UF HEALTH SHANDS HOSPITAL MEDICAL STAFF BYLAWS

Re-Adopted by

Board of Directors, Effective

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Preamble

UF Health Shands has established, within and as a constituent part of the entity, a Medical Staff consisting of all Practitioners who have been granted the right to exercise Clinical Privileges within the entity. The UF Health Shands Board of Directors has delegated to the Medical Staff the responsibility for the quality and appropriateness of the professional performance and ethical conduct of Medical Staff Members, as well as oversight of the quality of care, treatment, and services delivered by Allied Health Practitioners. In fulfilling its duties, the Medical Staff is accountable to the UF Health Shands Board of Directors.

The Medical Staff has adopted Medical Staff Bylaws and Rules, approved by the Board of Directors, to fulfill its responsibilities and govern its functions. The Bylaws and Rules shall not constitute contracts between the Hospital and the Medical Staff or its individual members. The Medical Staff Bylaws and Rules are intended to be compatible with each other. In the event of a conflict between the Bylaws and Rules, the Bylaws will control. In the event of a conflict between the Bylaws and federal or state law, such law will control. When taking action under the Bylaws or Rules, substantial compliance is required. Technical or minor deviations from the procedures set forth in the Bylaws or Rules shall not invalidate any review or action taken.

Article I Name, Purpose, and Responsibilities

1.1 Name

The name of the organization is the Medical Staff of UF Health Shands.

1.2 Purpose

1.2.1 To serve as the formal organizational structure through which the benefits and obligations of Medical Staff Membership are obtained and fulfilled;

1.2.2 To serve as the primary means of accountability to the Board of Directors for appropriate professional performance and ethical conduct of Medical Staff Members;

1.2.3 To provide a means through which the Medical Staff strive to ensure the provision of high quality within the Hospital through delineation of appropriate Clinical Privileges and ongoing review and evaluation of the quality of professional care rendered at the Hospital;

1.2.4 To provide a means through which the Medical Staff may participate in the development of Hospital policy and strategic planning; and

1.2.5 To provide a forum for communication, collaboration, and reporting between the organized Medical Staff, Hospital Administration, and the Board of Directors.

1.3 Responsibilities

1.3.1 Subject to the approval of the Board of Directors, to develop and adopt Medical Staff Bylaws and Rules for self-governance, and prepare amendments thereto, as necessary, to stay abreast of changes in clinical practice and legal standards;

1.3.2 To make recommendations to the Board of Directors for the appointment and reappointment of qualified and competent Practitioners to the Medical Staff;

1.3.3 To provide oversight of the quality of care, treatment, and services provided by Medical Staff Members;

1.3.4 To maintain professional, collegial, and ethical relationships and interactions between the Medical Staff and all other members of the healthcare team;

1.3.5 To ensure that all patients treated in Shands Hospital facilities receive appropriate care without regard to race, religion, color, ancestry, economic status, marital status, gender identity, age, sex, sexual orientation, national origin, payment, or any other potential discriminates;

1.3.6 To establish criteria for evaluating clinical practice and to oversee quality improvement, patient safety, and utilization review activities;

1.3.7 To conduct research and education in the setting of clinical care that will lead to advancement of professional knowledge and skill, while maintaining ethical and scientific standards and quality care and preserving the dignity and honor of all patients;

1.3.8 To enforce and ensure ongoing compliance with the Medical Staff Bylaws and Rules by members of the Medical Staff; and

1.3.9 To select and remove the Medical Staff officers.

Article II Definitions

2.1 Admitting Privileges. The privilege granted to Medical Staff Members to admit patients to the Hospital in inpatient or observation status.

2.2 Advanced Practice Professionals. Individuals who are trained as advanced practice nurses (APRNs), physician assistants (PAs), certified nurse midwives, certified registered nurse anesthetists (CRNAs), and certified anesthesia assistants (CAAs) who may apply for Allied Health Medical Staff Privileges.

2.3 Allied Health Professional. A non-physician health Practitioner who is granted Clinical Privileges in accordance with the Allied Health Policy on Clinical Privileges.

2.4 Associate Chief of Staff. The physician who is appointed to assist the Chief of Staff in performing their duties.

2.5 Attending, or Attending Physician. A physician, dentist, or podiatrist member of the Active Medical Staff who takes primary responsibility for patients in the inpatient setting. The Attending Physician is also responsible for the medical Students, Residents, and Fellows on the Attending's clinical service in any clinical setting.

2.6 Board Certification. Certification by an approved specialty board, as set forth in the Medical Staff Bylaws.

2.7 Board of Directors, or Board. The UF Health Shands Board of Directors or an appropriate Committee of the Board.

2.8 Chief Executive Officer, or CEO. The Chief Executive Officer of UF Health Shands.

2.9 Chief Medical Officer, or CMO. The physician employed by the Hospital to oversee clinical activity at UF Health Shands. The CMO is a Hospital executive who reports to the Hospital CEO, participates on Medical Staff committees, serves as liaison between the Medical Staff and Hospital Administration, and fulfills various duties prescribed by these Bylaws.

2.10 Chief of Service. The administrative and clinical head of a specific Clinical Service who fulfills the duties of leading the medical and operational aspects of the Clinical Service, in collaboration with hospital administrative staff.

2.11 Chief of Staff, or COS. An officer of the Medical Staff and Chair of the Medical Executive Committee.

2.12 Clinical Privileges, or Privileges. The authorization granted by the Board to render specific patient care services, for which the Medical Staff and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

2.13 Community Affiliate Staff. Non-employed or non-faculty Practitioners who do not provide care to patients in the Hospital setting but wish to be affiliated with the Hospital to order outpatient tests for their patients; request read-only access to the Electronic Health Record for the purpose of continuity of care; and participate in professional educational opportunities offered by the Hospital and Medical Staff. Community Affiliate Staff may attend general and special meetings of the Medical Staff and refer and follow patients, but they shall not be granted Clinical Privileges, shall not be eligible to vote or hold office, and shall not serve on committees.

2.14 Days. Calendar days, unless otherwise specified.

2.15 Ex-officio. A non-voting member of a committee appointed by virtue of their office.

2.16 Faculty. A University of Florida academic appointment. Faculty status does not equate to a Shands Hospital Medical Staff status, though many individuals will hold both a faculty appointment and Medical Staff appointment. The process for appointment to each of these is separate and unrelated.

2.17 Good Standing. A status that indicates a Medical Staff Member satisfies the basic eligibility requirements and qualifications for their Medical Staff Membership, has no outstanding Professional Review Activities, and is not currently subject to any type of Professional Review Action.

2.18 Hospital. For purposes of these Bylaws, Hospital means facilities recognized as part of UF Health Shands, including UF Health Shands Hospital, UF Health Psychiatric Hospital, UF Health Florida Recovery Center, and other UF Health Shands facilities as they are added to the organization.

2.19 Investigation. A formal process conducted by a Professional Review Body to make a detailed examination of facts related to a substantiated concern about a Practitioner's professional competence or conduct to determine whether a Professional Review Action should be recommended. Initial reviews of complaints or concerns to determine whether an Investigation should commence, collegial interventions, and routine peer review or patient safety activities, including, but not limited to, ongoing and initial focused professional practice evaluations, are not Investigations.

2.20 Medical Executive Committee, or MEC. A committee of the Medical Staff as described in these Bylaws.

2.21 Medical Staff, or Staff. Medical and osteopathic physicians, dentists, and podiatrists who have received an appointment by the Board in accordance with these Bylaws.

2.22 Notice. When Notice is required by these Bylaws, it shall be deemed given when a written communication is: (i) hand delivered to the addressee's business office, as indicated by signature of addressee or addressee's office staff member; or (ii) deposited with any type of delivery service offered by USPS, FedEx, or other commercial express delivery service to be delivered to the addressee's last known business or home

address with proof of delivery; or (iii) transmitted by facsimile or e-mail to the addressee's last known business fax or e-mail address.

2.23 Peer. A Practitioner in the same professional discipline.

2.24 Physician. A doctor of either medicine or osteopathy, including, when appropriate, as indicated by context, a Resident, or Fellow.

2.25 Practitioner. Unless otherwise indicated by context, a physician, dentist, or podiatrist.

2.26 Professional Review Action. An action or recommendation of a Professional Review Body which is taken or made in the conduct of a Professional Review Activity and that is: (i) based on an individual's competence or professional conduct that is or may be detrimental to the health or welfare of a patient or patients; and (ii) adversely affects or may adversely affect the Professional Staff Membership or Clinical Privileges of the individual.

2.27 Professional Review Activity. An activity to: (i) determine whether an individual may have Clinical Privileges or Medical Staff Membership; (ii) determine the scope or conditions of Clinical Privileges or Medical Staff Membership; or (iii) change or modify Clinical Privileges or Medical Staff Membership. A Professional Review Activity includes an Investigation.

2.28 Professional Review Body. The Board, the Credentials Committee, the MEC, or any other committee or panel which has the authority to make an adverse recommendation or take an adverse action against a Practitioner in accordance with the Medical Staff Bylaws.

2.29 Resident Staff. Physicians, dentists, or podiatrists who are actively participating in good standing in an accredited residency program or fellowship program. Resident Staff may attend general and special meetings of the Medical Staff and Medical Staff committees, but they shall not be entitled to vote and shall not be granted Admitting Privileges. Resident Staff who wish to continue their appointment following completion of or termination from their residency or fellowship program must meet the eligibility requirements of their preferred staff category and submit an application in accordance with these Bylaws.

2.30 Service Line Director. The clinical head of a specific clinical Service Line who fulfills the duties of leading the medical and operational aspects of the Service Line.

2.31 Student. An individual participating in internship or practicum phases of healthcare-related degree programs in the Hospital.

2.32 Telehealth. The use of medical information exchanged from one site to another via electronic communication for use in treatment of a patient. The originating site is the site at which the patient is receiving care and where the service is considered provided. The distant site is the site where the treating Practitioner or Allied Health Professional is located.

2.33 Unrestricted License. A fully active professional license without any conditions that limit or otherwise restrict the licensee's ability to practice their profession.

Article III Organizational Structure and Leadership

3.1 Officers of the Medical Staff

There will be a Chief of Staff, an Associate Chief of Staff (which shall be the Chief of Staff elect), and an Immediate Past Chief of Staff. These three individuals serve as the officers of the Medical Staff.

3.1.1 Eligibility. To be eligible to serve as an Officer, an individual must, at the time of nomination and appointment, be a licensed physician, dentist, or podiatrist who: (i) has been on the Active Staff in Good Standing for a minimum of three (3) years; (ii) has served as a voting member of the Medical Executive Committee; and (iii) has served as a Clinical Service Chief or Service Line Director at the Hospital. Failure to maintain such qualifications during the term of office shall immediately create a vacancy in the office involved.

3.1.2 Appointment.

3.1.2.1 The Chief of Staff and Associate Chief of Staff shall be appointed jointly by the CEO and the Dean of the University of Florida College of Medicine with confirmation by the Board of Directors.

3.1.2.2 The Chief of Staff will be automatically appointed to the position of Immediate Past Chief of Staff when their term expires and a new Chief of Staff takes office. In the event a Chief of Staff is removed from office, they are no longer eligible to serve as Immediate Past Chief of Staff. In such case, the office of Immediate Past Chief of Staff shall remain vacant until a duly qualified successor is appointed.

3.1.2.3 In addition to the basic eligibility requirements to serve as an Officer, individuals must also be knowledgeable of the Medical Staff Bylaws and Rules as well as regulatory aspects of Medical Staff affairs and have demonstrated leadership, collaboration, and problem solving skills.

3.1.3 Term of Office. The term of office for Medical Staff Officers shall be three (3) years. Officers assume office on January 1 following their appointment, except that an officer appointed to fill a vacancy assumes office immediately upon appointment. Each officer serves until the end of the term or until a successor is appointed**,** unless the officer is removed from office.

3.1.4 Vacancies in Office. If a vacancy occurs in the office of the Chief of Staff, the Associate Chief of Staff shall serve out the remainder of the Chief of Staff's term. If a vacancy occurs in the office of Associate Chief of Staff, the office shall be filled in the same manner as provided in these Bylaws. If a vacancy occurs in the office of Immediate Past Chief of Staff, the office shall remain vacant until it is filled upon the natural expiration of the current Chief of Staff's term as provided herein.

3.1.5 Resignation and Removal from Office. Any Medical Staff officer may resign by giving written Notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified in the Notice. Any Medical Staff officer may be removed from office by the Board of Directors acting on its own initiative, in consultation with the MEC. The Medical Staff may request removal of the Chief of Staff by petition of one hundred (100) members of the Active Staff. Such petition will be submitted to the MEC for review and recommendation to the Board. Permissible bases for removal include but are not limited to:

3.1.5.1 Psychiatric or physical impairment that prevents the individual from being able to fulfill the responsibilities of the office;

3.1.5.2 Inability, unwillingness, or failure to perform the duties and responsibilities of the position held in a timely and appropriate manner; or

3.1.5.3 Conduct that is damaging to the Hospital, its goals or programs.

3.2 Delegation of Functions

When an Officer or other individual assigned a function under these Bylaws is unavailable or unable to perform a necessary function, one or more Medical Staff Officers or the Chief Medical Officer may perform the function personally or delegate it to another appropriate individual. Any such designee is bound by all terms, conditions, and requirements of the Medical Staff Bylaws, Rules, and related policies. The delegating individual is responsible for ensuring that the designee appropriately performs the function in question.

3.3 Duties of Officers

3.3.1 Chief of Staff

3.3.1.1 Represent and communicate the views, policies, and needs—and report on the activities of—the Medical Staff to the CEO and the Board;

3.3.1.2 Serve as the liaison between the Medical Staff and Hospital Administration and between the Medical Staff and the Board of Directors in all matters of mutual concern involving patient care;

3.3.1.3 Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;

3.3.1.4 Serve as Chairperson of the MEC;

3.3.1.5 Take administrative actions for the MEC, when necessary, between meetings;

3.3.1.6 Promote adherence to the Bylaws, policies, and Rules and Regulations of the Hospital and its Medical Staff;

3.3.1.7 Oversee Medical Staff clinical activities, including quality improvement and patient safety;

3.3.1.8 Report to the CEO and the Board regarding clinical performance of the Medical Staff and quality improvement and patient safety activities;

3.3.1.9 Appoint, in consultation with the MEC, the members of the Medical Staff committees and designate chairs of each committee;

3.3.1.10 Represent the Medical Staff at the Hospital Board of Directors meetings, to outside licensing and accreditation agencies, and to the public;

3.3.1.11 Serve as a liaison to the Executive Committee of the College of Medicine, the Graduate Medical Education Committee, and outside licensing and accreditation agencies;

3.3.1.12 Serve as a spokesperson for the Medical Staff in external professional and public relations;

3.3.1.13 Serve as liaison between Hospital Administration and the Medical Staff regarding Hospital licensure, accreditation, and regulatory requirements affecting the Medical Staff; and

3.3.1.14 Fulfill such other duties as may be specified in the Medical Staff Bylaws, Rules, and Hospital policies.

3.3.2 Associate Chief of Staff

3.3.2.1 Serve as acting Chief of Staff when the Chief of Staff is not available;

3.3.2.2 Chair Medical Staff committees as assigned by the Chief of Staff;

3.3.2.3 Assist the Chief of Staff with their duties; and

3.3.2.4 Perform other duties as assigned by the Chief of Staff.

3.3.3 Immediate Past Chief of Staff

3.3.3.1 Serve as a resource to the Chief of Staff and Associate Chief of Staff; and

3.3.3.2 Assist the Chief of Staff and Associate Chief of Staff with specific duties and functions as needed to support the Medical Staff as assigned by the Chief of Staff.

3.3.4 Hospital Chief Medical Officer. In addition to fulfilling the role of Chief Medical Officer of the Hospital, the Medical Staff assign the following duties to the CMO:

3.3.4.1 Serve as Chairperson of the Medical Staff Quality and Operations Committee;

3.3.4.2 Enforce the Bylaws, policies, and Rules and Regulations of the Hospital and its Medical Staff; and

3.3.4.3 Fulfill such other duties as may be specified in these Medical Staff Bylaws.

3.4 Hospital Clinical Services and Hospital Service Lines

3.4.1 The Hospital may establish Hospital Clinical Services and multi-disciplinary Service Lines to facilitate the delivery of quality, safe, and effective patient care. The Hospital Clinical Services largely parallel the College of Medicine Departments and are structured to provide direct patient care in designated practice areas. For each Clinical Service, a physician, dentist, or podiatrist shall be designated to serve as the Service Chief who will be responsible for the day-to-day operations of the Clinical Service. When multiple practice areas cross multiple specialties, the Hospital may designate these as Service Lines. When Service Lines exist, a physician, dentist, or podiatrist shall be designated to serve as the Service Line Director who will be responsible for the overall clinical service and who will work collaboratively with an administrative partner to manage the operations of the Service Line.

3.4.2 Each credentialed member of the Medical Staff will be assigned to a primary Clinical Service. Additional Clinical Services or Service Lines may also be assigned in addition to the primary Clinical Service, and privileges may be granted from more than one Clinical Service or Service Line.

3.4.3 From time to time, Clinical Departments and Service Lines may be created, eliminated, subdivided, or combined in accordance with changes in clinical service delivery, or Hospital organization or management, in concordance with the Medical Executive Committee and the Board of Directors.

3.4.4 Current Hospital Clinical Services:

1. Anesthesiology
2. Clinical Health and Psychology
3. Community Health/Family Medicine
4. Dentistry
5. Dermatology
6. Emergency Medicine
7. Medicine
8. Neurology
9. Neurosurgery
10. Obstetrics/Gynecology
11. Ophthalmology
12. Orthopaedics
13. Otolaryngology
14. Pathology
15. Pediatrics
16. Physical Medicine and Rehabilitation
17. Psychiatry
18. Radiation Oncology
19. Radiology
20. Surgery
21. Urology

3.4.5 Current Hospital Service Line(s):

1. Congenital Heart Center

3.5 Clinical Service Organizational Structure

3.5.1 Service Chief and Service Line Directors. Each Hospital Clinical Service and Service Line will have an appointed Service Chief/Director to serve as the clinical head of the Service. A University of Florida Department Chair may concurrently serve as a Service Chief for their corresponding clinical department.

3.5.1.1 Recommendation and Approval. The Dean of the applicable college will recommend a candidate for Chief of Service or Service Line Director to the Hospital CEO and Medical Executive Committee for approval. If approved, the candidate will be submitted for vote to the Professional Staff Credentialing Committee of the Board of Directors for final vote and approval.

3.5.1.2 Qualifications. To be eligible to serve as a Service Chief or Service Line Director, an individual must be a member in Good Standing of the Active Staff and be credentialed and privileged in the area of specialty of the Clinical Service or an appropriate specialty for the applicable Service Line.

3.5.1.3 Accountability. The Service Chiefs and Service Line Directors are accountable to the Chief of Staff for Medical Staff-related affairs and to the Chief Medical Officer for service and overall quality and safety of the Clinical Service or Service Line.

