BYLAWS OF THE MEDICAL STAFF

OF

MT. SAN RAFAEL HOSPITAL
TRINIDAD, COLORADO

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# BYLAWS OF THE MEDICAL STAFF

OF MT. SAN RAFAEL HOSPITAL

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Article</th>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>4.1</td>
<td>Definition</td>
<td>9</td>
</tr>
<tr>
<td>IV</td>
<td>4.2</td>
<td>Appointment Procedures</td>
<td>9</td>
</tr>
<tr>
<td>IV</td>
<td>4.2-1</td>
<td>Applications</td>
<td>9</td>
</tr>
<tr>
<td>IV</td>
<td>4.2-2</td>
<td>Application Content</td>
<td>9</td>
</tr>
<tr>
<td>IV</td>
<td>4.2-3</td>
<td>References</td>
<td>11</td>
</tr>
<tr>
<td>IV</td>
<td>4.2-4</td>
<td>Effects of Application</td>
<td>11</td>
</tr>
<tr>
<td>IV</td>
<td>4.3</td>
<td>Processing the Application</td>
<td>12</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-1</td>
<td>Application Burden</td>
<td>12</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-2</td>
<td>Verification of Information</td>
<td>12</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-3</td>
<td>Service Action</td>
<td>12</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-4</td>
<td>Medical Executive Committee Action</td>
<td>12</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-5</td>
<td>Effect of MEC Action</td>
<td>13</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-6</td>
<td>Board Action</td>
<td>13</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-7</td>
<td>Basis for Recommendations and Actions</td>
<td>14</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-8</td>
<td>Conflict Resolution</td>
<td>14</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-9</td>
<td>Notice of Final Decision</td>
<td>14</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-10</td>
<td>Time Periods for Processing</td>
<td>14</td>
</tr>
<tr>
<td>IV</td>
<td>4.3-11</td>
<td>Waiting List for Denials based on Need or Ability to Accommodate</td>
<td>15</td>
</tr>
<tr>
<td>III</td>
<td>3.1</td>
<td>General Qualifications</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>3.1-1</td>
<td>Licensure</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>3.1-2</td>
<td>Performance</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>3.1-3</td>
<td>Attitude</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>3.1-4</td>
<td>Disability</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>3.1-5</td>
<td>Hospital and community need, and ability to accommodate</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>3.1-6</td>
<td>Professional Liability Insurance</td>
<td>8</td>
</tr>
<tr>
<td>III</td>
<td>3.1-7</td>
<td>Effect of Other Affiliations</td>
<td>8</td>
</tr>
<tr>
<td>III</td>
<td>3.1-8</td>
<td>Non-Discrimination</td>
<td>8</td>
</tr>
<tr>
<td>III</td>
<td>3.2</td>
<td>Basic Obligations of Individual Medical Staff Members</td>
<td>8</td>
</tr>
<tr>
<td>III</td>
<td>3.3</td>
<td>Term of Appointment</td>
<td>9</td>
</tr>
<tr>
<td>II</td>
<td>2.1</td>
<td>Purpose</td>
<td>5</td>
</tr>
<tr>
<td>II</td>
<td>2.2</td>
<td>Responsibilities</td>
<td>5</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>NAME</td>
<td>5</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF</td>
<td>5</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>PREAMBLE</td>
<td>2</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>DEFINITIONS</td>
<td>3</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Reappointment Procedures</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>4.4-1</td>
<td>Information Collection and Verification from Medical Staff Member</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>4.4-2</td>
<td>From Internal Sources</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>4.4-3</td>
<td>Service Action</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>4.4-4</td>
<td>Medical Executive Committee Action</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>4.4-5</td>
<td>Final Processing and Board Action</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>4.4-6</td>
<td>Basis for Recommendation and Action</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>4.4-7</td>
<td>Time Periods for Processing</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>4.4-8</td>
<td>Requests for Modification of Membership Status or Privileges</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Systems and Procedures for Delineating Clinical Privileges</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>4.5-1</td>
<td>Categories of Clinical Privileges</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>4.5-2</td>
<td>Category III Privileges</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>4.5-3</td>
<td>Category II Privileges</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>4.5-4</td>
<td>Category I Privileges</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>4.5-5</td>
<td>Consultation</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>4.5-6</td>
<td>Departmental Responsibilities</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>4.5-7</td>
<td>Procedure for Delineation Privileges</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>History and Physical</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>4.6-1</td>
<td>Medical Records Completion</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>4.6-2</td>
<td>Medical Records Preparation</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>4.7</td>
<td>Leave of Absence</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>4.7-1</td>
<td>Leave Status</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>4.7-2</td>
<td>Termination of Leave</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>4.8</td>
<td>Practitioners Providing Contractual Professional Services</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>4.8-2</td>
<td>Facilities/Services Subject to the Exclusivity Policy</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>4.8-3</td>
<td>Qualifications</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>4.8-4</td>
<td>Effect of Medical Staff Membership Termination</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>4.8-5</td>
<td>Effect of Contract Expiration or Termination</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>4.9</td>
<td>Employed Physicians</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>Physician Providing Services from Remote Location</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ARTICLE V. MEDICAL STAFF CATEGORIES</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Categories</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Active Staff</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>5.2-1</td>
<td>Qualifications for Active Status</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>5.2-2</td>
<td>Prerogatives of Active Status</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>5.2-3</td>
<td>Obligations of Active Status</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Courtesy Staff</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>5.3-1</td>
<td>Qualifications for Courtesy Status</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>5.3-2</td>
<td>Prerogatives of Courtesy Status</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>5.3-3</td>
<td>Obligations of Courtesy Status</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Consulting Staff</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>5.4-1</td>
<td>Qualifications for Consulting Staff</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>5.4-2</td>
<td>Prerogatives of Consulting Status</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>5.4-3</td>
<td>Obligations of Consulting Status</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Associate Staff</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>5.5-1</td>
<td>Qualification for Associate Staff</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>5.5-2</td>
<td>Prerogatives of Associate Staff</td>
<td>27</td>
<td></td>
</tr>
</tbody>
</table>
ARTICLE VI. Delineation of Practice Privileges

