to all Active Members stating the purpose, place, date and hour shall be made by those requesting the meeting at least twenty-four (24) hours prior to the meeting. No business shall be transacted at any special meeting except that given in the notice of the meeting.
3. Attendance: Active Members, Advanced Practice Registered Nurse members, and Physician Assistant Members of the Medical Staff shall be expected to attend all general and special meetings and all meetings of committees of which they are members. Each of these members is required to maintain an attendance of at least fifty (50%) of all required meetings. Practitioners who regularly work twenty-five (25) hours or less per week must attend twenty-five percent (25%) of meetings. A part-time practitioner is not excused if he/she is not scheduled to work on the meeting days.
4. Quorum: Forty percent (40%) of the Active and Advanced Practice Registered Nurse and Physician Assistant full-time Medical Staff shall constitute a quorum at any regular or special meeting. A majority of those present and voting shall be required to accept or reject an issue. For Medical Staff Committees, a quorum shall be 40% of the total membership. However, the Chair-person may declare a quorum for the purpose of conducting business.

ARTICLE XV. RULES AND REGULATIONS

The Medical Staff has the ability to adopt Medical Staff Rules and Regulations and to propose them directly to the Governing Body. If the Medical Staff proposes to adopt a Rule and Regulation, they first communicate the proposal to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff shall review the Rules and Regulations at least biannually and make amendments as may be necessary to implement more specifically any general principles found within these By-Laws, State or Federal statute or regulation, and/or articulated in the Hospital's policies and procedures. The Executive Committee of the Medical Staff is responsible for review and revision. All revisions shall be presented to the Medical Staff for majority vote of the voting members present for adoption by the Medical Staff and approval by Governing Body. Revised Rules and Regulations will be available to all members through the Office of the Chief of Staff.

ARTICLE XV. ADOPTION AND AMENDMENT OF THE BY-LAWS

Section 1 – Review and Revision

The Medical Staff Bylaws, are reviewed biannually by the Executive Committee of the Medical Staff and, when necessary, are revised to reflect the Hospital's current practices with respect to Medical Staff organization and functions. The Medical Staff has the ability to adopt Medical Staff By-Laws and to propose amendment to them directly to the Governing Body. For the adoption of amendments directly to the Governing Body, the procedure would follow the process in Section 2 except that the amendment would not be submitted to the Executive Committee of the Medical Staff.

Section 2 – Amendments

1. Proposals for amendment, additions and deletions that are not presented directly to the Governing Body shall be submitted to the Executive Committee of the Medical Staff, which shall submit its recommendations in writing to the Medical Staff for vote at least one (1) week before a vote is taken.

2. These By-Laws shall be adopted or amended at any regular or special meeting of the Active members and Advanced Practice Registered Nurse and Physician Assistant members following reasonable written notice. A vote of two-thirds (2/3) of the Active members, Advanced Practice Nurses, and Physician Assistant voting members present shall be required to adopt or amend the By-Laws. A quorum of 40% of the full time members of the Medical Staff is required for a vote to be taken. Absent members may register a proxy vote by advance arrangement with the President of the Medical Staff.

Section 3 – Adoption

These By-Laws and any further amendments thereto shall become effective when adopted by the Medical Staff and approved by the Governing Body.

Revision Effective Dates:

Proposed by Medical Staff: 8//18

Approved by Governing Body: 8//18

Implementation Date: 9/01/18