3.5.1.4 Responsibilities. The Service Chiefs and Service Line Directors are responsible for overseeing day-to-day operations as well as the practice of the assigned primary and secondary Medical Staff, including, but not limited to:

3.5.1.4.1 Ensuring that Medical staff Members adhere to Medical Staff Bylaws, Rules, and applicable policies;

3.5.1.4.2 Monitoring clinical practice of assigned Medical Staff Members to help ensure the delivery of safe, quality care that is consistent with the standard of care;

3.5.1.4.3 Developing, implementing, and enforcing policies necessary to conduct its affairs and discharge its responsibilities, ensuring that such policies are consistent with the Medical Staff Bylaws, Rules, and Hospital policies;

3.5.1.4.4 Developing clinical guidelines to help facilitate the delivery of safe, quality care;

3.5.1.4.5 Implementing and conducting peer review activities, such as Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE), to evaluate the professional practice of Practitioners and Allied Health Professionals who are assigned to the Clinical Service or Service Line, in accordance with Medical Staff Bylaws, Rules, and Hospital Policies;

3.5.1.4.6 Overseeing quality improvement, process improvement and patient safety initiatives in the area of clinical service provided;

3.5.1.4.7 Developing and implementing onboarding, orientation, and evaluation programs for newly credentialed Medical Staff assigned to the Clinical Service or Service Line;

3.5.1.4.8 Developing and maintaining, as current, privilege request forms that account for ongoing and evolving practice changes;

3.5.1.4.9 Reviewing credentialing documents and making recommendations to the Credentials Committee for appointment, reappointment, and the granting of Clinical Privileges, including performing any further investigation necessary to make an informed recommendation, within forty-eight (48) hours of assignment;

3.5.1.4.10 Reviewing OPPE data for all assigned Medical Staff Members on a routine and timely basis in accordance with Medical Staff Rules; implement and monitor completion and effectiveness of performance improvement plans; and report on such activities to the appropriate Medical Staff committees;

3.5.1.4.11 Timely reporting of any professionalism or practice concerns for assigned Medical Staff Members for which routine performance improvement activities have been unsuccessful or that are of such significance that time is of the essence to the Chief of Staff or Medical Staff Administration Office;

3.5.1.4.12 Assessing resource needs for the Clinical Service/Service Line, including staffing, space, equipment, and supplies, and making recommendations for resources necessary to, or that may optimize the provision of, safe and effective patient care and treatment;

3.5.1.4.13 Coordinating inter- and intra-department services and functions with the overall goals and objectives of the Hospital;

3.5.1.4.14 Establishing such committees, task forces, and other structures necessary to perform these functions; and

3.5.1.4.15 Reporting to the Credentials Committee, Medical Executive Committee, Quality and Operations Committee, and other Hospital and Medical Staff committees as directed.

3.5.1.5 Removal of a Service Chief/Service Line Director. A Service Chief or Service Line Director shall serve at the pleasure of the Board and may be removed with or without cause. If a Service Chief/Service Line Director is also a Department Chair, the role of Service Chief/Service Line Director shall terminate automatically upon the termination or resignation of the Department Chair.

Article IV Medical Staff Membership

4.1 Membership

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent Practitioners who are eligible to apply for appointment and who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and the Hospital. No Practitioner shall be entitled to membership on the Medical Staff or to exercise particular Clinical Privileges merely by virtue of licensure, certification by, or membership in, any professional organization, or privileges at any other healthcare organization.

4.2 Non-Discrimination

Medical Staff Appointment and Clinical Privileges shall not be limited or denied on the basis of race, religion, color, national origin, sex, sexual orientation, or gender.

4.3 Affiliation and Employment

No physician, dentist, or podiatrist may admit or provide services to patients in the Hospital unless they are a member of the Medical Staff and have been granted Clinical Privileges, or they have been granted emergency or disaster privileges with no Medical Staff Membership through the procedures set forth in these Bylaws.

4.4 Closed Medical Staff

The Board of Directors has determined that, for the purposes of ensuring the ongoing ability to provide quality care and maintain availability of appropriate clinical specialties to meet patient needs, standardization of services, and cost containment, the Active Medical Staff shall consist of Practitioners who are employed by the University of Florida. Practitioners not so employed may apply for other categories of Medical Staff Membership for which they are eligible.

4.5 Categories of Membership

4.5.1 Active Medical Staff Member. Appointees to the Active category are actively involved in the treatment of patients in the Hospital and actively engaged in quality improvement and/or Medical Staff leadership activities.

4.5.1.1 Qualifications. To be eligible to apply for membership on the Active Medical Staff, the individual must:

4.5.1.1.1 Be employed by the University of Florida and must meet other eligibility requirements as provided in these Bylaws;

4.5.1.1.2 Be able to provide continuous care, treatment, and services to their patients in the Hospital and Hospital-based Clinics, as defined in all relevant Service/Department policies, Rules, and Regulations; and

4.5.1.1.3 Regularly admit, or are otherwise regularly involved in the care of, patients in this facility, with a minimum of 25 unique patient encounters per calendar year.

4.5.1.2 Prerogatives. Appointees to the Active Category are to:

4.5.1.2.1 Admit, treat, or perform services on Hospital patients;

4.5.1.2.2 Exercise only such Clinical Privileges as are granted to them as provided in these Bylaws;

4.5.1.2.3 Be appointed as a voting member to Medical Staff committees;

4.5.1.2.4 Vote on all matters presented at general and special meetings of the Medical Staff; and

4.5.1.2.5 Vote in all elections for Medical Staff Officers, based on eligibility.

4.5.1.3 Responsibilities. Active Medical Staff Members must:

4.5.1.3.1 Abide by the general responsibilities as provided in these Bylaws;

4.5.1.3.2 Meet membership criteria as provided in these Bylaws;

4.5.1.3.3 Satisfy the specific requirements of the Hospital Clinical Service and/or Hospital Clinical Service Line for which they are a member;

4.5.1.3.4 Participate in on-call coverage and provide care for unassigned hospitalized and emergency patients, regardless of their ability to pay, in accordance with the Hospital and Staff's responsibilities under applicable law and as per Medical Staff Bylaws, Hospital Policies and Procedures, and/or as directed by the Clinical Service for which they are a member. This participation is considered a duty and responsibility derived from the privilege of Active Staff Membership, but is not a right of an Active Staff Member; and

4.5.1.3.5 Actively participate in committees, performance improvement functions, quality improvement activities, supervising provisional appointees, peer review, and risk management. This participation is a considered a duty and responsibility derived from the privilege of Active Staff Membership, but is not a right of an Active Staff Member.

4.5.2 Administrative Staff. Any physician, dentist, or podiatrist, who is not eligible for another membership category and who is employed by the Hospital to perform ongoing clinically operational or administrative duties may apply for membership to the Administrative Staff. Unless otherwise stated by the individual's employment agreement or other contract with the Hospital, such individual's staff appointment shall be contingent upon the continuance of such agreement or contract. Upon termination of such agreement or contract, the individual's appointment shall automatically terminate and the individual shall not be entitled to the procedural rights as provided in these Bylaws.

4.5.2.1 Qualifications. A physician, dentist, podiatrist, or psychologist is currently employed in a Hospital Administrative position that has responsibility for oversight or leadership of a clinical operational unit of the Hospital and that has been designated by the CEO and Chief of Staff as eligible for appointment to the Administrative Staff.

4.5.2.2 Prerogatives and Responsibilities

4.5.2.2.1 Administrative Staff may participate in Medical Staff committees, patient safety and quality improvement activities, performance improvement initiatives, and risk management activities. Such participation is considered a duty and responsibility derived from the privilege of Administrative Staff Membership and shall cease upon expiration of termination of appointment to the Administrative Staff.

4.5.2.2.2 Administrative staff are not eligible to hold office in the Medical Staff organization, admit patients, or exercise Clinical Privileges, unless otherwise stated in these Bylaws for specific roles.

4.5.2.2.3 Administrative Staff may attend Medical Staff meetings but are not eligible to vote in Staff-wide votes. They may serve as voting members on Medical Staff committees.

4.5.3 Contract Staff. This category of membership includes Practitioners who are contracted with the Hospital or UF Health to provide specific services to the Hospital or to provide services for a limited or temporary amount of time.

4.5.3.1 Qualifications. Each Contract Staff Member must meet the general qualifications required for Medical Staff appointment and Clinical Privileges. The Credentials Committee shall assign each Contract Staff Member to the appropriate Staff category, and the Contract Staff Member shall have the same prerogatives and responsibilities as other members of such category with the exception that Contract Staff shall not be eligible to hold office or vote on Medical Staff matters.

4.5.4 Resident Staff or House Staff. Physicians, dentists, or podiatrists who are actively participating in good standing in an accredited residency program or fellowship program at the Hospital and who hold a Florida medical license may apply for Clinical Privileges in their primary training specialty, as allowed by Accreditation Council for Graduate Medical Education (ACGME) regulations, that would allow for the physician, dentist, or podiatrist to provide clinical services to Hospital patients outside of their residency or fellowship program and for which they would not receive educational credit ("moonlighting").

4.5.4.1 Qualifications. To be eligible to apply for Resident Staff Membership, the physician, dentist, or podiatrist must provide a letter of attestation of clinical competency to perform the requested privileges from the Service Chief and a letter from their Program Director attesting ACGME eligibility, if applicable, and a plan for monitoring hours on duty.

4.5.4.2 Prerogatives and Responsibilities. If granted Clinical Privileges:

4.5.4.2.1 Resident Staff shall be subject to a focused professional practice evaluation for a minimum of six (6) months. Resident staff appointment shall not exceed a period of one (1) year.

4.5.4.2.2 Resident Staff may attend general and special meetings of the Medical Staff and Medical Staff committees, but they shall not be entitled to vote and shall not be granted Admitting Privileges.

4.5.4.2.3 Resident Staff Membership and Clinical Privileges shall be contingent upon the physician, dentist, or podiatrist remaining in their residency or fellowship program in Good Standing and ongoing ACGME or other applicable eligibility. Failure to maintain such shall result in automatic termination of staff membership and Clinical Privileges (without the rights provided in Article XIII herein).

4.5.4.2.4 Resident Staff who wish to continue their appointment following completion of or termination from their residency or fellowship program must meet the eligibility requirements of their preferred staff category and submit an application in accordance with these Bylaws.

4.5.5 Community Affiliate Staff. These consist of Practitioners who do not provide care to patients in the Hospital setting but wish to be affiliated with the Hospital to order outpatient tests for their patients and participate in professional educational opportunities offered by the Hospital and Medical Staff. Community Affiliate Staff shall not be granted Clinical Privileges.

4.5.5.1 Qualifications. Community Affiliate Staff must satisfy the general qualifications for Medical Staff appointment as provided in these Bylaws, as well as any requirements for Community Affiliate Staff established by the Clinical Department or Service Line to which they are applying.

4.5.5.2 Obligations

4.5.5.2.1 Pay any dues or fees assessed by the Medical Staff;

4.5.5.2.2 Acknowledge that they do not have Clinical Privileges and may not provide services at or admit patients to the Hospital, and agree to inform each patient for whom such outpatient services are ordered that, in the event Hospital admission is required for any reason, the patient will need to be admitted to the care of a Medical Staff Member with appropriate staff appointment;

4.5.5.2.3 Acknowledge that Community Affiliate Staff appointment is a courtesy extended by the Hospital for the purpose of accommodating special limited needs of Practitioners and their patients. Community Affiliate Staff are not members of the Medical Staff and do not have Clinical Privileges. Accordingly, the termination of, or the refusal to grant, renew, or modify Community Affiliate Staff appointment, is not a Professional Review Action and shall not entitle an affected Practitioner to procedural rights under Article XIII of these Bylaws; and

4.5.5.2.4 Acknowledge that they shall be subject to the same quality assurance oversight as Staff Appointees and Hospital policies related to the types of tests and therapeutic services that may be ordered and any specific medical indications required by Medical Staff Rules or Hospital policies.

4.5.5.3 Prerogatives and Responsibilities. Community Affiliate Staff may:

4.5.5.3.1 Order outpatient tests and therapeutic services, subject to any limitations in Hospital policies or Department or Medical Staff Rules;

4.5.5.3.2 Refer and follow patients, but they shall not be granted Clinical Privileges, shall not be eligible to vote or hold office, and shall not serve on committees;

4.5.5.3.3 Attend general and special meetings of the Medical Staff and their Clinical Department or Service Line; and

4.5.5.3.4 Attend educational programs offered by the Hospital or Medical Staff.

4.5.6 Allied Health Medical Staff Member. The Allied Health Professional (AHP) category of Medical Staff Membership is for non-physician Practitioners who are granted Clinical Privileges in the Hospital.

4.5.6.1 Clinical privileges of AHPs are coterminous with any employment or contractual relationship the AHP may have with the Hospital or their supervising Practitioner(s). Any termination of Clinical Privileges pursuant to this provision is not subject to the Hearing and appeals rights or procedures provided in Article XIII.

4.5.6.2 AHPs shall be supervised by a physician, dentist, or podiatrist member of the Medical Staff as required by state and federal laws and regulations.

4.5.6.3 The following types of AHPs, who otherwise meet all eligibility requirements, may seek Clinical Privileges at the Hospital:

4.5.6.3.1 Advanced practice registered nurses (APRNs) who are certified in the specialty area in which the APRN requests to practice;

4.5.6.3.2 Anesthesiologist Assistants (AAs) who are certified by the Commission on Accreditation of Allied Health Education Programs (CAAHEP);

4.5.6.3.3 Midwives who are certified by the American College of Midwives;

4.5.6.3.4 Certified Registered Nurse Anesthetists (CRNAs) who are certified by the Council on Certification of Nurse Anesthetists;

4.5.6.3.5 Certified Registered Nurse First Assistants who are certified by the Association of Perioperative Registered Nurses and the Competency and Credentialing Institute as CRNFA;

4.5.6.3.6 Genetic Counselors who are certified by the American Board of Medical Genetics or the American Board of Genetic Counseling;

4.5.6.3.7 Licensed Mental Health professionals, including clinical social workers, expressive therapists, mental health counselor, marriage and family therapists, and psychologists;

4.5.6.3.8 Licensed optometrists;

4.5.6.3.9 Licensed Physician Assistants who are certified by the National Commission on Certification of Physician Assistants; and

4.5.6.3.10 Licensed psychologist;

4.5.6.3.11 Radiologist Assistants who are certified by the Certification Board of Radiology Practitioner Assistants or the American Registry of Radiologic Technologists.

4.5.6.4 Prerogatives. Appointees to the Allied Health Medical Staff Category:

4.5.6.4.1 May exercise only such Clinical Privileges as are granted as provided in these Bylaws; and

4.5.6.4.2 Are not eligible to vote on Medical Staff matters or serve as an officer. They may serve on Medical Staff committees as voting members but shall not serve as chairpersons.

4.5.6.5 Responsibilities

4.5.6.5.1 Abide by the general responsibilities of Medical Staff Membership as provided in these Bylaws;

4.5.6.5.2 Continuously satisfy all eligibility criteria for the individual's category of membership as provided in these Bylaws;

4.5.6.5.3 Comply with these Medical Staff Bylaws and Rules and applicable Hospital, Clinical Service, and Service Line policies;

4.5.6.5.4 Participate in on-call coverage and provide care for unassigned hospitalized and emergency patients, regardless of their ability to pay; and

4.5.6.5.5 Actively participate, as assigned, in committees, performance improvement functions, quality improvement activities, supervising provisional appointees, as assigned, peer review, and risk management.

4.5.7 Honorary Medical Staff Member. Appointees to the Honorary Category are former Active Staff Members whom the Board and Medical Staff wish to honor. Honorary Staff Members are not eligible for Clinical Privileges and are therefore no longer required to meet the minimum required qualifications in these Bylaws. They may attend Medical Staff meetings as guests, may be involved in teaching, and may be appointed as non-voting members of committees. They may not hold office and are not considered to be current or active members of the Medical Staff.

4.6 Eligibility Requirements for Medical Staff Membership

4.6.1 Basic Requirements. In addition to any other requirements applicable to the category of Medical Staff Membership for which the individual wishes to apply, in order to be considered for membership, obtain membership and maintain membership on the Medical Staff, applicants must continuously have:

4.6.1.1 A current unrestricted license to practice from a Florida licensing board;

4.6.1.2 A full and unrestricted license to practice medicine in the State of Florida or a valid Medical Faculty Certificate to practice at the University of Florida. On occasion, the Florida Board may issue a license with restrictions. In those cases, credentialing and privileging shall be considered provisional until the restriction is lifted;

4.6.1.3 Eligibility to participate in Medicare, Medicaid and other federally sponsored health programs;

4.6.1.4 Eligibility for medical malpractice coverage through the Florida Self-Insurance Program (SIP); and/or compliance with insurance coverage as set forth in these Bylaws;

4.6.1.5 For Active, Contract Staff, Resident or House Staff, and Allied Health Medical Staff Members, a copy of the current certificate of liability coverage that denotes UF Health Shands as the Certificate Holder, provides the effective dates of the policy, identifies the applicant by name and coverage exclusions (if any), and provides for either claims made or occurrence-based coverage of $250,000 per claim, $750,000 in the aggregate, or appropriate confirmation/evidence of an unexpired irrevocable letter of credit that satisfies the Practitioner's licensure requirements in an amount of not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000;

4.6.1.6 Current and unrestricted Drug Enforcement Administration (DEA) registration, if required for the individual's practice. If DEA registration is pending, a sixty (60) day waiver may be granted provided an alternate prescriber with associated practice is designated.

4.6.1.7 For AHPs, any current certifications required by the AHP's licensing board to allow the AHP to exercise the Clinical Privileges requested.

4.6.2 Education and Training

4.6.2.1 Applicant must be a graduate of an accredited medical, dental, or podiatry school; an advanced practice nurse program; a physician assistant program; or be an anesthesiology assistant.

4.6.2.2 For appointment of a physician, dentist, or podiatrist to the Active Staff:

4.6.2.2.1 Satisfactory completion of a residency program in an appropriate specialty for the Clinical Service or Service Line to which the Practitioner is applying and that is approved by the ACGME in conjunction with the Residency Review Committee of the American Medical Association, the American Osteopathic Association, or the American Board of Podiatric Medicine; or an equivalent program approved by the Credentials Committee;

4.6.2.2.2 Continuous board certification or board eligibility in an appropriate specialty board for the Clinical Service or Service Line to which the Practitioner is applying;

4.6.2.2.3 For Practitioners who are unable to satisfy the requirements as provided in these Bylaws, have received a waiver of these requirements from the Credentials Committee after providing evidence of satisfactory alternative education and training to support the Clinical Privileges for which the Practitioner is applying and receiving a written recommendation for waiver from the applicable Service Chief or Service Line Director that such waiver is in the best interest of the Hospital and in support of patient needs;

4.6.2.2.4 Has actively practiced medicine (including residency) for at least twelve (12) of the last twenty-four (24) months, and has actively practiced in an acute care hospital for at least twenty-four (24) of the last thirty-six (36) months; and

4.6.2.2.5 Practitioners granted Active Staff Appointment on or before 2006 and dentists are exempt from the above residency and board certification/board eligibility requirements.

4.6.2.3 For Appointment to the Allied Health Professional Staff:

4.6.2.3.1 Successful completion of a training program in an accredited training program specific to the Clinical Privileges requested; and

4.6.2.3.2 As required by law or the applicable licensing board, continuous certification or registration in Good Standing in a specialty appropriate to the requested Clinical Privileges.

4.6.3 Practice. Practice in a branch of healthcare or a specialty which is consistent with the purposes, treatment, philosophy, methods, and resources of the Hospital and for which the Hospital has a current need.

4.6.4 Current Competence. Current competence, as demonstrated by background, experience, demonstrated ability, availability, physical and psychiatric health status, and clinical results, which document a continuing ability to provide quality patient care and perform the requested Clinical Privileges.

4.6.5 Ability. Freedom from or adequate control of any significant physical, psychiatric, or behavioral impairment that would interfere with the ability of the individual to safely and competently perform the Clinical Privileges requested, or comply with the Medical Staff Bylaws, Rules, Hospital policies or Code of Conduct.

4.6.6 Availability. Medical Staff Members are required to be readily available, personally or through on-call arrangements, to all patients under the individual's care and supervision to allow for continuity of care and must present to the Hospital when on-call within thirty (30) minutes of being called, unless a waiver has been granted by the Credentials Committee. Members are also responsible for providing current contact information to the Hospital so they can be reached immediately when providing on-call services or during an emergency.

4.7 Additional Rights of Medical Staff Member

In addition to the other rights set forth in these Bylaws, members of the Medical Staff have the following additional rights:

4.7.1 Each Practitioner on the Medical Staff has the right to an audience with the MEC upon presentation of a written request;

4.7.2 Any Practitioner may initiate a petition for a special meeting of the Medical Staff, upon presentation of a petition signed by one hundred (100) members of the Active Staff, which shall be scheduled in accordance with these Bylaws; and

4.7.3 A Practitioner may propose a change of the Bylaws in accordance with the Methods of Adoption and Amendment as provided in these Bylaws.

4.8 Conditions and Duration of Appointment

4.8.1 Initial appointments and reappointments to the Medical Staff shall be made by the Board of Directors. The Board shall act on appointments and reappointments only after there has been a recommendation from the MEC.

4.8.2 Appointments to the Active Staff, Allied Health Medical Staff, Community Affiliate Staff, and Contract Staff shall not exceed a period of thirty-six (36) months. Appointments to the Resident Staff shall not exceed a period of twelve (12) months. Administrative Staff appointments shall expire when the administrative role terminates. Honorary Staff appointments shall not expire.