6.1 Exercise of Privileges ................................................. 30
6.2 Basis for Privileges Determinations ................................. 30
6.3 System and Procedures for Delineating Privileges ................................................. 30
6.4 Special Conditions for Dental Privileges ................................................. 30
6.5 Emergency Privileges/Disaster Privileges ............................... 31
6.6 Temporary Privileges .................................................... 31
6.6-1 Conditions ............................................................ 31
6.6-2 Circumstances ........................................................ 31
6.6-3 Termination .......................................................... 32
6.6-4 Rights of the Practitioner ............................................. 33

ARTICLE VII. STAFF OFFICERS

8.1 General Officers of the Staff .......................................... 33
8.1-1 Identification .......................................................... 33
8.1-2 Qualifications ........................................................ 33
8.2 Terms of Office ........................................................ 33
8.3 Chief, Vice Chief and Secretary/Treasurer .......................... 33
8.3-1 Election ............................................................... 33
8.4 Vacancies in Elected Offices ......................................... 34
8.5 Resignation and Removal from Office ............................... 34
8.5-1 Resignation .......................................................... 34
8.5-2 Removal .............................................................. 34
8.6 Duties of Officers ...................................................... 34
8.6-1 Duties of the Chief of Staff ....................................... 34
8.6-2 Duties of the Vice Chief .......................................... 36
8.6-3 Duties of the Secretary-Treasurer .................................. 36