4.8.3 Each Medical Staff Member, as a condition of being granted and enjoying Medical Staff Membership and Clinical Privileges under these Bylaws, shall:

4.8.3.1 Continuously satisfy the basic eligibility requirements for their respective category of membership set forth in these Bylaws;

4.8.3.2 Comply with the Medical Staff Bylaws and Rules and applicable Hospital and Medical Staff policies;

4.8.3.3 Provide patients with quality patient care within the scope of the member's delineated Clinical Privileges;

4.8.3.4 Discharge such Medical Staff, Clinical Service, Service Line, committee, and Hospital functions for which the member is responsible by staff category, appointment, election, or otherwise;

4.8.3.5 Prepare and complete, in a timely manner, accurate and complete records for all patients to which the member provides care;

4.8.3.6 Cooperate fully with any review of the individual's credentials, qualifications, abilities, professional activities, compliance with Medical Staff Bylaws, Rules, and applicable policies, and refrain from interfering with or hindering any such review; and

4.8.3.7 Provide all necessary health information to allow the Hospital to comply with applicable federal and state laws and regulations.

Article V Appointment and Reappointment

5.1 Procedure for Application for Initial Appointment

Every applicant for appointment will:

5.1.1 Be subject to the appointment process as provided in these Bylaws.

5.1.2 Submit a properly completed application. Properly completed means that all provisions have been completed or an explanation has been provided for those that are not, and all required supporting documentation has been submitted and accepted. An application is not considered complete until an internal quality check has been completed by the Medical Staff Office, at which time it will enter into active application status. Incomplete applications or applications that indicate the applicant does not meet basic eligibility requirements shall not be processed. A complete application will include, but is not limited to:

5.1.2.1 Names and full current contact information for at least two (2) professionals who have knowledge of the applicant's current clinical competency.

5.1.2.1.1 At least one (1) reference should be from the same specialty professional practice area of the applicant.

5.1.2.1.2 None of the references may be related to the applicant.

5.1.2.2 A total of two (2) submitted and completed reference forms.

5.1.2.3 An attestation that the individual will notify the Chief of Staff/Medical Staff Administration Office of any changes in the information provided during the application period or after it has been reviewed.

5.1.2.4 A written and signed authorization to allow the Hospital and Medical Staff Administration Office to:

5.1.2.4.1 Carry out required background checks;

5.1.2.4.2 Obtain all records and documents that may be material to the evaluation of the applicant's qualifications, as per the judgement of the Chief of Staff, Department Service Chief, committees of the Medical Staff, or the Board of Directors; and

5.1.2.4.3 Authorize the Hospital to release information to UF Health and all related entities, so long as the release of information is given without malice and in good faith.

5.1.2.5 Information regarding any action, including any past, present or pending investigations, which have been undertaken since the last application regarding the applicant's professional status, qualifications, credentialing or privileging, including but not limited to:

5.1.2.5.1 Any action taken related to licensure, staff membership, privileges, professional organizations, and all related matters;

5.1.2.5.2 Any voluntary or involuntary termination of Medical Staff Membership;

5.1.2.5.3 Any voluntary or involuntary limitation, reduction, or loss of Clinical Privileges;

5.1.2.5.4 Any voluntary termination of Clinical Privileges when relinquishment was done to avoid an adverse action, to preclude an investigation, or when the licensee was under investigation related to professional conduct;

5.1.2.5.5 Any Precautionary suspension or temporary limitation of Clinical Privileges;

5.1.2.5.6 Any other corrective or quality-related action (whether disciplinary or not) including, but not limited to non-routine proctoring, mandatory chart review, requirements for additional or specific Continuing Medical Education (CME) or training programs, FPPE initiated other than for initial or additional privileges;

5.1.2.5.7 Any temporary or permanent restriction, denial, suspension, reduction, stipulation, limitation, probation, surrender, revocation, withdrawal, or non-renewal, whether voluntary or involuntary of professional license or DEA license, for any reason. This includes any reprimand, fine, or letter of guidance;

5.1.2.5.8 Any instance in which a membership in a local, state, or national professional organization was temporarily or permanently denied, reduced, suspended, revoked, relinquished, withdrawn or not renewed, for any reason; and

5.1.2.5.9 Any information about whether the applicant has ever had a confirmed/founded report of abuse or neglect of a patient.

Applicants are not required to disclose leave of absence requests or temporary privilege changes for treatment of any health conditions, unless the Practitioner is currently in a mandated monitoring program.

5.1.2.6 Information pertaining to the applicant's professional liability coverage, including appropriate amounts and coverage for all privileges requested, any prior claims, regardless of outcome, professional liability suits, judgments, settlements, arbitrations, or liability insurance denials, cancellations or non-renewals.

5.1.2.7 Information about:

5.1.2.7.1 Any health conditions that preclude or limit the applicant's ability to perform the Clinical Privileges being requested;

5.1.2.7.2 Whether the applicant has been engaged in or treated for the use or misuse of prescription drugs, use of illegal substance chemicals or substances that could impair the applicant's ability to perform their professional or medical practice duties; and

5.1.2.7.3 Whether the applicant has ever held or currently holds a contract with the Physician Resource Network or other similar healthcare professional recovery program.

5.1.2.8 Information about whether the applicant has ever been convicted of or pled guilty or no contest to any type of felony offense, entered into a pre-trial agreement for a felony, is presently under indictment for a felony.

5.1.2.9 Information about any past, present or current exclusion from any federal, state or other third-party healthcare benefit program, including, but not limited to:

5.1.2.9.1 Any past or current denials for enrollment or disqualifications by a private health plan or federal or state program.

5.1.2.9.2 Censuring or reprimands or suspension of participation in a health plan of any kind.

5.1.3 Provide a signed attestation that the applicant has:

5.1.3.1 Provided an application that is wholly true, complete and correct, and an agrees to notify the Hospital immediately, in writing, of any changes or additions to the information provided by the applicant.

5.1.3.2 Received and reviewed a copy of the current Medical Staff Bylaws and that they understand that they, if credentialed and privileged, will be bound by the terms of the most current version of the Bylaws, as they are amended from time to time.

5.1.3.3 Reviewed and signed the Code of Conduct for the Medical Staff and that they will abide by the elements stated within.

5.1.3.4 Released from liability all representatives of the Hospital and the Medical Staff for their acts performed in good faith in evaluating the applicant's qualifications.

5.1.3.5 Released from liability all individuals and organizations who, in good faith, provide information to the Hospital and the Medical Staff concerning the applicant, including privileged and confidential information.

5.1.3.6 Agreed to be bound by the policies, procedures, Bylaws, Rules and Regulations of the Medical Staff, Hospital and UF Health.

5.1.3.7 Agreed to undergo a health examination or neurocognitive assessment at any time, if requested by the Chief of Staff, Credentials Committee, MEC or the Board. Such request must be supported by a statement of reasons.

5.1.3.8 Agreed to appear for an interview, if requested.

5.1.4 Agree to notify the Credentials Committee and Medical Staff Administration within thirty (30) days of any change in the information provided in the individual's application.

5.2 Procedure for Application for Reappointment

Every applicant for reappointment will:

5.2.1 Be subject to the reappointment process as provided in these Bylaws. Factors that will be taken into consideration when considering appointment or reappointment include, but are not limited to their:

5.2.1.1 Current clinical competency, clinical judgment, quality of patient care, clinical activity level at Hospital;

5.2.1.2 Compliance with Medical Staff policies and Hospital Bylaws, procedures, Rules and Regulations;

5.2.1.3 Ethical behavior and compliance with professionalism expectations and the Code of Conduct;

5.2.1.4 Ability to perform the Clinical Privileges requested;

5.2.1.5 Attestation of the completion of appropriate State of Florida licensing board's mandated continuing medical education requirements for the most recent license renewal period; and

5.2.1.6 Any other findings relevant to the Practitioner's competency and ability to perform their professional duties and responsibilities.

5.2.2 Submit a properly completed application. Properly completed means that all provisions have been completed or an explanation has been provided for those that are not, and all required supporting documentation has been submitted and accepted. An application is not considered complete until an internal quality check has been completed by the Medical Staff office. Incomplete applications or applications that indicate the applicant does not meet basic eligibility requirements shall not be processed.

5.2.3 Attest that they will notify the Chief of Staff/Medical Staff Administration Office of any changes in the information provided during the application period or after it has been reviewed.

5.2.4 Authorize the Hospital to disclose and make available to any Hospital facility or program to which the applicant has made or makes application any and all information contained in their application and/or obtained as a result thereof.

5.2.5 Submit information related to any actions which have been undertaken since the individual's last application regarding the applicant's professional status, qualifications, credentialing, or privileging.

5.2.6 Submit information pertaining to the applicant's professional liability coverage, including appropriate amounts and coverage for all privileges requested, and since the individual's last application, regardless of outcome, any claims, professional liability suits, judgments, settlements, or arbitration proceedings against them and the status of each matter. This includes, but is not limited to:

5.2.6.1 Any malpractice actions, arbitrations or other judicial, quasi-judicial or administrative proceedings based on the applicant's medical or clinical practice;

5.2.6.2 Settlements paid by the applicant or on the applicant's behalf; and

5.2.6.3 Information about whether any professional liability carriers have ever denied, cancelled, limited, or not renewed the applicant's liability coverage.

5.2.7 Submit information regarding:

5.2.7.1 Any physical health conditions that preclude or limit the applicant's ability to perform the Clinical Privileges being requested;

5.2.7.2 Information about whether the applicant has been engaged in or treated for the use or misuse of prescription drugs, use of illegal substance chemicals or substances that could impair the applicant's ability to perform their professional or medical practice duties; and

5.2.7.3 Information about whether the applicant has ever held or currently holds a contract with the Physician Resource Network or other similar healthcare professional recovery program.

5.2.8 Submit information about whether the applicant has, since the last application, ever been convicted of or had adjudication withheld on a felony, pleaded guilty or nolo contendere to a felony, entered into a pre-trial agreement for a felony, or is presently under indictment for a felony.

5.2.9 Submit information about any exclusion from a healthcare program and/or healthcare insurance program that has occurred since the last application. This includes, but is not limited to:

5.2.9.1 Any denials for enrollment or disqualifications by a private health plan or federal or state program; or

5.2.9.2 Censuring or reprimands or suspension of participation in a health plan of any kind.

5.2.10 Agree to notify the Credentials Committee and Medical Staff Administration within thirty (30) days of any change in the information provided in the individual's application.

5.3 Conditions for Application or Reapplication

As a condition of making an application or reapplication for credentials and privileging, the applicant is agreeing to the following:

5.3.1 Any misrepresentation, misstatement, or omission may constitute cause for automatic and immediate rejection of the application, and that, in the event that approval has been granted prior to the

discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination of privileges; and

5.3.2 To be enrolled with all payers the Hospital chooses to contract within sixty (60) days. The Medical Staff Office shall submit the date it receives full and complete provider applications to the Agency for Health Care Administration on the appropriate forms when requested.

5.4 Applicant's Burden

5.4.1 The applicant shall have the burden of providing sufficient information for a proper evaluation of their competence, character, ethics, and other qualifications, and of resolving any questions.

5.4.2 The applicant shall have the burden of ensuring the application is complete and providing evidence that all statements made and information given on the application are true, complete, and correct.

5.4.3 An application is not considered complete until all information requested by the Hospital has been received and any requested interviews have been completed.

5.4.4 Any application that remains incomplete for sixty (60) days after Notice of deficiency shall be treated as a voluntary withdrawal of the application. Voluntary withdrawals are not considered an adverse Professional Review Action.

5.4.5 Expected timelines for credentialing actions:

5.4.5.1 Once received from the Service Chief or Service Line Director, the Credentials Committee and the MEC will use reasonable efforts to complete their reviews and recommendations and present the application to the Board within sixty (60) days.

5.4.5.2 In the event of a delay due to the need to obtain additional information or perform additional review, every effort will be made to complete the process within an additional sixty (60) days.

5.4.5.3 Notice of the Board's decision should be sent to the applicant within thirty (30) days or as otherwise required pursuant to the Fair Hearing and Appeals procedures set forth in Article XIII of these Bylaws.

Article VI Clinical Privileges

6.1 Privileges Extended to the Medical Staff

Members of the Medical Staff are entitled to exercise only those delineated privileges specifically granted to them by the Medical Executive Committee and the Board of Directors in accordance with these Bylaws. All Clinical Privileges must be requested and processed according to the procedures as provided in these Bylaws.

6.1.1 Medical Staff appointment or reappointment alone does not confer any Clinical Privileges or right to practice in the Hospital.

6.1.2 However, except as provided in these Bylaws, only Practitioners who have been given an appointment to the Medical Staff shall be entitled to request and then exercise Clinical Privileges granted by the Board.

6.1.3 The Clinical Privileges recommended to the Board shall be based upon the applicant's education, training, experience, current clinical competence, and ability to perform those privileges requested, the

availability of Hospital resources and personnel to support the privileges requested, and other relevant information.

6.1.4 The applicant shall have the burden of establishing their qualifications for and competence to exercise the Clinical Privileges requested and for assessing the Hospital and personnel resources available to safely exercise the Clinical Privilege.

6.1.5 Each Clinical Service or Service Line must define the unique privilege delineation for their specialty and must document the criteria the service will use for recommending privileges at initial and reappointment and the professional practice evaluation of the Medical Staff Members.

6.1.6 All elements under core privileges are assessed as a group, while any special requested privileges should be assessed individually.

6.1.7 A determination of the applicant's proficiency and competency in the core privileges and in each special privilege area should be made. Although training and educational background and volume data are important, they are not considered to be sufficient to judge competency. The decision to grant or deny and/or renew an existing privilege should be based on a cumulative assessment across a range of pieces of information. For new-in-practice Medical Staff Members, markers of competency for a Clinical Privilege may include, but are not limited to the following:

6.1.7.1 Educational background and training, including residency and/or fellowship training;

6.1.7.2 Specialized post-graduate training programs;

6.1.7.3 Board certification or other certifying examinations;

6.1.7.4 Applicant's experience and documented competency from other institutions or logs and portfolios from training; and

6.1.7.5 Reference assessments from individuals who have direct knowledge of the Practitioner's competency.

6.1.8 At the time of recredentialing, additional indicators of outcomes and results should be included, when possible. These are often in the form of OPPE data collected during the timeframe between credentialing cycles. Typical outcome and result type criteria to assess competency for a Clinical Privilege may include, but are not limited to the following:

6.1.8.1 Morbidity and mortality data and analysis;

6.1.8.2 Peer review for specific cases and chart reviews, or scheduled random case reviews;

6.1.8.3 Comparisons made to aggregate or nationally benchmarked data about performance, judgment, and clinical and technical skills;

6.1.8.4 Volume data, including the numbers and types of procedures or clinical encounters that have been completed;

6.1.8.5 Patient safety reporting data; and

6.1.8.6 Nationally reported metrics related to payment programs.

6.2 Provisional Clinical Privileges

6.2.1 All initial appointments to the Medical Staff and grants of Clinical Privileges shall be provisional for a period of at least six (6) months. At the end of the provisional period, the Credentials Committee may continue the provisional appointment for up to three (3) additional months.

6.2.2 During the provisional period, an FPPE will be conducted by the applicable Service Chief, who will be responsible for defining the components of the FPPE. The results of the FPPE will be shared with the individual and submitted to the Credentials Committee.

6.2.3 A Provisional Staff Member who receives a favorable review by the applicable Service Chief will be recommended for full appointment to the Medical Staff and provisional status shall cease upon approval by the Board of Directors. If the Provisional Staff Member receives an unfavorable review, they will be notified of such and afforded the opportunity to meet with the Credentials Committee. The Credentials Committee, in consultation with the Service Chief, will determine whether to recommend extension of the provisional period, recommend full appointment, or recommend non-appointment. In the event non-appointment is recommended, the Provisional Member shall be entitled to the Hearing and appeal rights set forth in Article XIII of these Bylaws.

6.3 Additional Clinical Privileges

A member of the Medical Staff may apply for additional Clinical Privileges after their initial appointment, using the privilege request form. If a new privilege is requested to be added onto an already credentialed Staff member, this will also be granted as a provisional privilege during the FPPE time period. These requests will be handled in the same way any new privileges are managed.

6.4 Temporary Clinical Privileges

On occasion, there is an urgent need for privileges to be extended to a Practitioner who has submitted a full application and is awaiting processing and approval. This may be because of an urgent clinical need or service coverage issue, the need for proctoring another Practitioner, or a unique clinical scenario, or for another unusual circumstance.

6.4.1 Process for granting of temporary provisional Clinical Privileges:

6.4.1.1 Only applicants with complete files that have been fully validated and verified by the Medical Staff Affairs Staff can be considered for temporary provisional Clinical Privileges. The file must meet the following criteria:

6.4.1.2 Current licensure in the State of Florida;

6.4.1.3 Training and experience that meets the stated expectations for the clinical service and privilege;

6.4.1.4 At least two (2) peer references who have observed and worked closely with the applicant and have no reservations about granting privileges;

6.4.1.5 No reports in the National Practitioner Database;

6.4.1.6 No current or previously successful challenge to licensure or DEA registration;

6.4.1.7 No involuntary termination of Medical Staff Membership or involuntary limitation, reduction, suspension, denial, or loss of Clinical Privileges at another organization;

6.4.1.8 No unfavorable peer reviews or limitations/restrictions related to quality of care or behavior, including restricting the Practitioner from working with trainees;

6.4.1.9 No reports or restrictions at the level of the Florida Board of Medicine;

6.4.1.10 No prior malpractice claims resulting in judgment; and

6.4.1.11 No concerns about clinical competency from the Chief of Service, Chief of Staff or Chair of Credentials Committee.

6.4.2 Conditions for granting temporary provisional Clinical Privileges:

6.4.2.1 The Service Chief must submit a written request for temporary provisional Clinical Privileges;

6.4.2.2 At the initiation of temporary provisional Clinical Privileges, the period of FPPE must also begin and all clinical service FPPE processes must be adhered to;

6.4.2.3 The total period of temporary privileges shall not exceed one hundred twenty (120) days worked in any rolling three hundred sixty-five (365) day period;

6.4.2.4 Extensions may be granted by the Chief of Staff or the CEO under extraordinary circumstances;

6.4.2.5 The clinical service is responsible for monitoring the one hundred twenty (120) day limit and ensuring that full and unrestricted privileges are requested and granted within that timeframe;

6.4.2.6 Temporary Clinical Privileges are granted for a specific period of time and specific purpose. They may be revoked or withdrawn with or without cause by the Chief of Staff, the Chief Medical Officer, the CEO, or the Chair of the Board at any time, ideally after consultation with the Service Chief. Revocation, withdrawal, refusal to grant, and non-renewal of temporary privileges are not adverse privileging actions and do not entitle the individual to any Hearing or appellate review rights set forth under Article XIII of these Bylaws; and

6.4.2.7 The responsibility for the care of any patients under the care of a Practitioner whose temporary privileges are terminated shall be transferred by the COS to another member of the Medical Staff. In making such a transfer, the wishes of the patient shall be considered whenever possible.

6.5 Emergency and Disaster Privileges: Emergency Privileges for Life-Saving Measures

6.5.1 In the case of an emergency, any member of the Medical Staff with Clinical Privileges shall be permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of their Clinical Privileges, provided that the care rendered is within the scope of the individual's license. For the purpose of this section, an "emergency" is defined as a condition which without immediate medical intervention could reasonably be expected to result in placing the life of the patient in serious jeopardy or in serious or permanent harm to a patient. Emergency privileges shall cease when the immediate emergency situation has passed.

6.5.2 In the event that there is a local or regional disaster or a public health emergency which causes an activation of the emergency management plan AND there is an identified shortage of Practitioners to meet immediate patient care needs, the CEO (or delegate) can grant disaster privileges for volunteer Practitioners upon presentation of appropriate identification and licensure and as further provided in the disaster plan. Formal verification of credentials will begin as soon as the immediate disaster situation is under control.

6.5.3 Volunteers granted disaster privileges will be assigned to a credentialed Practitioner who shall oversee the volunteer. Disaster privileges may be terminated by the CEO or Chief of Staff at any time. Disaster privileges shall automatically expire upon deactivation of the emergency management plan. Neither termination nor expiration of Disaster Privileges will be considered an adverse Professional Review Action and shall not entitle a volunteer to any right to Hearing or appeal as provided in Article XIII.