ARTICLE VIII. CLINICAL SERVICES ............................................. 36
9.1 Enumeration ............................................................ 36
9.1-1 Clinical Services ..................................................... 36
9.1-2 Future Clinical Services or Departments ........................ 37
9.2 Affiliation with Services .............................................. 37
9.3 Size of Clinical Service Committee .................................. 37
9.4 Function of the Service Committees ................................. 37
Section 3 Conduct of Hearing................................................................. 56
Section 4 Action of Hearing Committee/Hearing Officer Report .......... 59
Section 5 Appeal to the Governing Body........................................... 60
Section 6 Final Decision by Governing Body..................................... 62
Section 7 Hearing Specifications....................................................... 63

ARTICLE XIII. MEETINGS........................................................................ 63
12.1 Medical Staff Year................................................................. 63
12.2 Medical Staff Meetings......................................................... 64
12.2-1 Regular Meetings.............................................................. 64
12.2-2 Special Meetings............................................................... 64
12.3 Clinical Service and Committee Meetings................................. 64
12.3-1 Regular Meetings.............................................................. 64
12.3-2 Special Meetings............................................................... 64
12.4 Attendance Requirements...................................................... 64
12.4-1 Generally............................................................................ 64
12.4-2 Special Appearance of Conferences...................................... 65
12.4.5 Notice of Meetings............................................................ 65
12.6 Quorum................................................................................. 65
12.6-1 General Staff Meeting......................................................... 65
12.7 Order of Business at Regular Staff Meeting............................... 66
12.8 Manner of Action................................................................... 66
12.9 Minutes.................................................................................. 66
12.10 Procedural Rules................................................................. 66

ARTICLE XIV. CONFIDENTIALITY, IMMUNITY AND RELEASES................. 66
13.1 Special Definitions.................................................................... 66
13.2 Authorization and Conditions................................................... 67
13.3 Confidentiality of Information.................................................. 67
13.4 Immunity from Liability.......................................................... 68
13.4-1 For Action Taken.................................................................. 68
13.4-2 For Providing Information.................................................... 68
13.5 Activities and Information Covered........................................... 68
13.5-1 Activities............................................................................. 68
13.5-2 Information......................................................................... 69
13.6 Releases.................................................................................. 69
13.7 Cumulative Effect.................................................................... 69

ARTICLE XV. GENERAL PROVISIONS..................................................... 69
14.1 Staff Rules and Regulations....................................................... 69
14.2 Clinical Service........................................................................ 70
14.3 Construction of Terms and Headings......................................... 70

ARTICLE XVI. ADOPTION AND AMENDMENT....................................... 70
5.1 Action Required........................................................................ 70
BYLAWS OF THE MEDICAL STAFF
OF
MT. SAN RAFAEL HOSPITAL

PREAMBLE

WTHHEREAS, Mt. San Rafael Hospital is a Hospital organized under the laws of the State of Colorado to serve as a general community Hospital providing patient care, education, and research with all of its activities subject to the ultimate authority of its Board of Directors; and

WTHHEREAS, the laws, regulations, customs and generally recognized professional standards that govern Hospitals require that all practitioners practicing at a Hospital be formally organized into a collegial body of professions, providing for its members mutual education, consultation and clinical support, constituting the Hospital’s Medical Staff; and

WTHHEREAS, a Hospital’s Medical Staff is the organizational component to which a Hospital board must delegate responsibilities relating to, and exact accountability for, the quality and appropriateness of professional performance; and

WTHHEREAS, a purpose of the Hospital is to provide optimal, achievable patient care and otherwise fulfill professional and institutional obligations to patients, students and the community; and

WTHHEREAS, dedication to this purpose requires a cooperative effort among the professional peers practicing in the Hospital and between them and the Hospital Board and management, with well defined lines of communication, responsibility and authority throughout the organizational structure;

THEREFORE, the Practitioners practicing in the Hospital are thereby organized into a Medical Staff in conformity with these Bylaws, rules and regulations, and the Bylaws of the Hospital.
BYLAWS OF THE MEDICAL STAFF
OF
MT. SAN RAFAEL HOSPITAL

DEFINITIONS

1. BOARD OF DIRECTORS or BOARD means the governing body of the Hospital.

2. ADMINISTRATOR or CHIEF EXECUTIVE OFFICER means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

3. CLINICAL PRIVILEGES or PRIVILEGES means the rights granted to a practitioner to provide those diagnostic, therapeutic, medical, or surgical, services specifically delineated by him/her.

4. EX OFFICIO means service as a member of the body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

5. HOSPITAL means the Mt. San Rafael Hospital of Trinidad, Colorado.

6. MEDICAL EXECUTIVE COMMITTEE or MEC means the Executive Committee of the Medical Staff as appointed by the Medical Staff.

7. MEDICAL STAFF means all licensed physicians who are privileged to attend patients in the Hospital.

8. ORGANIZED MEDICAL STAFF is a formally organized body of those individuals who, as a group, are responsible for establishing and amending the Bylaws and rules and regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The Organized Medical Staff is limited to Practitioners who are Medical Staff Members in the Active category of membership and have therefore been granted the rights to vote, to be a Member of a Medical Staff committee, and to hold office in the organized Medical Staff.

9. MEDICAL STAFF YEAR means the period of January 1 to December 31.

10. MEDICAL STAFF BYLAWS means the Medical Staff Bylaws and the Rules and regulations and related protocols and manuals of the Medical Staff.

11. PRACTITIONER means, unless otherwise expressly limited, any appropriately licensed physician (M.D. or D.O.), applying to or exercising clinical privileges in this Hospital.
12. PREROGATIVE means a participatory right granted, by virtue of Medical Staff category or otherwise, to a Medical Staff member and exercisable subject to the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

13. SPECIAL NOTICE means written notification sent by mail, return receipt requested, or email.
ARTICLE I. NAME

The name of this organization is “The Medical Staff of Mt. San Rafael Hospital.”

ARTICLE II. PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 PURPOSES

The purposes of the Medical Staff are:

2.1-1. To constitute a professional collegial body, providing for its members mutual education, consultation and professional support, to the end that quality patient care be provided at the Hospital given the state of the healing arts and the available resources.

2.1-2 To serve as the collegial body through which individual practitioners may obtain membership prerogatives and clinical privileges at the Hospital to provide clinical services to patients and to engage in teaching and research.

2.1-3 To develop an organization structure, reflected in Medical Staff Bylaws, Rules, Regulations and other related protocols and manuals, which adequately defines responsibility and concomitant authority and accountability of every organizational component and is designed to assure that each Medical Staff member exercise responsibility and authority commensurate with his/her contributions to patient care and to the teaching and research needs at the Hospital, and fulfills like accountability obligations.

2.1-4 To provide a mechanism for accountability to the Board, through defined Medical Staff components, for the appropriateness of the patient care services, professional and ethical conduct, and teaching and research activities of each individual practitioner holding membership in the Medical Staff.

2.1-5 To provide a means with which the Medical Staff will participate in the Hospital’s policy making and planning processes

2.2 RESPONSIBILITIES

To effectuate the purposes enumerated above, it is the obligation and responsibility of the organized Medical Staff:

2.2-1 To participate in the Hospital’s Performance Improvement and Utilization Review programs by conducting activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, including without limitation:

(a) Evaluating practitioner and institutional performance through valid and reliable measurement systems, including but not limited to National Practitioner Data Bank, the Colorado State Board of Medical Examiners, and the American Medical Association Master File, Education Communications for Foreign Medical Graduates, American Board of Medical Specialties, and American Osteopathic Association Data Base.
(b) Engaging in the on-going monitoring of critical aspects of care and enforcement of Medical Staff and Hospital policies.

(c) Evaluating practitioner credentials for initial and continued membership in the Medical Staff organization and for the delineation of clinical privilege for each individual practitioner in the Hospital.

(d) Arranging for Medical Staff participation in programs designed to meet the educational needs of patients and families coordination of care with other practitioners and other Hospital personnel as relevant to the care of individual patients and accurate, timely and legible completion of patient’s medical records.

(e) Assuring that medical and health care services at the Hospital are appropriately employed for meeting patient’s medical, social and emotional needs, consistent with sound health care resource utilization practices.