6.6 Leave of Absence

6.6.1 A Medical Staff Member may be considered for a voluntary leave of absence by submitting a written request, to the Chief of Staff or the Medical Staff Administration Office, that provides the general reason for the leave of absence and the anticipated approximate time of the leave of absence.

6.6.2 During a leave of absence, the Clinical Privileges are considered to be administratively suspended. This is not a restriction or limitation of privileges or credentialing action, but a simple administrative and operational action.

6.6.3 The Chief of Staff can place a Medical Staff Member on leave of absence if it is determined that this is an appropriate action.

6.6.4 All leaves of absence must be approved by the Medical Executive Committee.

6.6.5 Timeframe for Leave of Absence:

6.6.5.1 A leave of absence can be initially granted for up to one (1) year. The leave of absence can be renewed for up to one (1) additional year (total of two [2] years), upon approval of the Medical Executive Committee.

6.6.5.2 If the staff member is up for reappointment during the leave of absence, they may be reappointed through the regular process.

6.6.5.3 Failure to request termination of a leave of absence or extension of the leave of absence at the end of the leave period may be deemed a voluntary resignation from the Medical Staff.

6.6.6 A denial of reinstatement by the Medical Executive Committee or a reinstatement with a privilege limitation will entitle the member to procedural rights for a Hearing as per Article XIII only if the action is reportable as an adverse action.

6.6.7 Re-entry into clinical practice: To terminate the leave of absence, the Practitioner must submit a written request to the Chief of Staff or Medical Staff Administration Office.

6.6.7.1 The Practitioner should provide a description of any clinical activities that were performed during the leave of absence.

6.6.7.2 The Practitioner should provide documentation of fitness to resume clinical practice, with a written medical provider letter of support if the reason for the leave of absence was medical or a letter from the Physician Resource Network if a monitoring plan is in place.

6.6.7.3 The Medical Staff Member shall work with the Chief of Staff and Service Chief to develop a re-entry plan, which may include an FPPE, if applicable.

6.7 Voluntary Relinquishment of Privileges

6.7.1 At the time of termination of employment or contract, resignation from employment, or retirement, clinical privileges are considered to be automatically relinquished. Service Chiefs and Service Line Directors are expected to provide timely notification to the Medical Staff Administration Office of all resignations or terminations of employment for any reason.

6.7.2 A Medical Staff Member may voluntarily relinquish all of their core privileges, or all or part of any special Clinical Privileges that have been granted, by submitting a written request to the Chief of Staff or the Medical Staff Administration Office.

6.7.2.1 In the setting of low volume for particular privileges to the extent that a Medical Staff Member's ongoing competence to perform the privileges cannot be adequately evaluated, the Credentials Committee, Service Chief, or Service Line Director may, in consultation with the member, submit a written request to the Chief of Staff for voluntary relinquishment of the Clinical Privileges.

6.7.2.2 If core privileges are voluntarily relinquished, the member's Medical Staff Membership shall also cease on the effective date of the resignation or relinquishment unless the member has applied for or, in the case of Honorary Staff, been appointed to another category of membership for which the member is eligible without the relinquished privileges.

6.7.2.3 A relinquishment of privileges is generally not considered an adverse action. If a relinquishment occurs while a Medical Staff Member is under Investigation or in lieu of an Investigation or other Professional Review Action or Professional Review Activity, such will be reported to federal agencies as an adverse action as required by law.

6.8. Telehealth Privileges

6.8.1 The Hospital may rely on credentialing information provided by the Practitioner's distant site for credentialing and privileging decisions if that site is accredited by an approved accreditation agency.

6.8.2 When the applicant's distant site is not accredited by an approved accreditation agency, a Practitioner providing any telemedicine services must be fully credentialed in accordance with these Bylaws.

Article VII Code of Conduct and Professionalism

7.1 A Fair and Just Culture

7.1.1 The Hospital has adopted the framework of a fair and just culture. In the Just Culture environment, the organization is accountable for safe system designs and for responding to staff behaviors in a fair and just manner. Likewise, staff is accountable for reporting errors and unsafe conditions, and for following all procedures and policies created to safeguard patients, within a learning environment focused on designing safer healthcare systems.

7.1.2 The Just Culture framework provides a structured method to standardize the investigation of medical errors and management of staff behavioral choices in order to nurture and advance a culture of patient safety, and improve reliability and patient outcomes.

7.2 The Code of Conduct

7.2.1 Behaviors that undermine a culture of safety can foster medical errors, contribute to poor patient satisfaction, and result in adverse outcomes. In addition, such behavior may increase the cost of care, and may cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of patient care are dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, the Medical Staff is committed to addressing the problem of behaviors that threaten the performance of the healthcare team. The Medical Staff shall work to ensure optimum patient care by fostering desirable behavior in order to promote a safe, cooperative, and professional healthcare environment. Episodes of unprofessional behavior shall be addressed, and appropriate action taken, to eliminate behaviors that undermine a culture of safety.

7.2.2 To support the Hospital's Just Culture, Medical Staff Members are required to conduct themselves in a professional manner at all times, treating all persons with courtesy, respect and dignity. Expected behaviors include:

7.2.2.1 Timely communication involving the appropriate people and in the appropriate setting;

7.2.2.2 Communication, including spoken remarks, body language, written documents and emails, text messages and electronic health record messages that are honest, direct, professional, constructive, courteous and respectful;

7.2.2.3 Appropriate preparation for telephone conversations and meetings by gathering all necessary information, organizing questions or comments and coordinating with others to effect efficient communication regarding all necessary issues;

7.2.2.4 Cooperation and availability when on call, including responding promptly and appropriately to the issue(s) at hand; and

7.2.2.5 Understanding that a variety of experience levels exists, and exhibiting patience and tolerance for orientees, students, trainees, and others with less experience.

7.2.3 Behavior that undermines a culture of safety is defined as conduct, whether verbal or physical, that negatively affects or may affect patient care, including behavior that:

7.2.3.1 Disrupts the operation of the Hospital;

7.2.3.2 Adversely affects the ability of others to perform their jobs;

7.2.3.3 Has the effect of being personally degrading to others in the workplace;

7.2.3.4 Interferes with an individual's ability to practice competently; and

7.2.3.5 Creates a hostile work environment.

Appropriate criticism offered in a constructive manner and in an appropriate place and time with the aim of improving patient care, will not be construed as behavior that undermines a culture of safety.

7.2.4 Specific examples of behaviors that undermine a culture of safety include, but are not limited to:

7.2.4.1 Refusal to accept Medical Staff assignments or refusal to participate in committee or departmental affairs in a professional and appropriate manner;

7.2.4.2 Hostile, condemning, or demeaning communications, including: (i) criticism of performance and/or competency that is delivered in an inappropriate location and not aimed at performance improvement; and, (ii) criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies ignorance or incompetence;

7.2.4.3 Other behavior demonstrating disrespect, or intimidation, or disrupting the delivery of patient care (e.g., reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions);

7.2.4.4 Comments (or illustrations) made in patient medical records or other official documents that are unnecessary for patient care, impugn the quality of care in the Hospital, or attack particular individuals or Hospital policies;

7.2.4.5 Attacks or outbursts—verbal or physical—leveled at anyone, including: shouting or yelling; use of profanity; and slamming or throwing objects in anger or disgust, whether or not directed at a specific individual; or

7.2.4.6 Retaliation against any person who addresses or reports such behaviors.

7.2.5 Code of Conduct Violations—Basis for Review and Process

7.2.4.1 Reporting mechanisms for professionalism complaints and code of conduct violations:

7.2.4.1.1 Medical Staff Members and Hospital employees who witness or experience behaviors that undermine a Just Culture are encouraged to file a report in the patient safety reporting system.

7.2.4.1.2 Reports will be reviewed and addressed as set forth in Hospital Core Policy and Procedure CP01.030, *Patient Safety Reports and Event Management*, and the matter may be referred to the Chief of Staff for an Investigation and further action as appropriate and as provided in these Bylaws.

Article VIII Initial Competency Assessment and Ongoing Monitoring of Professional Competency

8.1 Verification of Initial and Ongoing Competency for Medical Staff Members

8.1.1 Overview of Competency Assessment. At the time of initial credentialing, a deep and thorough investigation of a potential Medical Staff Member's training, expertise, and experience is performed. These indicators are used as markers of presumed competency. At the same time, it is incumbent upon the Medical Staff to verify and validate clinical competency in real time in the clinical setting in which the Practitioner will be delivering clinical care through the FPPE process. After initial competency is ascertained, ongoing professional competency is assessed on a regular basis through the OPPE process. These processes promote patient safety by providing for initial and ongoing competency assessments and helping to identify opportunities for quality or process improvements.

8.2 Focused Professional Practice Evaluation (FPPE) for New Privileges

8.2.1 Initial FPPE. An initial FPPE will be performed whenever new clinical privileges are granted. The initial FPPE is a routine, systematic review and planned evaluation process that is used to verify and validate that individuals who have been granted initial or additional privileges are performing those new privileges competently in the setting of observed and documented patient care that is delivered at the Hospital.

8.2.2 Creation and implementation of FPPE for specific privileges.

8.2.2.1 Each Service Chief and/or Service Line Director will develop monitoring specifications to evaluate privilege-specific competence of every Practitioner granted new privileges in their service, including core privileges and any special privileges. The monitoring plan may include:

8.2.2.1.1 The number or types of procedures or activities that will be reviewed to confirm competency;

8.2.2.1.2 The name of the assigned reviewer;

8.2.2.1.3 How data will be collected and reviews documented;

8.2.2.1.4 The expected time frame in which the evaluation will be completed; and

8.2.2.1.5 Any thresholds that may be used to determine competency or a need for further analysis.

FPPE plans for core privileges must be reviewed by the Clinical Service Chief or Service Line Director at least every two (2) years, revised as needed.

8.2.3 Mechanisms for performing FPPE and verifying competency may include, but are not limited to:

8.2.3.1 Proctoring in the presence of another credentialed Medical Staff Member;

8.2.3.2 Precepting of procedures or patient encounters, which may be in or outside the presence of the preceptor and which result in discussion and dialogue between the Medical Staff Member and preceptor;

8.2.3.3 Simulation;

8.2.3.4 Retrospective chart review;

8.2.3.5 Data analysis, audits and assessment of metrics associated with high quality care; or

8.2.3.6 Peer review of selected cases, using either internal or external experts.

8.2.4 Conclusion of FPPE period and transition from Provisional Clinical Privileges to Full and Unrestricted Clinical Privileges

8.2.4.1 At the conclusion of the monitoring period for the FPPE, the Service Chief or Service Line Director shall collect and review all the FPPE data and provide a summary report that indicates whether the Practitioner fulfilled the clinical activity requirements and confirmation of clinical competence or any recommendations for additional monitoring. The Service Chief or Service Line Director is expected to engage in collegial discussion with the Practitioner throughout the FPPE process about how the Practitioner is progressing and any opportunities for improvement.

8.2.4.2 The report will be submitted to the Medical Staff Administration Office and then reviewed by the Credentials Committee. Following its review, the Credentials Committee will make one of the following recommendations to the MEC:

8.2.4.2.1 Competence and professionalism are confirmed and full clinical privileges are recommended;

8.2.4.2.2 The FPPE should be extended due to ongoing questions or additional time needed to confirm clinical competence and professionalism;

8.2.4.2.3 Concerns exist about competency or professionalism and a performance improvement plan or other appropriate intervention is recommended; or

8.2.4.2.4 Significant concerns about competency or professionalism exist which may require a change, limitation, suspension, or revocation of the Practitioner's Clinical Privileges. Prior to making such a recommendation, the Credentials Committee will obtain input from the Practitioner.

8.2.4.3 The MEC may adopt the recommendations of the Credentials Committee, refer the matter back to the Credentials Committee, or disagree with the recommendations of the Credentials Committee by submitting a report to the Board with supporting information for the disagreement and an alternate recommendation. The MEC may obtain additional input from the Practitioner prior to making its recommendation.

8.2.4.4 The recommendation of the MEC will be submitted to the Board of Directors for final review and approval. Any recommendation to limit, suspend, or revoke Clinical Privileges due to competency or professionalism concerns shall entitle the Practitioner to Hearing and appeal rights as set forth in Article XIII of these Bylaws.

8.3 Ongoing Professional Practice Evaluation (OPPE)

8.3.1 Purpose of OPPE. The purpose of OPPE is to continually and regularly verify clinical competency of Medical Staff Members with full and unrestricted privileges in the setting of the patient care they deliver at the Hospital.

8.3.2 Creation and Implementation of OPPE for Specific Privileges

8.3.2.1 Each clinical Service Chief or Service Line Director must develop, in collaboration with other quality leaders in the clinical department, monitoring specifications to continuously evaluate privilege-specific competence of every Practitioner with privileges in their service.

8.3.2.2 OPPE plans must be approved by the Medical Executive Committee and should be reviewed by the Clinical Service every two (2) years and revised as necessary.

8.3.3 Elements that may be identified for a Clinical Service or Clinical Service Line-specific OPPE:

8.3.3.1 The data collection elements that will be monitored and the source of these data that will be used for collection;

8.3.3.2 The thresholds that will be used to identify a need for further analysis;

8.3.3.3 The person or persons who are tasked with review and monitoring of data; and

8.3.3.4 The frequency for which the data will be monitored.

8.3.4 Mechanisms for performing OPPE may include, but are not limited to the following:

8.3.4.1 Precepting of procedures or patient encounters;

8.3.4.2 Simulation;

8.3.4.3 Chart review for review of clinical care, which is usually asynchronous;

8.3.4.4 Data analysis, audits, and assessment of metrics associated with high-quality care; and

8.3.4.5 Peer review and patient safety activities.

8.3.5 Schedule for OPPE review:

8.3.5.1 The Service Chiefs or Service Line Directors will review OPPE data for each credentialed Medical Staff Member at least annually and as requested by the Credentials Committee or Chief of Staff.

8.3.5.2 OPPE metrics that have exceeded the designated threshold should be investigated internally in the clinical service or Service Line.

8.3.5.3 When appropriate, OPPE results may result in a triggered FPPE or other type of Investigation in collaboration with the Chief of Staff, or a performance improvement plan or other appropriate action needed to assist Practitioners who are not meeting expected benchmarks for competency and professionalism.

8.3.5.4 At the time of reappointment, the Service Chief or Service Line Director will use OPPE data from the recredentialing period to inform the recommendation made to the Credentials Committee for continuation of clinical privileges.

Article IX Investigation, Remediation, Corrective Action, and Action for Medical Staff Clinical and Professional Conduct and Impairment

9.1 Automatic Termination and Administrative Suspension

9.1.2 Automatic Termination. Issues that affect a Medical Staff Member's eligibility to practice at the Hospital. Automatic termination is not a Professional Review Action and is not subject to hearing or appeal. Automatic termination of clinical privileges and Medical Staff Membership shall occur upon any of the following events and as may otherwise be provided in these Bylaws or the Medical Staff Rules and Regulations:

9.1.2.1 Expiration, loss, suspension, or revocation of professional licensure;

9.1.2.2 Expiration, loss, suspension, or revocation of DEA registration (if applicable);

9.1.2.3 Expiration or loss of the Medical Staff Member's professional liability insurance;

9.1.2.4 Involuntary exclusion from Medicare, Medicaid, or any other federal or state health care program;

9.1.2.5 Conviction of any felony offense or any offense involving healthcare fraud;

9.1.2.6 When such automatic termination is provided for in the terms of an employment agreement or other contract with the Hospital;

9.1.2.7 Lack of patient care activity as required by these Bylaws within a recredentialing cycle unless such person qualifies for and requests another appropriate category of Staff Membership;

9.1.2.8 Failure to continuously meet the basic eligibility requirements of the member's Medical Staff category as set forth in these Bylaws unless such person qualifies for and requests another appropriate category of Staff Membership;

9.1.2.9 Failure to comply with the reappointment process set forth in these Bylaws; or

9.1.2.10 Failure to return after a leave of absence.

9.1.3 Notice. Medical Staff Members are required to notify their Service Chief, Service Line Director or the Chief of Staff immediately upon the occurrence of any automatic termination event listed in Section 9.1.2.

9.1.4 Reinstatement. A request for reinstatement may be made following the end of an automatic termination event. Requests made greater than one (1) year after the automatic termination event will be treated as an initial application.

9.1.5 Administrative Suspension. A Medical Staff Member's Clinical Privileges may be administratively suspended for issues that are expected to be temporary in nature and are unrelated to competency or professional conduct. An administrative suspension is not a Professional Review Action and is not subject to hearing or appeal. Access to the Hospital's electronic health record may be revoked or reduced commensurate with an administrative suspension during such time as the suspension is in force. The CEO, Chief Medical Officer, or Chief of Staff or Associate Chief may impose an administrative suspension for the following:

9.1.5.1 Failure to timely and accurately complete medical records as required by the Medical Staff Rules;

9.1.5.2 Failure to appear at a Medical Staff or Hospital committee meeting to which the Medical Staff Member has been invited, and at which a discussion of the Medical Staff Member's clinical or professional practice is scheduled, unless excused by the MEC upon a showing of good cause;

9.1.5.3 Failure to undergo a health examination at the request of the Credentials Committee, MEC or Board of Directors;

9.1.5.4 Failure to maintain a practice or residence in sufficient proximity to allow the Medical Staff Member to timely respond to the Hospital when on call as required by these Bylaws, unless the member has been granted a waiver of such requirement from the Board of Directors;

9.1.5.5 Failure to acquire and maintain Board Certification in an appropriate specialty for the member's practice within the timeframe established in these Bylaws, unless the member has been granted a waiver of such requirement from the Board of Directors;

9.1.5.6 Failure to comply with Hospital mandatory training, health screening, or immunization requirements; or

9.1.5.7 Failure to pay any dues that may be assessed to the Medical Staff.

9.1.6 Notice. Members are required to notify their Service Chief or Service Line Director immediately upon the occurrence of any administrative suspension event.

9.1.7 Scope of Administrative Suspensions. Members who are administratively suspended may continue to provide care to patients who are currently admitted or scheduled for care, but the member will not be allowed to admit or schedule new patients until the administrative suspension is lifted. A member's access to the Hospital's electronic health record may be revoked or reduced commensurate with the administrative suspension during such time as the suspension is in effect.

9.1.8 Failure to Cure. Failure to cure within ninety (90) days any deficiency resulting in administrative suspension shall be deemed a voluntary resignation from the Medical Staff. Any member subject to voluntary resignation under this Section may request reinstatement after curing the deficiency. Requests made greater than one (1) year after such a resignation shall be treated as an initial application.

9.1.9 Patient Reassignment. If an automatic termination or administrative suspension results in removal of clinical privileges necessary for patient care, the affected member's patients will be reassigned to another member by the respective Service Chief, Service Line Director, Chief Medical Officer or Chief of Staff to avoid interruption in care. The wishes of patients will be considered when choosing a substitute Medical Staff Member.

9.1.10 Notice to Medical Staff Members. Medical Staff Members will be promptly notified of automatic termination or administrative suspension and the reason for such by the CEO and/or Chief of Staff. The affected Medical Staff Member may**,** within ten (10) days of receipt of such Notice, present written evidence to the CEO that negates the grounds for the action. If the CEO determines, in their sole discretion, that the written evidence is sufficient to negate the grounds for the automatic termination or administrative suspension, they shall give Notice to the affected Medical Staff Member and the action shall be considered void from the beginning. Automatic terminations may be held pending a pending request for a Board waiver but shall take immediate effect if the request for waiver is denied. Members subject to automatic termination due to lack of clinical activity or failure to return reappointment applications will not be able to reapply for a period of one (1) year**.**

9.1.11 Enforcement. It is the responsibility of the COS and the CEO, to enforce all administrative suspensions and automatic terminations.

9.2 Clinical Competency Concerns or Complaints

9.2.1 Basis for review. The procedures in this Article will be invoked whenever it appears that the activities or professional conduct of any member of the Medical Staff:

9.2.1.1 Jeopardizes or may jeopardize the safety and best interests, quality of care, treatment, or services of a patient, or the safety and best interests of a visitor or employee.

9.2.1.2 Presents a question regarding the competency, qualifications, character, judgment, ethics, emotional stability, moral character, including the ability to work cooperatively with others in the provision of safe and effective patient care, treatment and service.