(f) Patients are entitled to receive a comparable level of care for the same condition, regardless of what department provides the care, the discipline of the practitioner, or the setting.

2.2-2 To make recommendations to the Board concerning appointments and reappointments to the Medical Staff including membership category and clinical service assignments, clinical privileges, specified services for allied health professionals, and corrective action.

2.2-3 To maintain sound professional practices and an atmosphere conducive to the diagnosis and treatment of illness and to teaching.

2.2-4 To develop or participate in and to monitor the Medical Staff’s education and training programs.

2.2-5 To develop, administer and recommend amendments to these Bylaws, its supporting manuals, and the rules and regulations of the Medical Staff and its various components.

2.2-6 To enforce compliance with the Bylaws and Rules and Regulations of the Medical Staff and of its administrative and clinical components, and with Hospital Bylaws and policies, and to that end assist and cooperate with the Board and/or committees thereof, administration and/or designees thereof.

2.2-7 To participate in the Board’s short and long-term planning activity, to assist in identifying community health needs and to suggest to the Board appropriate institutional policies and programs to meet those needs.

2.2-8 To exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.
ARTICLE III. MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

Every practitioner who seeks or enjoys Medical Staff membership must, at the time of appointment, reappointment, and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and of the Board the following qualifications:

3.1-1 LICENSURE

A currently valid license issued by the State of Colorado to practice medicine.

3.1-2 PERFORMANCE

Professional education, training, experience and clinical results, documenting a continuing ability to provide patient care services meeting generally acceptable medical standards with respect to both quality and utilization.

3.1-3 ATTITUDE

A willingness and ability, based on current attitude and evidence of performance,

(a) To work with and relate to other Medical Staff members, residents and students, members of other health disciples, Hospital management and employees, visitors, and the community in general, in a cooperative, professional manner that is essential for maintaining a Hospital environment appropriate to quality patient care; and

(b) To participate in the discharge of Medical Staff obligations appropriate to Medical Staff membership category; and

(c) To adhere to generally recognized standards of professional ethics, including without limitation, prohibitions against fee-splitting, "ghost" surgery, delegating the responsibility for diagnosis and care of patients to a practitioner not qualified to undertake that responsibility and failing to obtain appropriate patient consent to treatments.

3.1-4 DISABILITY

To be free of or have under adequate control a significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, the qualifications required by Section 3.1-2 or 3.1-3, such that patient care is or is likely to be adversely affected.

3.1-5. HOSPITAL AND COMMUNITY NEED, AND ABILITY TO ACCOMMODATE

In acting on new applications for Medical Staff membership and clinical privileges, and on application for changes in clinical privileges, in Medical Staff membership status, or in clinical service affiliation, consideration must be given to and an explicit
finding made concerning the Hospital’s current and projected patient care, and teaching needs and the Hospital’s ability to provide the facilities, beds and support services that will be required if the application is acted upon favorably. In making these required need/ability determinations, consideration will be given to utilization patterns, present and projected patient mix, actual and planned allocations of physical, financial and human resources to general and specialized clinical and support services, and the Hospital’s and Medical Staff’s general and specific goals and objectives as reflected in the Hospital’s short and long-range plans.

3.1-6 PROFESSIONAL LIABILITY INSURANCE

All members of the Medical Staff attending patients shall be required to maintain professional liability insurance or other evidence of financial responsibility in accordance with Colorado statues.

3.1-7 EFFECT OF OTHER AFFILIATIONS

No practitioner is automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by an clinical board, or because he/she is a member of the faculty of a medical school, or because he/she had, or presently has, staff membership or privileges at another health care facility or in another practice setting. Nor is any practitioner automatically entitled to appointment, reappointment or particular privileges merely because he/she had, or presently has, Medical Staff membership or those privileges at this Hospital.

3.1-8 NON-DISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, handicap or national origin.