9.2.1.3 Violates these Medical Staff Bylaws, the Rules and Regulations or policies of the Medical Staff or Hospital, the requirements of the clinical service, the Code of Conduct or otherwise constitutes clinical or professional conduct that is, or is reasonably probable of being, disruptive of Hospital operations.

9.2.2 Mechanism for Reporting a Clinical Competency or Professionalism Concern

9.2.2.1 A concern or complaint can be lodged by any member of the Medical Staff, employee, staff person, patient, visitor, or other person who is involved in operations or clinical care in the Hospital.

9.2.2.2 Other sources of information that may lead to clinical competency or professionalism conduct review may include, but are not limited to the following:

9.2.2.2.1 Peer review, including both informal and formal mechanisms for clinical peer review;

9.2.2.2.2 OPPE or FPPE data or other audits;

9.2.2.2.3 Patient Safety reports;

9.2.2.2.4 Self-insurance program case review, notification of malpractice suits, or other medical legal concerns;

9.2.2.2.5 Human Resources complaints;

9.2.2.2.6 Compliance reports or audits or other regulatory data sources; or

9.2.2.2.7 Verbal or written complaints.

9.2.2.3 **Self-Referral.** If a Medical Staff Member has cause to question their own ability to perform their professional responsibilities for any reason, the Chief of Staff may initiate:

9.2.2.3.1 Referral to medical professionals or state agencies for care of the Medical Staff Member;

9.2.2.3.2 Reassignment of clinical duties, in collaboration with the Service Chief;

9.2.2.3.3 Leave of absence or temporary privilege restrictions, as deemed appropriate; or

9.2.2.3.4 Other immediate actions deemed necessary to ensure the safety of the Medical Staff Member, the patients and the employees and visitors of the Hospital.

9.2.3 Necessary Components of a Complaint or Concern

9.2.3.1 Concerns and complaints will ordinarily be written and attributed to a specific person. On occasion, a third party may provide written documentation to preserve confidentiality.

9.2.3.2 Complaints should include: A factual and objective description of the situation and the questionable behavior (including date and time).

9.2.3.3 A statement of whether the behavior affected or involved a patient or patient care in any way, and if so, the identification of the patient.

9.2.3.4 Persons present during the incidents.

9.2.3.5 A description of any immediate responses taken in response to the situation.

9.2.4 Confidentiality

9.2.4.1 Every attempt is made to maintain confidentiality for the reporter in cases of concerns brought forth regarding a Medical Staff Member's clinical or professional conduct. Given the nature and necessity of investigation, this is not always possible.

9.2.4.2 Anti-Retaliation Policy: The University of Florida has a strict anti-retaliation policy which forbids any action that may be construed as retaliation against any person who in good faith addresses or reports unacceptable behavior.

9.3 Processing, Assessing, and Investigating Reports and Concerns

9.3.1 Initial Exploration of Facts and Circumstances

9.3.1.1 Reports about the clinical care or professional conduct of a credentialed Medical Staff Member will be referred to the Chief of Staff for initial processing and assessment, and initiation of an investigation, if appropriate.

9.3.1.2 Any report of gross negligence, serious patient safety risk, or gross policy violations may result in immediate corrective action as provided in these Bylaws, up to and including Precautionary suspension. These categories of reports may also be referred to Human Resources, Risk Management and the Self-Insurance program as appropriate.

9.3.1.3 Nothing in this Article is meant to restrict the ability of any medical review or peer review committee to conduct a review of a member's practice in connection with such committee's routine quality improvement and/or assurance responsibilities.

9.3.1.4 Ordinarily, the initial processing of a report involving a Practitioner's clinical competence, the provision of safe patient care, or a violation of the Medical Staff Bylaws, Rules or policies should include a discussion with the identified Medical Staff Member, which may include, but won't be limited to the following:

9.3.1.4.1 Review the circumstances and facts that were reported;

9.3.1.4.2 Provision of relevant Bylaws, policies, Rules and Regulations and the code of conduct to the Medical Staff Member;

9.3.1.4.3 Outlining the process, if it is determined a report, concern, or complaint may be valid and/or violation of policy may have occurred; and

9.3.1.4.4 Provision of the anti-retaliation policy to the Medical Staff Member and informing them that any attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question will be considered grounds for further and potentially immediate disciplinary action.

9.3.1.5 If the Chief of Staff determines that the report does not reflect a clinical competence or patient safety concern and does not constitute a violation of Medical Staff Bylaws, Rules or policies:

9.3.1.5.1 The matter may be closed without further action.

9.3.1.5.2 A copy of the report and decision will be submitted to Medical Staff Administration office and included in the Practitioner's credentialing file for a minimum of two (2) years.

9.3.1.5.3 Any system reports will be closed.

9.3.1.5.4 Coaching and collegial counseling may be provided to the Medical Staff Member.

9.3.1.5.5 Internal monitoring may occur for future patterns or subsequent complaints.

9.3.1.6 If the Chief of Staff determines that the report does reflect a potential clinical competence concern or a violation of Medical Staff Bylaws, Rules or policies, the Chief of Staff will initiate an investigation in accordance with these Bylaws. A preliminary review of the matter to gain additional facts and determine if an Investigation is warranted shall not be considered an Investigation as such term is defined herein. Depending on the nature of the report, the matter may be referred to a peer review committee, Hospital Risk Management or Self-Insurance program, Compliance, or Human Resources. The Service Chief or Service Line Director will be notified any time an Investigation is initiated or a matter is referred for further review.

9.3.2 Initiation of Investigation. The Chief of Staff may assign an investigation committee or may assign the Investigation to an individual investigator, depending upon the circumstances of the initial report, concern or complaint.

9.3.2.1 An Investigating Committee shall consist of at least three (3) individuals, any of whom may or may not hold an appointment to the Medical Staff. If possible, this committee should not include partners, associates, or relatives of the subject of the Investigation, nor Practitioners in direct economic competition with the subject of the Investigation.

9.3.2.2 The Investigating Committee or investigator shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use external consultants, as necessary.

9.3.2.3 The Investigating Committee or investigator may require a health or neurocognitive examination of the Practitioner under review by a physician(s) satisfactory to the committee and the results of such examination must be made available for the committee's consideration.

9.3.2.4 The subject of the investigation shall have an opportunity to meet with the Investigating Committee or the Investigator, Chief of Staff and CEO before they complete a report. At this meeting (but not, as a matter of right, in advance of it) the member will be informed of the general nature of the evidence supporting investigation and will be invited to discuss, explain or refute it. This

interview does not constitute a Hearing, and none of the procedural Rules provided in these Bylaws with respect to Hearings, including the right to have legal counsel present, apply. A written summary of such interview shall be made by the Investigating Committee or Investigator.

9.3.2.5 The Investigating Committee or Investigator shall submit a report to the Credentials Committee that includes its findings and a summary of all evidence reviewed and any interviews with the Practitioner.

9.3.2.6 Precautionary suspension or privilege restriction during an investigation: At any time during an investigation, the COS, the CEO, or the Chair of the Board may suspend all or any part of the Clinical Privileges of the member being investigated upon a reasonable belief that failure to take such action may result in an imminent danger to the health and/or safety of any individual as provided in these Bylaws.

9.4 Precautionary Suspension. A Precautionary Suspension of all or specific Clinical Privileges may be imposed without benefit of a Hearing or personal appearance, if there is reasonable cause to believe that failure to take such action may result in imminent danger to the health and/or safety of any individual.

9.4.1 Empowered Individuals

9.4.1.1 It is expected that a precautionary suspension will be a collaborative decision between the Chief of Staff (or the Associate Chief of Staff, when acting for the Chief of Staff) and the Chief Executive Officer.

9.4.1.2 Under certain circumstances, the Service Chief or Service Line Chief of which the affected Medical Staff Member is a member, the Chief Medical Officer, the Medical Executive Committee and/or the Board of Directors are empowered to enact a Precautionary suspension. It is expected that two (2) or more of the above will make a collaborative decision and immediately notify the Chief of Staff and CEO of the decision.

9.4.1.3 A Precautionary restriction or suspension of Clinical Privileges will be effective immediately upon imposition and will remain in effect until notification by the Chief of Staff and CEO.

9.4.1.4 In the event of a Precautionary suspension, the Chief of Staff shall initiate an investigation of the matter prompting the Precautionary suspension as provided in these Bylaws.

9.4.1.5 Precautionary suspension under this Section shall be deemed an interim precautionary step in the Professional Review Activity and shall not imply a final finding of responsibility for the situation that prompted the suspension.

9.4.2 Process for Enacting a Precautionary Suspension or Temporary Privilege Restriction

9.4.2.1 It is expected that a Precautionary suspension will be a collaborative decision. Prior to, or at the time of imposition of such Precautionary suspension or restriction, all of the following notifications should be made: Chief of Staff, Associate Chief of Staff, Chief Medical Officer, Service Chief and/or Service Line Chief, and Members of the Professional Staff Credentialing Committee of the Board of Directors.

9.4.2.2 Immediately upon the imposition of a Precautionary suspension, the appropriate Service Chief, or in their absence, the COS shall transfer the care of the suspended member's patients to another Medical Staff Member. In making such a transfer, the wishes of the patient shall be considered whenever possible.

9.4.2.3 Reasonable efforts will be made to complete within fourteen (14) days of the suspension or reasons for the delay must be transmitted to the Board so that it may consider, as soon as practicable, whether the suspension should be lifted prior to its completion.

9.4.3 Notice of Precautionary Suspension or Temporary Privilege Restriction

9.4.3.1 The Chief of Staff or the CEO will provide the affected Medical Staff Member with Notice of their right to review the suspension as soon as possible. The Notice shall contain:

9.4.3.1.1 A statement of the general reasons for the suspension or privilege restriction;

9.4.3.1.2 A statement that the individual has a right to request review of the suspension and has two days from receipt of the Notice to request such a review in writing to the Chief of Staff or CEO;

9.4.3.1.3 A statement that failure to request a review in the time and manner specified will result in a waiver of the Practitioner's right to a review of the Precautionary suspension; and

9.4.3.1.4 A statement that the Practitioner may meet with the review panel to rebut the need for the Precautionary suspension.

9.4.3.2 The affected Practitioner shall have five (5) business days from the date of receipt of such Notice, as indicated by proof of delivery, to submit a written request for a review to the CEO

9.4.3.2.1 If the affected Practitioner does not submit a written request for a review within five (5) days of receipt of the Notice, they shall be deemed to have waived their right to such review and the suspension shall remain in effect until modified by the CEO or by the Board.

9.4.3.2.2 If the affected Practitioner requests a review, they shall be deemed to have waived their right to a Hearing on any Precautionary suspension initiated under this Section in effect for thirty (30) days or less.

9.4.3.2.3 Upon receipt of an appropriate request for a review, the CEO, in consultation with the Chief of Staff, shall promptly appoint an ad hoc review panel composed of three members of the Credentials Committee, schedule the review as soon as practicable, and give Notice to the Practitioner of its date, time, and place. Every reasonable effort should be made to schedule the review within twenty-seven (27) days of the initial suspension. The Notice must also list the patient records and/or other information supporting the initiation of the Precautionary suspension.

9.4.3.2.4 The only matter to be considered during the interview and review is the reasonableness of initiating a Precautionary suspension to address the imminent risk to the health or safety of a patient or others. The individual initiating the suspension will provide the ad hoc panel with a Precautionary of the reason for initiation prior to its interview with the affected Practitioner. After interviewing the Practitioner, the ad hoc review panel may recommend continuation of the suspension, termination of suspension or a modification of its terms. A recommendation for termination or modification of the Precautionary suspension may be made only if the review panel concludes that the basis for the suspension did not

reasonably meet the requirements of this Policy. The Panel's recommendation and the reasons therefore will be provided to the CEO and the Chief of Staff as soon as possible after the interview for their consideration.

9.5 Medical Executive Committee Actions

9.5.1 The Credentials Committee shall review the Investigation findings and submit a proposal to address the findings to the Medical Executive Committee. The MEC will review the findings and proposal and may:

9.5.1.1 Request an audience with the affected member to further view the issue;

9.5.1.2 Close the matter with no action taken;

9.5.1.3 Recommend a corrective action plan;

9.5.1.4 Issue a written warning, admonition, or reprimand to the member;

9.5.1.5 Recommend the member receive additional training or education;

9.5.1.6 Recommend the member seek assistance from appropriate resources, such as physical, psychiatric or emotional rehabilitative programs; or

9.5.1.7 Recommend revocation, reduction or limitation of clinical privileges to the Board of Directors.

9.5.2 Failure of a member to agree to or fully comply with MEC recommendations will result in additional action in accordance with these Bylaws. Any proposed reduction, revocation or limitation of clinical privileges shall be considered a Professional Review Action which shall entitle the member to the hearing and appeal rights set forth in Article XIII of these Bylaws.

9.6 Fair Hearing and Due Process

9.6.1 If the recommendation of the MEC would entitle the affected member to a Hearing in accordance with Article XIII of these Bylaws, the recommendation shall be forwarded to the CEO, who shall promptly give Notice to the affected member. The CEO shall then hold the recommendation until after the member has exercised or waived their right to a Hearing and appeal as provided in Article XIII. At that time, the CEO shall forward the MEC's recommendation, together with all supporting documentation, to the Board. The COS or their designee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

9.6.2 If the recommendation of the MEC would not entitle the individual to a Hearing, in accordance with Article XIII, the action shall take effect immediately.

9.6.3 In the event the Board considers modification of an MEC action given immediate effect, and such modification would entitle the individual to a Hearing, the affected member, will be given Notice by the CEO, and no final action thereon shall be taken by the Board until the individual has exercised or waived their right to a Hearing and appeal.

Article X Medical Staff Committees and Organizational Structure

10.1 Background

10.1.1 Confidentiality and Reporting

10.1.1.1 All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are deemed confidential and/or privileged pursuant to federal and/or state statutes providing protection to peer review or related activities and to such policies regarding confidentiality as may be adopted by the Hospital. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Hospital and its Board when engaged in such Professional Review Activities and thus shall be deemed the "Professional Review Bodies" as that term is defined in the Healthcare Quality Improvement Act of 1986.

10.1.1.2 Reports of actions taken pursuant to this Policy shall be made by the CEO to such governmental agencies as may be required by law.

10.2 Organizational Structure

10.2.1 Medical Executive Committee. There shall be a Medical Executive Committee and such other standing and ad hoc committees as established by the MEC. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions.

10.2.1.1 Purpose. The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff Members with clinical privileges. This authority may be removed or modified by amending these Bylaws.

10.2.1.2 Composition. The MEC will consist of:

10.2.1.2.1 Voting Members:

1. The officers: The Chief of Staff, who will serve as chair; the Associate Chief of Staff, who will serve as the Chair in the absence of the Chief of Staff; the Immediate Past Chief of Staff; the Chief Medical Officer. This group will also serve as the executive committee of the Medical Executive Committee.
2. Ex-officio voting Members: The Service Chief for each Clinical Service and the Service Chief for each Clinical Service Line; the Credentials Committee Chair; the Chief Quality Officer.
3. Up to three (3) at-large Active Medical Staff Members who are appointed by the Chief of Staff and shall serve two (2) year terms, with eligibility for successive terms.

10.2.1.2.2 Non-Voting Members:

1. Ex-officio non-voting members: The Dean of the College of Medicine; the Chief Executive Officer of the Hospital; Chief Nursing Officer; Chief Operating Officer; College of Medicine Senior Associate Dean of Education; Senior Associate Dean of Graduate Medical Education; College of Medicine Senior Associate Dean and CEO of UF Health Physicians; Chief Information Officer; Associate Chief Medical Officers; Chief Legal Officer; the President of UF Health and Senior Vice President of Health Affairs; President of the UF College of Medicine Faculty Council.

2. Regular invited guests: Chief Financial Officer; Dean of the College of Dentistry; Dean of the College of Public Health and Health Professions.

10.2.1.3 Areas of Responsibility and Authority. The MEC has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by the Medical Staff and other Practitioners privileged through the Medical Staff process.

10.2.1.4 Meetings, Quorum, Manner of Action, and Delegation of Vote to a Representative

10.2.1.4.1 The MEC shall meet as required to perform its assigned functions, but at least quarterly. Minutes and a record of attendance shall be maintained.

10.2.1.4.2 Fifty percent (50%) of the voting membership of the Medical Executive Committee shall constitute a quorum.

10.2.1.4.3 Unless other specified in these Bylaws, action may be taken by the majority of voting members present at the meeting at which quorum is present.

10.2.1.5 Duties

10.2.1.5.1 Representing and acting on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws, in the intervals between Staff meetings.

10.2.1.5.2 Coordinating the activities and general policies of the various clinical services and Service Lines.

10.2.1.5.3 Receiving, reviewing and acting committee and department reports and recommendations.

10.2.1.5.4. Implementing through Rules, policies of the Medical Staff not otherwise the responsibility of a clinical service or Service Line.

10.2.1.5.5 Making recommendations on Hospital management matters (for example, long-range planning) to the Board through the COS.

10.2.1.5.6. Making recommendations to the Board for its approval pertaining to: the structure of the Medical Staff; the mechanism used to review credentials and to delineate individual clinical privileges; the mechanism by which Medical Staff Membership and/or clinical privileges may be granted, suspended, reduced or revoked; the mechanism for fair-hearing procedures; and the organization of the quality assessment and improvement activities of the Staff as well as the mechanism used to conduct, evaluate and revise such activities.

10.2.1.5.7 Making recommendations to the Board for its approval concerning Medical Staff appointment and clinical privileges for applicants and Practitioners.

10.2.1.5.8. Fulfilling the Medical Staff's accountability to Board for the medical care rendered to patients in the Hospital and, in conjunction with other Staff committees and

the clinical departments, to be responsible for reviewing and evaluating the quality of medical or hospital care.

10.2.1.5.9 Taking steps to ensure professionally ethical conduct and competent clinical performance on the part of all Practitioners.

10.2.1.5.10 Reviewing the Medical Staff Bylaws and recommending any proposed amendments to the Staff for adoption.

10.2.1.5.11 Overseeing the review and evaluation of the quality of medical care at the Hospital.

10.2.1.5.12 Carrying out such other functions as are required of it by Staff Rules.

10.2.1.6 Operations. Quality and safety in the Hospital (with the Medical Staff Quality and Operations Committee).

10.2.1.6.1 In collaboration with the Service Chiefs, Service Line Chiefs and other key Hospital leadership stakeholders, set the Service objectives and service standards for establishing and maintaining excellent high-quality clinical care and the service standards at the Hospital.

10.2.1.6.2 Propose, create, approve and enforce Medical Staff policies related to clinical care delivery and expected thresholds for quality and clinical practice delivery.

10.2.1.6.3 Ensure that the findings, conclusions, recommendations, and actions taken to improve performance are communicated to appropriate Medical Staff Members and the Board.

10.2.1.6.4 Receive and act upon reports and recommendations from the Medical Staff Committees, clinical services and Service Lines, University of Florida Clinical Departments , and other groups or committees concerning patient care operations, quality, patient safety, and other clinically related items.

10.2.1.6.5 Report to the Board and to the Staff for the overall quality and efficiency of patient care in the Hospital and the participation of the Medical Staff in organization performance improvement activities.

10.2.1.6.6 Make recommendations to the Board on medical-administrative and Hospital management matters.

10.2.1.6.7 Policy, procedure, Rules and Regulation oversight.

10.2.1.6.8 Subject to the authority of the Medical Staff, determine all Medical Staff policies of the Hospital.

10.2.1.6.9 Formulate, review, and recommend changes for the Medical Staff Bylaws to the Board of Directors.

10.2.1.6.10 Act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

10.2.2 Standing Committees

10.2.2.1 General. Except as otherwise specified in these Bylaws, the following are general Rules for Medical Staff Committees.

10.2.2.1.1 Appointment to Medical Staff Committees, with the exception of ex-officio members, will be made by the Chief of Staff.

10.2.2.1.2 Appointments will be for a two (2) year term.

10.2.2.1.3 Quorum will represent fifty percent (50%) of the voting members.

10.2.2.1.4 Action may be taken by the majority of voting members present at the meeting at which quorum is present.

10.2.2.1.5 Committee members are expected to attend at least fifty percent (50%) of the meetings held.

10.2.2.2 Medical Staff Quality and Operations Committee

10.2.2.2.1 Purpose. The Medical Staff Quality and Operations Committee oversees the quality and operational aspects of the Hospital.

10.2.2.2.2 Composition. The Medical Staff Quality and Operations Committee includes the same membership as the Medical Executive Committee.