3.2 BASIC OBLIGATION OF INDIVIDUAL MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff, regardless of his/her assigned Medical Staff category, and each Practitioner exercising temporary privileges under these Bylaws shall:

(a) Provide his/her patients with care at the generally recognized professional level of quality and efficiency.

(b) Abide by the Medical Staff Bylaws, and by all other lawful standards, policies and rules of the Hospital.

(c) Discharge such Staff, committee, clinical services, and Hospital functions for which he/she is responsible by Medical Staff category assignment, appointment, election or otherwise.

(d) Prepare and complete in timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital.
(e) Abide by generally recognized standards of professional ethics and Hospital code of conduct.

3.3 TERMS OF APPOINTMENT

Appointments to the Medical Staff are for a period of two (2) years except that the Medical Executive Committee, (MEC), with the approval of the Board, may set a more frequent reappraisal period for the exercise of particular privileges in general.

ARTICLE IV. CREDENTIALING PROCEDURES

4.1 DEFINITION

The following definitions apply to the provisions of the Credentialing Manual:

1. BOARD OF DIRECTORS or BOARD means the governing body of the Hospital.

2. PRACTITIONER means any physician applying for or exercising clinical privileges or providing other diagnostic, therapeutic, teaching or research services in the Hospital.

3. PHYSICIAN means an individual with an M.D. or D.O. degree who is licensed to practice medicine.

4. CLINICAL PRIVILEGES means the rights granted to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to him/her.

4.2 APPOINTMENT PROCEDURES

4.2-1 APPLICATIONS

Application or reapplication for Medical Staff membership may be submitted by the applicant or a search committee where appropriate. The application or reapplication must be in writing and on such form as designated by the Medical Executive Committee and approved by the Board. Prior to the application being submitted, the applicant will be provided a copy of, or access to a copy of, the Hospital Bylaws, the Medical Staff Bylaws, and its accompanying manuals, the Rules and Regulations of the Medical Staff and its services, and summaries of other Hospital and Medical Staff policies and resolutions relating to clinical practice in the Hospital.

4.2-2 APPLICATION CONTENT

Every application must furnish complete information concerning the following:

(a) Postgraduate training, including the name of each institution, degree granted, program completed and dates attended.
(b) All currently valid medical, dental and other professional licensure or certifications, and Drug Enforcement Administration registration, with the date and number of each.

(c) Specialty or subspecialty board certification, recertification and eligibility.

(d) Physical or mental health impairments, if any, affecting the applicant’s ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully; Hospitalization or other institutionalizations for significant physical or mental health problems during the past five (5) year period; any continuing health problems requiring current therapy.

(e) Professional liability insurance coverage, or other evidence of financial responsibility for professional liability, and information on malpractice claims history and experience (suits and settlements made, concluded and pending) during the past five (5) years, including the names of present and past insurance carriers.

(f) The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of: license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state, or national professional organizations; specialty or subspecialty board certification or eligibility; faculty membership at any medical or other professional school; Medical Staff membership status, prerogatives or clinical privileges at any other Hospital, clinic or health care institution, any restrictions or suspensions under Medicare or Medicaid programs.

(g) Location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; names and locations of any other Hospital, clinic or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation.

(h) Service assignment, Medical Staff category, and specific clinical privileges requested.

(i) Any current felony criminal charges pending against the applicant and any past charges including their resolution.

(j) Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of the Medical Staff Bylaws and this Credentialing Procedures Manual.
The application must include the names of three (3) individuals who have personal knowledge of the applicant's current clinical ability, ethical character, and ability to work cooperatively with others and who will provide specific written, substantive comments on these matters upon request from Hospital or Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time and at least one must have had organizational responsibility for supervision of his/her performance (e.g., department chairman, service chief, training program director).

4.2-4 EFFECTS OF APPLICATION

The applicant must sign the application and in so doing:

(a) Attests to the correctness and completeness of all information furnished;

(b) Signifies his/her willingness to appear for interviews in connection with his/her application;

(c) Agrees to abide by the terms of the Bylaws, Rules and Regulations, policy and procedure manuals of the Medical Staff and those of the Hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted;

(d) Agrees to maintain an ethical practice and to provide appropriate continuous professional care for his/her patients;

(e) Authorizes and consents to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to elevation of said qualifications and competence;

(f) Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's competence, professional ethics, character, health status and other qualifications for Medical Staff appointment and clinical privileges;

(g) Consents to a health examination, if requested, including laboratory exams.

For purposes of this Section, the term “Hospital representative” includes the Board, its directors and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his/her applications; and any authorized representative for any of the foregoing.
4.3 PROCESSING THE APPLICATION

4.3-1 APPLICANT’S BURDEN

The applicant has the burden of producing adequate information for a proper evaluation of his/her experience, training, demonstrated ability and physical and mental health status, and of resolving any doubts about these or any of the qualifications required for Medical Staff membership or the requested Staff category, service assignment, or clinical privileges, and of satisfying any reasonable requests for information or clarification (including health examinations) made by appropriate Medical Staff or Board authorities.

4.3-2 VERIFICATION OF INFORMATION

The completed application is submitted to the Credentialing Coordinator. The Credentialing Coordinator collects or verifies the references, licensure and other qualification evidence submitted and promptly notifies the applicant of any problems in obtaining information. Upon such notification, it is the applicant’s obligation to obtain the required information. When collection and verification is accomplished, the Credentialing Coordinator transmits the application and all supporting materials to the chairman of each service in which the applicant seeks privileges and then to the Medical Executive Committee (MEC).

4.3-3 SERVICE ACTION

The chairman of each service in which the applicant seeks privileges shall review the application and its supporting documentation and forwards to the Medical Executive Committee a written report evaluating the evidence of the applicant’s training, experience and demonstrated ability. This report shall state the service chairman’s recommendation as to approval or denial of, and any special limitations on, Medical Staff appointment, category of Medical Staff membership and prerogatives, service affiliation, and scope of clinical privileges.

A service chairman may also, at his/her discretion, conduct an interview with the applicant. If a service chairman requires further information about an application, may exceed thirty (30) days, but not more than 60 days. In case of a deferral, the applicable chairman must notify the applicant, the Chief of the Medical Staff and the Administrator in writing of the deferral and the grounds.

4.3-4 MEDICAL EXECUTIVE COMMITTEE ACTION

The MEC, at its next regular meeting, shall review the application, the supporting documentation, the reports and recommendations from the service chairman and any other relevant information available to it. The MEC shall either defer action on the application or prepare a written report with recommendations as to approval or denial of, or any special limitations to, Medical Staff membership and prerogatives, service affiliation, and scope of clinical privileges.
4.3-5 EFFECT OF MEC ACTION

(a) **Deferral:** Action by the MEC to defer the application must be followed up within 30 days with subsequent recommendations as to approval or denial of, of any special limitations on, Medical Staff appointment, category of Medical Staff membership and prerogatives, service affiliation, and scope of clinical privileges. The Chief Executive Officer shall promptly send the applicant written notice of an action to defer.

(b) **Favorable Recommendations:** When the MEC’s recommendation is favorable to the applicant in all respects; the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board. “All supporting documentation” means the application form and its accompanying information, the reports and recommendations of the services, and MEC and dissenting views.

(c) **Adverse Recommendation:** When the MEC’s recommendation is adverse to the applicant, the Chief Executive Officer shall immediately inform the applicant by special notice, and he/she is then entitled to the procedural rights as provided in Article XVI therein. An “adverse recommendation” by the MEC is defined as a recommendation to deny appointment, requested Medical Staff category, requested service assignment, or to deny or restrict requested clinical privileges.

4.3-6 BOARD ACTION

(a) **On Favorable MEC Recommendation:** The Board may adopt or reject, in whole or in part, a favorable recommendation of the MEC for further consideration stating the reasons for such referral back and setting a time limit which a subsequent recommendation must be made.