10.2.2.2.3 Duties. The Committee will be responsible for recommendations regarding development and maintenance of standards of medical practice within the Hospital, evaluation and supervision of such practice, and coordination of patient care. Additionally, the Quality and Operations Committee shall monitor compliance with and enforce the Medical Staff Rules and Regulations as provided by these Bylaws, and make recommendations to the MEC on Rules and Regulations. Specifically, the Quality and Operations Committee shall:

1. Oversee the Medical Staff participation in the measurement, assessment, and improvement of patient care processes, including
    i) Medical assessment and treatment of patients;
    ii) Accurate, timely, and legible completion of patients' medical records;
    iii) Use of medications;
    iv) Use of blood and blood components;
    v) Use of operative and other procedure(s);
    vi) Appropriateness of clinical practice patterns;
    vii) Significant departures from established patterns of clinical practice;
    viii) Education of patients and families; and
    ix) Coordination of care, treatment, and services with other Practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient.
2. In collaboration with other appropriate Hospital staff, oversee development and use of criteria that identify deaths in which an autopsy should be recommended.
3. Utilize patient safety data in identifying and implementing performance improvement opportunities and activities.
4. Oversee clinical quality functions, including but not limited to:
    i) Monitor indicators related to clinical care, as evidenced by performance in comparison to appropriate benchmarks (e.g., Vizient, Centers for Medicare and Medicaid Services, Agency for Health Care Administration, accreditation agencies, National Surgical Quality Improvement Program)
    ii) Establish quality, safety, and patient satisfaction priorities and accountabilities for inpatient care
5. Make recommendations to the MEC regarding the establishment of standards and measures of effectiveness in patient care by each of the respective health disciplines and the implementation of a coordinated patient care program, including review and analysis of the quality and efficiency of clinical services and programs and the effectiveness of patient care monitoring and evaluation activities.
6. Approve and implement action plans developed by interdisciplinary teams.
7. Remove barriers to implementation of action plans developed by interdisciplinary teams.
8. Review ongoing results related to action plans and quality priorities and report to the MEC.
9. Resolve issues identified by Medical Staff committees and report to MEC.
10. Assist and make recommendations where appropriate regarding long-range budgeting, facility planning, quality assurance and improvement recommendations from departments and Medical Staff committees, and similar related functions.
11. Review ongoing results related to action plans and quality priorities and report to the MEC.
12. Participate in the establishment of patient care priorities and long-term goals as related to patient care within the clinical setting of the

Hospital, and advise the CEO, or designee, on priorities.
13. Establish subcommittees to assist in the performance of its duties.

10.2.2.3 Credentials Committee

10.2.2.3.1 Purpose. To review and make recommendations on applications for medical staff appointment and clinical privileges.

10.2.2.3.2 Composition

1. The Chair of the Credentials Committee will be nominated by the Chief of Staff and approved by the Medical Executive Committee. The Associate Chief of Staff (or Chief of Staff Elect) may be nominated and appointed to serve as the Chair of the Credentials Committee.
2. The Chief of Staff, the Associate Chief of Staff, and the Immediate Past Chief of Staff will serve as ex-officio members of the Credentials Committee.
3. Additional members of the Credentials Committee shall consist of nine (9) or more members of the Active Staff:
   i) Two (2) members from Hospital-based services (Pathology, Anesthesia, Emergency Medicine, Radiology).
   ii) One (1) member from Pediatrics, Medicine, Surgery, Psychiatry.
   iii) Three (3) Allied Health Professional members, including at least one APRN, one PA, and one other member.
   iv) Other members from other specialty areas deemed appropriate by the Chief of Staff.
4. Appointment to the Credentials Committee for non-ex-officio members will be for a two (2) year term and shall be eligible for reappointment for successive terms. Committee members are expected to attend at least fifty percent (50%) of the meetings held.

10.2.2.3.3 Duties

1. Review the Hospital's criteria for granting privileges and the application forms relating to Medical Staff and Allied Health Professional appointment, reappointment, and/or Clinical Privileges, and other credentialing matters, and make recommendations regarding same to the MEC.
2. Review the credentials of all applicants for Medical Staff and Allied Health Professionals appointment, reappointment, and Clinical Privileges.
3. Investigate and interview applicants as may be necessary.
4. Make report of findings and recommendations to the MEC for credentialing and privileging Medical Staff Members.
5. Review Service and Service Line privileges forms, FPPE and OPPE criteria and any amendments thereto, and forward to MEC with recommendations for approval.
6. Appoint subcommittees as determined necessary by the Committee to assist in fulfillment of its duties.

10.2.2.3.4 Meetings, Quorum, Manner of Action, and Delegation of Vote to a Representative

1. The Credentials Committee shall meet as required to perform its assigned functions, but at least quarterly. Minutes and a record of attendance shall be maintained.
2. Fifty percent (50%) of the voting membership of the Committee shall constitute a quorum. Certain meetings and executive sessions may be called where representatives and delegate voting will not be allowed.
3. Unless other specified in these Bylaws, action may be taken by the majority of voting members present at the meeting at which quorum is present.

10.2.2.4 Other Medical Staff Committees

10.2.2.4.1 Additional standing or ad hoc committees may be established or dissolved by the MEC as are necessary for the Medical Staff to carry out its various functions effectively. Such committees shall be defined as appropriate in the Medical Staff Committee Manual. Any function required to be performed by these Bylaws not assigned to a standing or ad hoc committee shall be performed by the MEC.

10.2.2.4.2 The Chief of Staff shall appoint the Chairs of the Medical Staff committees with the approval of the MEC and in consultation with the CEO. The Chairs shall serve at the pleasure of the Chief of Staff, but will generally be appointed for a term of three (3) years, which will be automatically renewed unless another appointment is made by the COS. Unless otherwise specified, the committees shall report their activities to the Medical Executive Committee.

10.2.2.4.3 Recommendations for members of the committees shall be made to the COS by the Committee Chairs and/or Hospital Administration, as appropriate.

Article XI Methods of Adoption and Amendment of the Medical Staff Bylaws

11.1 Originated by the MEC or Another Standing Committee, or by Active Staff Member. The Medical Staff Bylaws and any proposed amendments may be originated by the MEC or another standing committee, or by an Active Staff Member. Such proposed Bylaws or amendments must be reviewed and voted upon by the Quality and Operations Committee and the MEC. Favorable recommendations by the MEC will be presented for a vote to the Active Staff.

11.2 Originated by Petition of an Active Staff Member. Medical Staff Bylaws and any proposed amendments may also be originated by petition of an Active Staff Member(s) signed by at least thirty percent (30%) of the Active Staff, and presented to the Quality and Operations Committee and the MEC for their review and recommendation. After the MEC has reviewed, the proposed Bylaws or amendments will be presented, including the MEC's recommendation and comments, for a vote to the Active Staff.

11.3 Distribution Timeline. The proposed amendment and ballot shall be distributed to all Active Staff Members at least fourteen (14) calendar days prior to scheduled vote.

11.4 Eligibility to Vote. Each member of the Active Category of the Medical Staff will be eligible to vote on the proposed amendment via either printed or electronic ballot. An amendment will be deemed approved by a majority of affirmative votes of the returned ballots days prior to the required return date of the ballot.

11.5 If Amendment Fails to Be Approved. If an amendment recommended by the MEC fails to be approved by vote of the Active Staff, the MEC may implement the conflict management process in these Bylaws.

11.6 If Amendment Proposed by Petition of the Active Staff Is Not Recommended by the MEC but Is Approved by Vote of the Active Staff. If an amendment proposed by petition of the Active Staff pursuant to Paragraph B that is not recommended by the MEC gets approved by vote of the Active Staff, the MEC may implement the conflict management process.

11.7 Amendments by Urgent Requirement. The MEC may, provisionally, without vote by the Medical Staff, recommend to the Board such amendments of these Bylaws (Rules and Regulations) as are, in the committee's judgment and as documented in the minutes urgently required in order to comply with any federal, state, or local law or regulation.

11.7.1 Upon adoption of the recommendation by the Board, the MEC must promptly notify the Medical Staff of the amendment, and provide the Active Staff Members an opportunity to submit comments to the MEC regarding the amendment within fourteen (14) days of notification.

11.7.2 If comments received indicate disapproval of the provisional amendment by at least thirty percent (30%) of the Active Staff, the MEC will implement the conflict management process.

11.7.3 If the conflict management process results in a recommendation for repeal or revision of the provisional amendment, such repeal/revision is subject to Board approval.

11.8 Changes That May Be Made Without Approval of the Active Staff. Changes made by the MEC or Board merely for the purpose of reorganization or renumbering, or to correct punctuation, spelling, or other errors of grammar or expression are not considered amendments for the purpose of this Section, and may be made without approval of the Active Staff.

11.9 When Amendment Becomes Effective. Any amendment deemed approved by the Active Staff or recommended by the MEC shall become effective only after approval by the Board. In the event of implementation of the conflict management process, final approval by the Board shall be postponed until conclusion of the process.

11.10 Conflict Management. The following process should be implemented to resolve (i) any dispute between members of the Active Staff and the MEC regarding the adoption of or amendment to these Bylaws or any provision thereof, or (ii) upon a petition signed by thirty percent (30%) of the Active Staff with regard to any other Medical Staff matter.

11.10.1 The Active Staff engaged in the dispute and the MEC should first make reasonable efforts to manage and, when possible, resolve the matter collegially and informally through discussion. Three designated representatives from the Active Staff will be invited to meet with the Chief of Staff to discuss the concerns of the Active Staff.

11.10.2 If informal efforts at conflict management are not successful, or the Active Staff or the MEC believes that those efforts would be ineffective in a particular circumstance, either group may request that the CEO convene a Conflict Resolution Committee.

11.10.3 A Conflict Resolution Committee will consist of up to five (5) representatives of the Active Staff engaged in the conflict and an equal number of representatives from the MEC designated by the COS. The CEO or their designee will be an ex-officio non-voting member of the Conflict Resolution Committee.

11.10.4 The Conflict Resolution Committee will gather information regarding the conflict, discuss the disputed matter, and work in good faith to resolve the differences between the MEC and the Active

Staff in a manner that protects and enhances quality and safety and assures compliance with relevant laws and standards.

11.10.5 Any recommendation that is approved by a majority of each party's representatives will be submitted to the Board for its consideration and final action.

11.10.6 If the committee is unable to make a recommendation, one MEC representative and one Active Staff representative from the Conflict Resolution Committee will jointly make a report of the unresolved differences to the Board for its consideration and final decision regarding the matter in dispute.

11.10.7 Disputes between leaders or segments of the Medical Staff will be resolved in accordance with the Hospital policy on Conflict Management.

Article XII Meetings of the Medical Staff

12.1 Actions of Quorum. Except as otherwise specified, the action of a majority of the voting members present at a meeting at which a quorum is present is the action of the group. Action may be taken without a meeting by the Staff or Committee by presentation of the question to each member eligible to vote, in writing. Such vote shall be binding so long as a vote is returned in writing by at least the number of voting members of the group that could constitute a quorum.

12.2 Medical Staff Meetings

12.2.1 An Annual meeting of the Medical Staff shall be held at the discretion of the MEC. Notice of an annual meeting shall be sent to all Medical Staff Members.

12.2.2 The Chief of Staff may call a Special Meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within twenty (20) days of receipt of a petition signed by at least 100 of the Active Staff Members, or upon a resolution by the MEC stating the purpose of the meeting. The Chief of Staff shall designate the time and place of any Special Meeting.

12.2.3 Notice stating the time, place and purposes of any Special Meeting of the Medical Staff shall be sent to each member of the Medical Staff at least seven (7) days before the date of such meeting, except as provided in Section 6 of this Article for emergency special meetings. No business shall be transacted at any Special Meeting except that stated in the Notice of such meeting.

12.2.4 Quorum will be considered those Active Members present shall constitute a quorum and a vote of fifty percent (50%) or more of the members present will be considered an affirmative vote.

12.3 Committee and Department Meetings

12.3.1 Committees may, by resolution, provide the time for holding regular meetings without further notice. Department chairs shall hold meetings as needed to carry out department business.

12.3.2 A special meeting of any committee or department may be called by or at the request of the chairperson or by the Chief of Staff.

12.3.3 Quorum: Quorum will be set as per committee charge documents**.**

12.3.4 Attendance: No minimum meeting attendance is required but frequency of attendance will be considered in reappointments to committees except as otherwise specified in these Bylaws or in charters, policies and procedures, and Rules and Regulations.

12.3.4.1 Unless otherwise determined by the Chief of Staff or committee chairperson, meetings may be attended remotely when such technology is available, at the discretion of the Committee chairperson. Any time remote attendance is allowed at a meeting where patient, peer review, quality, or other confidential data will be discussed, the meeting shall be structured in such a way as to ensure the confidentiality of the meeting is maintained.

12.4 Notice of Meetings

12.4.1 Notice stating the date, time, and place of any Special Meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee not less than seven (7) days before the time of such meeting by the person or persons calling the meeting.

12.4.2 If an emergency Special Meeting is deemed necessary by the Chief of Staff or other appropriate chair, such emergency Special Meeting may be held upon two (2) days written or verbal notice.

12.4.3 Emergency meetings of the MEC may be held at any time without advance notice, and action taken, as long as a quorum is present.

12.4.4 The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

12.5 Action at Meetings

The recommendation of a majority of the voting members present at a meeting at which a quorum is present shall be the action of a committee.

12.6 Minutes

Minutes and a record of each Medical Staff meeting activities shall be maintained. The minutes shall be signed by the presiding officer.

Article XIII Fair Hearing and Appeals Procedures

13.1 Initiation and Scheduling of a Hearing

13.1.1 Right to a Hearing

13.1.1.1 Except as provided in Section 13.1.1.3 of this Article, a Practitioner is only entitled to a Hearing whenever any of the following adverse recommendations, or adverse actions, have been made or taken by the MEC, or the Board:

13.1.1.1.1 Denial of Medical Staff appointment or reappointment;

13.1.1.1.2 Revocation, limitation, or suspension of Medical Staff Membership;

13.1.1.1.3 Denial of requested Clinical Privileges; or

13.1.1.1.4 Revocation, limitation, or suspension of Clinical Privileges.

13.1.1.2 No Practitioner shall be entitled to more than one (1) Hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a Hearing right. A Hearing right provided as to an initial or proposed adverse recommendation or action by the MEC

satisfies the requirements for a Hearing right as to the final recommendation or action by the Board that is based on the same subject matter.

13.1.1.3 Actions Not Giving Rise to Hearing Right

13.1.1.3.1 Recommendations for, or imposition of, any of the following actions by the MEC or Board do not constitute grounds for a Hearing:

1. Denial of Medical Staff, appointment or reappointment, or revocation of Medical Staff appointment based on an inability to meet any one (1) of the minimum objective criteria for appointment set forth in these Bylaws.
2. Automatic suspension of privileges or termination of membership as provided in these Bylaws.
3. Revocation of Clinical Privileges as a result of change and/or elimination of services offered by the Hospital.
4. Precautionary suspension as provided in these Bylaws, unless such suspension remains in effect for more than fourteen (14) days and the affected Practitioner has not requested a review of the Precautionary suspension.
5. Denial or termination of temporary privileges.
6. Any other corrective action which does not restrict the Clinical Privileges of the Practitioner, including but not limited to:
   i) General consultation or corrective counseling requirement;
   ii) Issuance of a letter of warning, admonition, or reprimand; and
   iii) Denial of a request for waiver from the Board of any appointment criteria as provided in these Bylaws.

13.1.2 Notice of Adverse Recommendation or Action and Request for Hearing

13.1.2.1 When a recommendation is made or action is taken that entitles an individual to a Hearing prior to final action of the Board, the affected Practitioner shall promptly be given written Notice by the CEO. This Notice shall contain:

13.1.2.1.1 A statement of the recommendation/action and the general reasons for it;

13.1.2.1.2 A statement that the individual has a right to a Hearing on the recommendation/action and thirty (30) days from receipt of the Notice to request such Hearing;

13.1.2.1.3 A statement that failure to request a Hearing in the time and manner specified will result in a waiver of the Practitioner's right to a Hearing and acceptance of the adverse recommendation/action;

13.1.2.1.4 A summary of the Practitioner's rights during the Hearing; and

13.1.2.1.5 If the Hearing is regarding a Precautionary suspension, a statement that the Hearing is limited to the reasonableness of initiation of the suspension.

13.1.2.2 The affected Practitioner shall have thirty (30) days from the date of receipt of such Notice, as indicated by proof of delivery, to submit a written request for a Hearing to the CEO.

13.1.2.3 If the affected Practitioner does not submit a written request for a Hearing within thirty (30) days of receipt of the Notice, they shall be deemed to have waived their right to such Hearing and to have accepted the recommendation and/or action, and any action taken by the Board shall be deemed final.

13.1.3 Scheduling and Notice of Hearing

13.1.3.1 Within fifteen (15) days of receipt of the affected Practitioner's written request for a Hearing, the CEO must schedule the Hearing and give Notice to the Practitioner of its time, place, and date. The Hearing must begin as soon as practicable, but no sooner than thirty (30) days from the date of Notice, unless an earlier Hearing date has been specifically agreed to in writing by the affected Practitioner.

13.1.3.2 The Notice must also:

13.1.3.2.1 Include a concise statement of the specific reasons for the recommendation(s) giving rise to the Hearing;

13.1.3.2.2 List the patient records and other information supporting the recommendation(s);

13.1.3.2.3 In accordance with Paragraph E of this Section, list the witnesses who are expected to testify or present evidence at the Hearing in support of the recommendation, and inform the Practitioner of their obligation to provide the CEO within fifteen (15) days of receipt of the Notice with a list of witnesses they expect to testify or present evidence on their behalf; and

13.1.3.2.4 Inform the Practitioner of their right to be represented at the Hearing by an attorney or other person of their choice and their obligation to advise the CEO within fifteen (15) days of receipt of the Notice of the name and address of such attorney or other person.

13.1.3.2 The statement of reasons and list of supporting documents may be amended or supplemented at any time, even during the Hearing, provided the new material is relevant to the appointment or Clinical Privileges of the affected Practitioner, and that the Practitioner and their counsel have sufficient time to study the new information and rebut it.

13.1.4 Exchange of Witness Lists. A written list of the names, titles and/or professional affiliation(s) of the individuals expected to give testimony or present evidence In support of the recommendation(s) giving rise to the Hearing shall be provided to the affected Practitioner with the Notice of Hearing. Within fifteen (15) days of receiving the Notice of the Hearing, the affected Practitioner must provide a written list of names, titles and/or professional affiliations of the individuals expected to give testimony or present evidence at the Hearing on their behalf. The witness list of either party may be supplemented or amended at any time prior to the Hearing, provided that Notice of the change is given to the other party.

13.2 Hearing Procedure

13.2.1 The purpose of the Hearing shall be to recommend a course of action to the Board, and the duties of the Hearing Panel shall be so defined. The Hearing is to be conducted in as informal a manner as possible, subject to the Rules and procedures set forth in these Bylaws.

13.2.2 Hearings shall be conducted in-person whenever possible. In the event the Hearing officer or Hearing Panel determines there is a need to conduct the Hearing remotely for health or safety reasons or for

other good cause, the Hearing shall be conducted via simultaneous, two-way, audio-visual technology that has sufficient security features to ensure the security and confidentiality of the Hearing. Individuals participating in a remote Hearing shall be required to attend from a location designated by the presiding officer/chair to ensure that the proceedings remain confidential and to prevent the attendance of unauthorized persons and unnecessary interruptions.

13.2.3 Appointment of Hearing Panel

13.2.3.1 When a Hearing is requested, the CEO, after considering the recommendations of the COS (and that of the Chair of the Quality Committee of the Board of Directors, if the Hearing is occasioned by a Board determination), shall appoint a Hearing Panel.

13.2.3.2 A Hearing Panel shall be composed of not less than three (3) individuals, who may or may not be members of the Medical Staff, and must include peer representation. Medical Staff appointees to the Hearing Panel shall not have actively participated in consideration of the matter involved at any previous level; knowledge of the matter involved, however, shall not preclude any individual from serving as a member of the Hearing Panel. Nor shall the Hearing Panel include any individual who is in direct economic competition with the affected Practitioner, nor any individual who is related to the Practitioner. The CEO shall designate a Chair of the Hearing Panel.

13.2.4 Appointment of Presiding Officer

13.2.4.1 The CEO shall select a person to act as the Presiding Officer during the Hearing.

13.2.4.2 The Presiding Officer may either be the Chair of the Hearing Panel, or an individual who is not a member of the Hearing Panel, including an attorney, who:

13.2.4.2.1 Did not actively participate in consideration of the matter involved at any previous level. Knowledge of the matter involved, however, shall not preclude any individual from serving as the Presiding Officer;

13.2.4.2.2 Is not in direct competition with the affected Practitioner; and

13.2.4.2.3 Is not related to the affected Practitioner.

13.2.4.3 The Presiding Officer shall:

13.2.4.3.1 Act to ensure that all participants in the Hearing have a reasonable opportunity to be heard and to present relevant oral testimony and/or documentary evidence and that decorum is maintained throughout the Hearing;

13.2.4.3.2 Determine the order of proceeding throughout the Hearing;

13.2.4.3.3 Have the authority and discretion to make rulings, consistent with this Policy, on all questions of procedure and admissibility of evidence; and

13.2.4.3.4 Have the authority to remove any person who is disruptive to the orderly and professional process of the Hearing.

13.2.4.4 The Presiding Officer may be advised on these matters by legal counsel to the Hospital.

13.2.4.5 The Presiding Officer must not act as a prosecuting officer, or as an advocate for either side at the Hearing. They may participate in the private deliberations of the Hearing Panel and act as advisor to it, but shall not be entitled to vote on its recommendations, unless they are the Chair of the Hearing Panel.

13.3 Rights of Affected Practitioner and Hospital

13.3.1 During the Hearing, both the affected Practitioner and the Professional Review Body whose recommendation prompted the Hearing have the right to:

13.3.1.1 Representation by an attorney or any other person of their choice; except that, if the affected Practitioner is not represented by an attorney, the Hospital will not be represented by an attorney;

13.3.1.2 Call, examine, and cross-examine witnesses;

13.3.1.3 Present evidence, unless it is determined to be irrelevant by the Presiding Officer; and

13.3.1.4 Submit a written statement at the close of the Hearing.

13.4 Requests for Documents

13.4.1 At least five (5) days prior to the Hearing, each party must provide to the other party documents in its possession that it plans to rely on as evidence at the Hearing. Such documents may be supplemented at any time prior to the conclusion of the Hearing, as long as the receiving party has sufficient time to study the new information and rebut it.

13.4.2 Providing documents to the other party shall not waive any privilege or confidentiality provided by law or policy to those documents; all documents will remain subject to such privilege and confidentiality protections.

13.5 Postponement of Hearing

Upon agreement by both parties, the Hearing may be postponed beyond the time originally noticed. If the parties cannot agree, postponement will be permitted only by the Presiding Officer, upon a showing of good cause by the requesting party.

13.6 Failure to Appear and Participate

The personal presence of the affected Practitioner at the Hearing is required. Failure of the affected Practitioner to appear and participate at the Hearing, without good cause as determined by the Presiding Officer, shall be deemed to constitute acceptance of the recommendation(s) or action(s) pending. Such recommendation(s) or pending action(s) shall become final and effective upon Board action.

13.7 Attendance by Hearing Panel Members

It is preferable to have all members of the Hearing Panel continually present during the Hearing; however, to assure conclusion of a Hearing within a reasonable timeframe, the Hearing may continue even though all members of the Hearing Panel are not present at all times. The fact that not all panel members were physically present at all times during the Hearing shall not invalidate it.

13.8 Hearing Record

A record of the Hearing shall be documented by a court reporter or by an electronic recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcripts or electronic recording shall be provided upon request to the affected Practitioner at their expense.

The Hearing Panel may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by a person authorized to notarize documents in this State.

13.9 Presentation of Evidence

13.9.1 The Professional Review Body whose recommendation prompted the Hearing shall present its evidence first. Upon completion of its presentation, the affected Practitioner shall present their evidence. The Professional Review Body shall then have an opportunity to rebut any evidence presented by the affected Practitioner.

13.9.2 Both parties to the Hearing shall be permitted to present evidence, unless it is determined not to be relevant by the Presiding Officer, regardless of the admissibility of such evidence in a court of law. The Presiding Officer shall admit any evidence which is commonly relied upon by reasonably prudent persons in the conduct of serious affairs.

13.9.3 The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence.

13.9.4 The Hearing Panel shall have the discretion to take official notice of any relevant matters as to which the Panel believes there can be no reasonable dispute. Official notice may also be taken of generally recognized technical or scientific facts within the Hearing Panel's members' specialized knowledge. Participants in the Hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the Hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

13.9.5 At the close of the Hearing, each party shall have the right to submit a written statement concerning any issue, procedure, or alleged fact. Such written statement may take the form of a memorandum of points and authorities. The Hearing Panel may request that such a statement or memorandum be filed by either party.

13.10 Standard of Proof

The affected Practitioner has the burden of proving that the recommendation that prompted the Hearing was unreasonable or not supported by substantial evidence. Unless they so prove, the Hearing Panel must recommend in favor of the Professional Review Body.

13.11 Adjournment and Conclusion

The Presiding Officer may, without special Notice, adjourn and reconvene the Hearing at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence, the Hearing shall be closed.

13.12 Deliberations and Recommendation of the Hearing Panel

13.12.1 Within twenty (20) days after conclusion of the Hearing, the Hearing Panel must:

13.12.1.1 Conduct its deliberations outside the presence of any other person, except the Presiding Officer, and upon the request of the Hearing Panel, appropriate Hospital support personnel (including the Hospital's attorney);

13.12.1.2 Render a report containing a recommendation(s) and a concise summary of the reasons supporting the recommendation. The recommendation shall be based on material allowed into evidence at the Hearing, which may include: oral testimony of witnesses; documentary evidence; all officially noticed matters; or any other evidence that has been admitted. In addition, the Hearing Panel shall consider any written statement or memorandum of points and authorities submitted by the parties. The recommendation shall comport with the burden-of-proof requirement. Agreement by a majority of the members of the Hearing Panel is required for the issuance of its report;

13.12.1.3 Deliver its report to the CEO;

13.12.1.4 Upon its receipt, the CEO shall promptly provide the Hearing Panel's report to the affected Practitioner by any manner permitted for a Notice. The CEO shall also send a copy of the report to the Professional Review Body whose adverse recommendation prompted the Hearing, and the MEC. Once the affected Practitioner exhausts or waives any appeal rights, the CEO shall promptly forward the Hearing Panel report to the Board for final action; and

13.12.1.5 The CEO shall make available to the Board all supporting documentation and transcripts of the Hearing at the time of its review.

13.13 Appellate Review

13.13.1 Request for Appellate Review. Within ten (10) days of notification by the CEO of an adverse recommendation from the Hearing Panel, the affected Practitioner may request appellate review, unless the Hearing Panel recommendation is one that would not be subject to Hearing. The request must be in writing and delivered to the CEO with receipt acknowledged by signature, and shall include a brief statement of the facts supporting grounds for the appeal. The CEO shall promptly forward the request to the Chair of the Board. If such appellate review is not requested in a timely fashion and in the manner required, the affected Practitioner shall be deemed to have waived the right to an appeal and to have accepted the adverse recommendation of the Hearing Panel.

13.13.2 Grounds for Appeal. The grounds for an appeal are that:

13.13.2.1 There was substantial failure on the part of the Hearing Panel to comply with these Bylaws, and such failure significantly prejudiced the affected Practitioner;

13.13.2.2 The recommendations of the Hearing Panel were arbitrary or capricious; or

13.13.2.3 The recommendations of the Hearing Panel were not supported by the evidence.

13.13.3 Scheduling and Notice of Appellate Review

13.13.3.1 Within ten (10) days of receipt of a request for an appeal, the CEO shall schedule and arrange for an appellate review. The date of appellate review must not be less than twenty (20) days, nor more than forty-five (45) days, from the date of receipt of the request; provided, however, that when a request for appellate review is from a Practitioner who is under a suspension then in effect, the appellate review must be held as soon as the arrangements may reasonably be made. The CEO shall give the affected Practitioner Notice of the time, place, and date of the appellate review.

13.13.3.2 The time set for the appellate review may be postponed by the Chair of the Board beyond the time originally Noticed upon a showing of good cause by the Appellate Review Panel.

13.13.4 Appointment of Appellate Review Panel

13.13.4.1 The Chair of the Board shall appoint a Review Panel composed of not less than three (3) nor more than five (5) persons, who may be members of the Board or others, including reputable persons outside the Hospital, but must include at least one (1) peer, to consider the record upon which the Hearing Panel recommendation was made.

13.13.4.2 Appointees to the Appellate Review Panel must not have actively participated in the consideration of the matter involved at any previous level; knowledge of the matter involved, however, shall not preclude any individual from serving as a member of the Appellate Review Panel. Nor shall it include any individual who is in direct economic competition with the affected Practitioner, nor any individual who is related to the Practitioner. The Chair of the Board shall designate a Chair of the Appellate Review Panel.

13.13.4.3 Attendance by Appellate Review Panel Members. A majority of the members of the Appellate Review Panel must be present at each meeting of the Panel. The Chair of the Appellate Review Panel may, without special Notice, adjourn and reconvene the review meeting at the convenience of the participants.

13.13.5 Purpose and Standard of Appellate Review

13.13.5.1 The purpose of the Appellate Review is to ascertain the fairness of the Hearing procedure and to determine whether the recommendation of the Hearing Panel is supported by the evidence submitted at the Hearing. The Appellate Review Panel shall review the Hearing record, including all documentary evidence and any written statements submitted by the parties before making its determinations and recommendations to the Board.

13.13.5.2 The Appellate Review Panel must uphold the recommendation of the Hearing Panel unless it finds that:

13.13.5.2.1 The Hearing Panel's recommendation was not supported by substantial evidence in the record, or was arbitrary or capricious; or

13.13.5.2.2 The procedures followed in reaching the recommendation were not fair or not in substantial compliance with these Bylaws and such unfairness or lack of compliance significantly prejudiced the affected Practitioner.

13.13.6 Additional Evidence. The Appellate Review Panel may not accept additional oral or written evidence, unless so directed by the Board upon a good faith belief that the affected Practitioner was unfairly denied the opportunity to present such evidence at the Hearing, except that the Appellate Review Panel may, in its sole discretion, invite the affected Practitioner to appear and make a statement.

13.13.7 Recommendation of the Appellate Review Panel

13.13.7.1 Within fourteen (14) days of the date Noticed for the Appellate Review, the Appellate Review Panel shall render a written report containing a recommendation in accordance with this Section and a concise summary of the reasons supporting its recommendation and forward such report to the Board and the CEO. The recommendation shall comport with the standard of review set forth in this Article. If the Appellate Review Panel's recommendation does not uphold the Hearing Panel's

recommendation, it may recommend referral back to the Hearing Panel or the MEC, as appropriate, with instructions for remedial action. Agreement by a majority of the members of the Appellate Review Panel is required for the issuance by the Panel of any recommendation or report. In the preparation of its written report with recommendation, the Appellate Review Panel may obtain assistance from the Hospital support staff (including the Hospital attorney).

13.13.7.2 Upon its receipt, the CEO shall forward the Appellate Review Panel's report with recommendation to the Hearing Panel, the Professional Review Body whose adverse recommendation prompted the Hearing, and the MEC, and communicate the report with recommendation by Notice to the affected Practitioner.

13.13.8 Final Decision of the Board

13.13.8.1 The Board may affirm, modify, or reverse the recommendation presented to it for final action, after exhaustion or waiver of Hearing and appeal rights by the affected Practitioner, or, in its sole discretion, refer the matter for further review and recommendations, to be completed within thirty (30) days, as per the Board's direction.

13.13.8.2 If the Board proposes an adverse final action inconsistent with that of the final recommendation before it, the Chair of the Board shall consult with the COS before taking such final action.

13.13.8.3 The CEO shall promptly give Notice of the final Board action to the affected Practitioner, and inform the Panel providing the recommendation and the COS, who shall distribute to the MEC.

13.13.8.4 All final actions shall be reported to state and federal agencies as required by law.

13.13.9 Further Review. Final Board action shall be effective immediately and is not subject to further review. No Practitioner shall be entitled as a matter of right to more than one Hearing or appellate review on any single matter.

13.13.10 Reapplication After Adverse Final Action. In the event that the Board denies initial appointment or reappointment to the Practitioner, or revokes or terminates the Practitioner's Medical Staff appointment and/or Clinical Privileges, the Practitioner may not again apply for Medical Staff appointment or Clinical Privileges at this Hospital for a period of five (5) years, unless the Board provides otherwise in its written final decision.

Article XIV Rules and Regulations

14.1 Admission, Transfer, and Discharge of Patients

14.1.1 Admissions

14.1.1.1 Admitting Practitioners and Their Responsibilities

14.1.1.1.1 Each patient shall be accepted and/or admitted only upon order of a Medical Staff Member with Admitting Privileges. The admitting Practitioner may order the patient's status to be determined in accordance with the Case Management Protocol. See Hospital Core Policy and Procedure CP01.076, *Level of Care Designation for Patients*, and Hospital Core Policy and Procedure CP 2.73 and CP2.73g, *Case Management Admission Protocol.*

14.1.1.1.2 All admissions shall be made in accordance with these Rules and Regulations and the requirements of Hospital Core Policy and Procedure CP01.010, *Patient Acceptance, Admission, Transfer and Discharge*.

14.1.1.2 Practitioners without Admitting Privileges. Active Medical Staff who practice in specialties that do not generally require Admitting Privileges shall not be privileged to admit patients to the Hospital without specific request for and grant of Admitting Privileges. Such Practitioners include, but are not limited to, those in the following specialties: Anesthesia, Emergency Medicine, General Dentistry, Pathology, and Radiology.

14.1.1.3 Provisional Diagnosis. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

14.1.1.4 Emergency Admissions and On-Call Responsibilities

14.1.1.4.1 Practitioners admitting emergency cases shall be prepared to demonstrate to the COS and to the Hospital Admissions Office, that the admission was an emergency. The history and physical (H&P) examination must clearly justify the emergency admission and these findings must be recorded in the patient's medical record as soon as possible after admission.

14.1.1.4.2 An on-call Attending list shall be maintained by each department or service. A patient to be admitted on an emergency basis through the Emergency Department (ED) who does not have an otherwise designated admitting Practitioner will be assigned to the on-call Attending in the appropriate department or service.

14.1.1.4.3 The on-call Attending, or their designee, must respond to a call (page) from the ED, Transfer Center or an inpatient unit within thirty (30) minutes. If the on-call Practitioner is requested by the ED Attending to appear in person, they must do so as soon as possible to personally evaluate and/or care for the patient.

14.1.1.4.4 The on-call Medical Staff Member who will knowingly be unavailable to care for emergency patients must arrange for an appropriate alternate Medical Staff Member to cover emergency calls during the period of unavailability, except where such unavailability is a result of the on-call Medical Staff Member's engagement in an emergency.

The Medical Staff Member making such an arrangement maintains the ultimate responsibility for call.

14.1.1.5 Psychiatric Admissions. For psychiatric patients, the admitting Practitioner shall be responsible for providing such information as may be necessary to assure the protection of the patient from self-harm and the protection of others.

14.1.1.6 Emergency Medical Screening Exams. All patients presenting to the Hospital ED seeking an emergency examination or treatment shall receive an appropriate Medical Screening Examination by a Qualified Physician or Other Qualified Medical Professional to determine whether or not an Emergency Medical Condition exists, and treated, admitted, stabilized, discharged, and/or transferred, as appropriate. This screening shall be without regard to insurance status or ability to pay. Qualified Physician is defined as credentialed physicians, Residents, and Fellows. Other Qualified Medical Professional is defined as Licensed Registered Nurses and include APRNs, Physician Assistants, and Psychiatric and Substance Abuse Evaluation Counselors qualified to perform Medical Screening Examinations, provided that they have been approved by the Service Chief, or when not applicable, the Medical Director of the Emergency Services, Labor & Delivery, or Psychiatry as appropriate.

14.1.1.7 Utilization Review. The Attending is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Management Committee. This documentation must contain:

14.1.1.7.1 An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient;

14.1.1.7.2 The estimated period of time the patient will need to remain in the Hospital; and

14.1.1.7.3 Plans for post-Hospital care.

14.1.1.8 In instances where the Utilization Management Committee determines that admission or continued stay is not justified based upon review of the medical record, the Attending must provide written justification of the necessity for admission or continued hospitalization, including an estimate of the number of days of stay expected. This documentation must be accomplished within twenty-four (24) hours of request. Should the Attending be unable to provide justification for admission or continued stay, hospitalization will be denied and the Attending must discharge the patient within twenty-four (24) hours and/or notify the patient that third-party payment will not fund the stay.

14.1.1.9 Admission Laboratory Screening

14.1.1.9.1 All patients being admitted must have a laboratory admission screen performed in accordance with the Attending's orders appearing on the "Request for Hospital Admission and Physician's Orders" form.

14.1.1.9.2 Pre-admission laboratory screens performed by licensed and appropriately accredited (College of American Pathologists, COLA, or another approved accreditation agency Commission) laboratory facilities in the State of Florida may be accepted in lieu of the admission screen upon the approval of the Attending and the Director of Laboratory Services. These test results must accompany the patient and be immediately available upon admission. Each such laboratory report should clearly state the patient's full name and other identifying information, including laboratory of origin.

14.1.2 Transfer of Inpatient Responsibilities. Transfers of inpatient responsibility must be done in accordance with the requirements of Hospital Core Policies and Procedures CP01.010 and CP02.061, *Patient Acceptance, Admission, Transfer and Discharge* and *Hand-Off Communication,* respectively.

14.1.3 Discharges. Patients shall be discharged only upon a written order of the patient's Attending physician or dentist or their Resident, and in accordance with Hospital Core Policy and Procedure CP01.010, *Patient Acceptance, Admission, Transfer and Discharge*.

14.2 Patient Deaths. See also Hospital Core Policies and Procedures CP01.013 andCP01.044, *Death of a Patient—Required Procedures, Notifications and Consents,* and *Autopsies*, respectively.

14.2.1 Pronouncement. Pronouncement of death must be made within a reasonable time. The pronouncement of death must be made by the appropriate Attending or their designee Physician, except that in the case of an anticipated or expected death, pronouncement may be made by an Advanced Practitioner (PA or APRN). The deceased body shall not be moved until a pronouncement of death has been documented.

14.2.1 Autopsy. These criteria are meant to provide guidance to the Medical Staff, rather than mandate that a request for autopsy be made in each of these cases. It shall be the duty of all Staff Members to secure autopsies whenever appropriate and possible. An autopsy may be performed only with appropriate consent. All autopsies performed in the Hospital shall be performed by a pathologist who is a member of the Medical Staff. A provisional anatomic diagnosis shall be recorded in the medical record within three (3) days and the completed autopsy protocol must be made a part of the medical record within sixty (60) days except in extenuating circumstances. Medical Staff are advised to document in the medical record when an autopsy is requested, but not approved. An autopsy should be considered for:

14.2.1.1 Unexpected deaths, including deaths under the following circumstances:

14.2.1.1.1 Admission for elective surgical procedure;

14.2.1.1.2 Admission for trauma or an acute medical condition where the prognosis was considered favorable or the initial course indicated favorable response to therapy;

14.2.1.1.3 Admission for therapy of a chronic condition where discharge was expected; or

14.2.1.1.4 During diagnostic or therapeutic procedures (if case waived by medical examiner).

14.2.1.2 Deaths where significant diagnostic uncertainties exist or where the cause of death is not clinically certain;

14.2.1.3 Deaths where family and/or public health concerns exist;

14.2.1.4 Deaths of patients on clinical study protocols;

14.2.1.5 Death on arrival (DOA), provided the case is waived by the medical examiner, or death within twenty-four (24) hours of admission;

14.2.1.6 All obstetrical deaths;

14.2.1.7 All perinatal and pediatric deaths;

14.2.1.8 Deaths where the illness may have a bearing on surviving family members or a transplant recipient; or

14.2.1.9 Deaths from known or suspected environmental or occupational hazards.

Article XV Medical Records

15.1 General Requirements

15.1.1 Medical Record Entries. all credentialed providers and Residents must directly access the electronic medical record to appropriately document the provision of care. Prior to obtaining access to the medical record, all credentialed providers and Residents must be trained to use the electronic medical record. All entries in the medical record must be made in accordance with Hospital Core Policy and Procedure CP01.095, *Medical Record Documentation Requirements.* Entries must contain essential information only, recorded in a scientific and professional manner.

15.1.2 Co-Signature. Co-signature of an entry signifies acknowledgement by the co-signer that the entry was made and concurrence with the statements or conclusions contained in the entry. If there is a disagreement with the conclusion of the author, the co-signer should record their differing conclusions or expand on the entry as appropriate.

15.2 Medical Record Content

15.2.1 The Attending is responsible for the accurate, timely, and legible completion of a medical record for each patient they admit or for whom they provide care.

15.2.2 Each medical record must contain at least the following information, as appropriate:

15.2.2.1 The patient's name, address, date of birth, and the name of any legally authorized representative;

15.2.2.2 For patients receiving mental health services, the patient's legal status;

15.2.2.3 Emergency care provided to the patient prior to arrival;

15.2.2.4 The record and findings of the patient's assessment;

15.2.2.5 A medical H&P examination including a statement of the conclusions or impressions;

15.2.2.6 The diagnosis or diagnostic impression;

15.2.2.7 The reason(s) for admission or treatment; the goals of treatment, and the treatment plan with episodic review;

15.2.2.8 Evidence of known advance directives;

15.2.2.9 Evidence of informed consent;

15.2.2.10 Reports of operative and other procedures, tests, and their results;

15.2.2.11 Records of donation and receipt of transplants or implants;

15.2.2.12 Diagnostic and therapeutic orders;

15.2.2.13 All diagnostic and therapeutic procedures and tests performed and the results;

15.2.2.14 Progress notes that include clinical observations and the patient's response to medications and care provided;

15.2.2.15 All reassessments;

15.2.2.16 Consultation reports;

15.2.2.17 Medications ordered or prescribed during treatment or upon discharge;

15.2.2.18 All diagnoses established during the course of care;

15.2.2.19 Conclusions at the termination of hospitalization;

15.2.2.20 Discharge summary, or a final progress note or transfer summary;

15.2.2.21 Discharge instructions to the patient or family;

15.2.2.22 Referrals and communications made to external or internal care providers and to community agencies; and

15.2.2.23 Autopsy results.

15.2.3 In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

15.3 History and Physical

15.3.1 General Requirements

15.3.1.1 A H&P examination must in all cases, except normal obstetrical and newborn cases, be dictated or electronically created, signed, and available in the Electronic Health Record prior to the performance of any invasive procedure (whether inpatient or outpatient) or within twenty-four (24) hours after admission of the patient, whichever occurs earliest, or for emergency admissions, as soon as conditions permit. In addition, an H&P examination is required for observation patients within twenty-four (24) hours or before discharge. If the H&P has been performed by a Resident Physician, APRN or PA, the Attending should review the H&P and enter a note of concurrence. For inpatients, an H&P performed at admission may be used for all subsequent inpatient procedures. If an H&P is performed and dictated within twenty-four (24) hours after admission, the Practitioner performing the H&P must make an entry in the record stating the H&P has been performed and dictated.

15.3.1.2 If an H&P examination has been performed by a Medical Staff Member, Resident Physician, APRN, or PA within thirty (30) days prior to the admission/procedure, the Attending should review the H&P and enter a letter of concurrence. A legible copy of the H&P may be used in the patient's medical record provided that, at the time of admission/the procedure, an appropriate assessment is performed and documented, including a physical examination of the patient, to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed. The update note must also confirm that the

necessity for the care/procedure is still present and the H&P is still current. The update note must be on or attached to the full H&P, or, when the H&P is accessed on-line by the Practitioner, must refer specifically to the date of the H&P being updated. Updates may be done by the Attending or their Resident or appropriately privileged APRN or PA.

15.3.1.3 An H&P that was performed within thirty (30) days prior to admission/procedure by a non-credentialed (non-Resident) Practitioner must be reviewed by a Medical Staff Member and a note of concurrence entered into the medical record.

15.3.1.4 Dentists are responsible for the part of their patients' H&P examinations that relate to dentistry. Podiatrists are responsible for the part of their patients' H&P examinations that relate to podiatry. A credentialed M.D. or D.O. must confirm the findings and conclusions of the H&P and assessment of risk(s) of any proposed operative or other procedure requiring written informed consent pursuant to Hospital policy, done by a Dentist (except an Oral and Maxillofacial Surgeon) or Podiatrist, when the patient involved has a severe systemic disease that is considered a constant threat to the life of the patient.

15.3.2 H&P Required Elements

15.3.2.1 For Inpatients. The H&P must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; social history; family history; review of systems, and a relevant physical examination. A comprehensive assessment should integrate the elements from the H&P examination that support the reason for admission or need for intervention followed by the treatment plan.

15.3.2.2 For Outpatient Procedures. An H&P must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; review of relevant systems, including pain assessment and relevant physical examination that supports the need for intervention followed by the treatment plan.

15.3.2.3 If Anesthesia or Sedation Is Planned. The anesthesia assessment shall include, at a minimum: medication history, including drug allergies; previous experience with sedation and analgesia; results of relevant diagnostic studies; physical status assessment; airway assessment; and NPO status.

15.4 Pre-Procedure Documentation

15.4.1 Pre-procedure verification (including site marking and time out) must be performed and documented in accordance with Hospital Core Policy and Procedure CP02.056, *Pre-Procedure Verification Process (Universal Protocol)*.

15.4.2 No anesthesia shall be given, nor invasive/significant risk procedure started, until the H&P examination, pre-procedure diagnosis, indicated laboratory/diagnostic tests, and informed consent are on the chart, unless the Attending documents in the Medical Record that delay would be detrimental to the patient's health. In an emergency, the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of procedure, including, at a minimum: heart rate, respiratory rate, and blood pressure.

15.4.3 Admission Notes. In addition to the dictated H&P, an admission note must be written for all inpatients and admitted observation patients. The admission note must include the reason for admission, pertinent findings, conclusions and plan of care. A handwritten update to an H&P dictated within the past thirty (30) days may be considered the admission note.

15.4.4 Pre-Anesthesia Assessment. Within forty-eight (48) hours prior to the procedure, a pre-anesthesia assessment of each patient for whom anesthesia is contemplated shall be performed and a determination made and documented by the Anesthesiologist that the patient is an appropriate candidate to undergo the planned anesthesia. Immediately prior to induction, an evaluation of the patient must be completed and documented.

15.5 Post-Operative Documentation and Discharge from Recovery Area

15.5.1 The patient's post-operative status is to be assessed on admission to and discharge from the post-anesthesia recovery area.

15.5.2 If discharge criteria are to be used for patient discharge from post-anesthesia care, they must be approved by the Medical Staff.

15.5.3 Post-operative documentation includes at least: a record of vital signs and level of consciousness; medications (including intravenous fluids); blood and blood components; any unusual events or post-operative complications, including drug and transfusion reactions, and the management of those events; identification of all care providers; the patient's discharge from the post-anesthesia care area, including documentation of the responsible discharging physician, dentist, or podiatrist, or, if discharge was by criteria, documentation of criteria used to determine patient readiness.

15.5.4 In addition, for inpatients, a post-anesthesia evaluation must be completed and documented by a qualified anesthesia provider within forty-eight (48) hours following anesthesia.

15.6 Operative Reports

15.6.1 Operative reports shall be dictated or, when permitted, written as soon as possible after surgery and include:

15.6.1.1 Name and medical record number of the patient;

15.6.1.2 Date and time of surgery;

15.6.1.3 Pre- and post-operative diagnosis(es);

15.6.1.4 Name of the surgical procedure(s) performed;

15.6.1.5 Type of anesthesia administered;

15.6.1.6 Complications, if any;

15.6.1.7 Identification of participating surgeons and other Practitioners;

15.6.1.8 Findings;

15.6.1.9 A description of the specific significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, or altering tissues);

15.6.1.10 Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;

15.6.1.11 Specimens removed; and

15.6.1.12 Estimated blood loss. Operative reports must be dictated; except that, with the exclusion of tracheostomies, procedures done at bedside may be handwritten or dictated. All tracheostomies, regardless of where performed, must be dictated.

15.6.3 When the operative report is not placed in the medical record immediately after surgery, a progress note is entered in the patient's medical record immediately (before the patient moves to the next level of care). The immediate post-operative progress note must include at a minimum: date of procedure, pre-op diagnosis, post-op diagnosis, procedure(s) performed, surgeon(s) and assistant(s) names, findings, complications, estimated blood loss, specimens removed, surgeon's signature, and provider ID number.

15.7 Progress Notes

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. An Attending or their Resident, PA, or APRN shall enter a progress note in the medical record at least daily. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

15.8 Consultations

15.8.1 The name of the requesting Practitioner, and the date and time of the request, must appear on all consultation requests.

15.8.2 All consultation requests are to be responded to by Practitioners or other appropriate healthcare professionals within twenty-four (24) hours, unless a shorter time frame is important for a positive patient outcome, either through the completion of a consultation report form, or documentation in the progress note labeled "Consultation."

15.8.3 Consultations shall be provided upon request without regard to the patient's insurance or payment status.

15.8.4 The consultation report/note must include:

15.8.4.1 The name of the requesting physician, dentist, or podiatrist;

15.8.4.2 The name of the responding service;

15.8.4.3 Reason for the consultation;

15.8.4.4 Evidence of a review of the patient's record;

15.8.4.5 Pertinent findings on examination;

15.8.4.6 Consultant's opinion and recommendations; and

15.8.4.7 Signature, date, and time by the consultant.

15.8.5 A limited statement such as "I concur" does not constitute an acceptable report of consultation.

15.8.6 When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

15.8.7 Follow-up consultations must be designated as such and again signed by the consultant.

15.9 Obstetrical Record

The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the referring Practitioner's office record transferred to the Hospital before admission, but an admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

15.10 Discharge Progress Note

A discharge progress note must be written prior to discharge of the patient that includes: principal and secondary diagnoses, major procedures, list of current medications (after reconciliation in compliance with Hospital Core Policy and Procedure CP02.009, *Medication Reconciliation*) and instructions to the patient, including medication instructions and prescriptions given. The note must be signed, dated, and timed by the Attending or their Resident.

15.11 Discharge Summary

15.11.1 Immediately prior to or within forty-eight (48) hours of discharge, a discharge/death summary shall be dictated for all observation patients and inpatients, except that, for normal newborns, observation obstetrical patients, and obstetric patients with uncomplicated deliveries, a final progress note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the summary. The summary should concisely recapitulate: a complete listing of final diagnoses; the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to the patient and/or family, e.g., instructions relating to physical activity; complete current medication list (after reconciliation in compliance with Hospital Core Policy and Procedure CP02.009, *Medication Reconciliation*); diet and follow-up care. All summaries must be signed by the Attending.

15.11.2 The discharging Attending is responsible for appropriate communication regarding treatment of the patient to the referring and/or next treating Practitioner.

15.12 Symbols and Abbreviations

Only symbols and abbreviations recognized by an approved reference source designated by the Patient Record Committee may be used. A list of prohibited abbreviations can be found in Hospital Core Policy and Procedure CP02.053, *Abbreviations*. Abbreviations on the prohibited abbreviations list must not be used in any handwritten medical order, medication-related documents, or on pre-printed forms.

15.13 Removal of Medical Records

15.13.1 Original records may not be removed from the Hospital except as required by court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be removed without permission of the Director of the Health Information & Record Management Department.

15.13.2 Unauthorized removal of a record from the Hospital is grounds for disciplinary action in accordance with the Medical Staff Bylaws.

15.14 Release of Medical Records

Written consent of the patient or surrogate is required for release of medical information to persons not otherwise authorized by law to receive this information. Refer to Hospital Core Policies and Procedures (CP03 series, CP01.008, CP01.011, and CP01.035).

15.15 Completion of Medical Records

15.15.1 Medical records of discharged patients are to be completed promptly. Physicians, dentists, and podiatrists are expected to electronically complete all medical records, including dictations, physician, dentist, and podiatrist queries, and electronic signatures in all systems at least once every seven (7) days. Failure to do so may be cause for disciplinary action including suspension of Clinical Privileges according to these Bylaws and the procedures established by the Department of Health Information Management.

15.15.2 Medical Staff Members shall not complete a medical record for a patient who has not been under their care. If the Attending is unavailable for completion of the record and no other physician, dentist, or, podiatrist is adequately familiar with the care to allow completion of the record, it will be closed in accordance with the policy established by the Health Record Shared Governance Committee.

Article XVI General Conduct of Care

The management of each patient's care, treatment, and services is the responsibility of a Medical Staff Member with appropriate Clinical Privileges.

16.1 Residents and Non-Faculty Patients

16.1.1 Fellows, Residents, and students will not be involved in the evaluation or treatment of non-faculty Medical Staff Member patients, except that, in an emergency, Fellows and Resident physicians will assist in providing the necessary care until the patient's physician's, dentist's, or podiatrist's arrival.

16.2 Informed Consent

Informed consent must be obtained prior to any non-routine treatment or procedure, except in emergency situations when the patient is incapacitated and a surrogate/proxy, or parent if the patient is a minor, cannot be immediately reached. Written informed consent shall be obtained in conformance with Hospital Core Policy and Procedure CP02.010, *Informed Consent for Treatment,* prior to any diagnostic or therapeutic procedure or treatment (i) that entails significant risk to the patient or (ii) for which it is otherwise required by law, Regulation, or Hospital policy. The Attending scheduled to perform the procedure or another Physician designated by the Attending is required to obtain such consents.

16.3 Disclosure of Unanticipated Events

In accordance with Hospital Core Policy and Procedure, CP01.043, *Disclosure of Adverse Incident,* in order to be designated an "appropriately trained physician," all Attendings must complete the Self Insurance Program training concerning disclosure.

16.4 Orders

16.4.1 Orders for treatment may only be given by Attendings, Residents and Fellows, and by APRNs/PAs within the authority of their Clinical Privileges to practice, and in accordance with Hospital Core Policy and Procedure CP02.058, *Medical Orders*. Orders that are illegible or improperly written shall not be carried out until rewritten and understood by the healthcare professional responsible for implementing the order.

16.4.2 Orders for Restraint or Seclusion must be given in accordance with Hospital Core Policy CP02.021, *Restraints and Seclusion*.

16.4.3 Verbal orders must be given in accordance with Hospital Core Policy and Procedure CP02.058, *Medical Orders.*

16.4.4 For DNR order procedures, refer to Hospital Core Policies and Procedures CP02.012 and CP02.013, *"Do Not Resuscitate" Orders*, and *Withholding or Withdrawing Life-Prolonging Treatment or Measures,* respectively.

16.4.5 Orders written by medical students cannot be executed without the co-signature of a Practitioner with authority to give that order, in which case the order is deemed to be that of the co-signing Practitioner.

16.5 Advance Directives

Advance directives should be reviewed by the Attending or another Physician designated by the Attending with the patient or their proxy/surrogate at the time of each admission, when there is a significant change in the patient's condition, or at the patient's request. This discussion should be documented in the progress notes and, if appropriate, a new advance directive should be executed. Unless otherwise provided for by law, advance directives or a proxy/surrogate's decision on behalf of a patient shall be honored. See also Hospital Core Policy and Procedure, CP02.029, *Advance Directives*.

16.6 Permitted Medications

16.6.1 All drugs, diagnostic agents, and commercially available dietary supplements administered to patients shall be listed in the latest edition of the USP-NF (United States Pharmacopoeia/National Formulary) or American Hospital Formulary Service. Medications listed in these compendia that have been deemed unavailable for safety or cost reasons by the Pharmacy and Therapeutics Committee will not be administered to patients.

16.6.2 Drugs for IRB-approved clinical investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of the Federal Drug Administration. All drugs used for patient care will be issued or verified by the Hospital Pharmacy Department. All compounded injectable medication and narcotics will be supplied by the Pharmacy.

16.6.3 A patient may bring in their own formulary or non-formulary medications for use during their hospitalization only in accordance with the provisions of Hospital Core Policy and Procedure, CP02.077, *Patient Medications Brought into the Hospital and Patient Self-Administration of Medications*.

16.7 Sedation by Non-Anesthesia Providers

Sedation and analgesia for procedures shall be ordered and supervised only by Medical Staff privileged to do so, and only in accordance with Hospital Core Policy and Procedure CP02.022, *Sedation by Non-Anesthesiologists/Non-CRNAs*.

16.8 Students

All students must work directly under the supervision of a licensed or registered professional.

16.9 Tissue Removal

All tissues removed at the operation, except those approved by the Perioperative Governance Committee and Quality and Operations Committee, shall be sent to the Hospital pathologist who shall make such examination as they may consider necessary to arrive at the tissue diagnosis. Their authenticated report shall be made a part of the patient's medical record.

16.10 Consults

16.10.1 High-quality medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the Attending. Each clinical service should exercise its judgment regarding the specific conditions for which consultations are to be obtained.

16.10.2 Any qualified Practitioner with Clinical Privileges/scope of practice in this Hospital must respond to a request for a consultation within their area of expertise within twenty-four (24) hours, unless a shorter timeframe is important for a positive patient outcome.

16.10.3 Except in an emergency situation, consultation must be obtained at a minimum in the following situations:

16.10.3.1 To confirm the appropriateness of proceeding with a planned operation or treatment, despite the fact that the patient may not be a good risk for said operation/treatment;

16.10.3.2 Where the diagnosis is unclear after diagnostic procedures have been completed;

16.10.3.3 Where there are questions regarding the choice of therapeutic measures;

16.10.3.4 In cases where skills beyond the scope of the Attending may be needed, or where a second Attending's presence is advisable, e.g., complex, high-risk surgery;

16.10.3.5 Prior to medical or surgical intervention when the patient exhibits severe psychiatric symptoms;

16.10.3.6 When requested by the patient or their proxy or surrogate;

16.10.3.7 When an ethics consult appears to be indicated, such as disagreements between or amongst the healthcare team and the patient and/or patient's proxy or surrogate on treatment issues. See also Hospital Core Policy and Procedure, CP02.028, *Ethics Consultation*; or

16.10.3.8 In all instances of attempted suicide and drug overdose, psychiatric consultation shall be obtained.

16.11 Practitioner Self Care or Care of Immediate Family Member

16.11.1 Physicians, dentists, or podiatrists generally should not treat themselves or immediate family members (parents, siblings, children, or spouses); however, there may be occasions where this is acceptable and appropriate.

16.11.2 Any physician, dentist, or podiatrist who desires to provide treatment to themself or a family member must first contact the Service Chief of their assigned department or the Chair of the Medical Executive Committee. The physician, dentist, or podiatrist shall provide a memo to the Service Chief describing the nature of the problem and/or the intended treatment and advise the Service Chief of the reason that a non-related physician, dentist, or podiatrist is not providing the care. The Service Chief must provide the requesting

physician, dentist, or podiatrist with the American Medical Association's Code of Ethics statement on this issue, which is appended (Appendix A) to these Rules and Regulations.

16.11.3 If, after reviewing the AMA Code of Ethics, the physician, dentist, or podiatrist informs the Service Chief of their intent to proceed with the delivery of care to self or family members, the Service Chief shall notify Quality Management and initiate a concurrent chart review of the care.

Article XVII General Rules Regarding Dental Care

A patient admitted for dental care is the responsibility of both the Dentist and a Physician or oral and maxillofacial surgeon.

17.1 Dentist's Responsibilities

17.1.1 A detailed dental history justifying Hospital admission;

17.1.2 A detailed description of the examination of the oral cavity and pre-operative diagnosis;

17.1.3 A complete operative report, describing the findings and techniques used. For tooth extractions, the Dentist shall clearly state the number of teeth and fragments removed. All tissue and teeth fragments shall be sent to pathology; and

17.1.4 A discharge of the patient, including Discharge Order and Summary, in accordance these Bylaws.

17.2 Physician's or Oral and Maxillofacial Surgeon's Responsibilities

17.2.1 A medical H&P in accordance with these Bylaws; and

17.2.2 Supervision of the patient's general health status while hospitalized.

Appendix A

AMA *Code of Medical Ethics*

1.2.1 Treating Self or Family

Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

1. In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

2. For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

1. Document treatment or care provided and convey relevant information to the patient's primary care physician.

2. Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

3. Avoid providing sensitive or intimate care, especially for a minor patient who is uncomfortable being treated by a family member.

4. Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics: I,II,IV