Favorable action by the Board is effective as its final decision.

(b) **Without Benefit of MEC Recommendation:** If, in its determination, the Board does not receive an MEC recommendation in timely fashion, it may, after notifying the MEC of its intent including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Medical Staff. Any favorable action is effective as its final decision.

(c) **After Procedural Rights:** In the case of an adverse MEC recommendation, the Board takes final action in the matter as provided in Article XII therein.

(d) **Adverse Board Action Defined:** “Adverse action” by the Board means action to deny appointment, requested Medical Staff category, requested service assignment, or to deny or restrict requested privileges.
4.3-7 BASIS FOR RECOMMENDATIONS AND ACTIONS

The report of each individual or group required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

4.3-8 CONFLICT RESOLUTION

Whenever the Board determines that it will decide a matter contrary to the MEC’s recommendation, the matter will be submitted to a joint conference, composed of three members each of the Medical Staff and the Board appointed respectively by the Chief of the Medical Staff and the Chairman of the Board, for review and recommendation before the Board makes its decision.

4.3-9 NOTICE OF FINAL DECISION

(a) Notice of the Board’s final decision is given through the Chief Executive Officer to the MEC, to the chairman of each service concerned, and to the applicant by special notice.

(b) A decision and notice to appoint includes: (1) the Medical Staff category to which the applicant is appointed; (2) the service to which he is assigned; (3) the clinical privileges the may exercise; and (4) any special conditions attached to the appointment.

4.3-10 TIME PERIODS FOR PROCESSING

All individuals and groups required to act on an application for Medical Staff appointment must do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods:

<table>
<thead>
<tr>
<th>INDIVIDUAL/GROUP</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Credentialing Coordinator</td>
<td>60 days</td>
</tr>
<tr>
<td>(b) Service Chairman</td>
<td>30 days</td>
</tr>
<tr>
<td>(c) Medical Executive Committee</td>
<td>Next regular meeting</td>
</tr>
<tr>
<td>(d) Board</td>
<td>Next regular meeting</td>
</tr>
</tbody>
</table>

These time periods are to be deemed guidelines and are not directives such as to create any rights for a practitioner to have an application processed within these precise periods. If the provisions of Article X are activated, the time requirements provided there govern the continued processing of the application.
4.3-11 WAITING LIST FOR DENIALS BASED ON NEED OR ABILITY TO ACCOMMODATE

When Staff membership, service affiliation, or particular clinical privileges is denied on the basis of what is reasonably projected to be a temporary lack of Hospital or community need, inability of the Hospital to provide adequate facilities or supportive services or inadequate patient load, the application shall, upon written request by the applicant to the Chief Executive Officer, be kept in a pending status for the next succeeding two years.

If, during this period, the Hospital finds it possible to accept Medical Staff applications for which the applicant is eligible, and there is no obligation to applicants with prior pending status, the Chief Executive Officer shall promptly inform him by special notice. Within 30 days of receipt of such notice, the applicant must provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 4.3 is followed.

4.3-12 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment, Medical Staff category, service assignment or clinical privileges is not eligible to reapply to the Medical Staff or for the denied category, service or privileges for a period of two (2) years. Any such reapplication is processed as an initial application, and the applicant must submit such additional information as the Medical Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

4.4 REAPPOINTMENT PROCEDURES

4.4-1 INFORMATION COLLECTION AND VERIFICATION FROM MEDICAL STAFF MEMBER

On or before three months prior to the date of expiration of a Medical Staff member’s appointment, the Credentialing Coordinator shall notify him/her of the date of expiration. At least sixty (60) days prior to this date, the member furnishes in writing: (a) complete information to update his/her file on the items listed in Section 2.2, and 4.2-2, items c-l of this manual; (b) continuing training and education external to the Hospital during the proceeding period; (c) specific request for the clinical privileges sought on reappointment, with any basis for changes; (d) requests for changes in Medical Staff category or service assignments; (3) All currently valid medical, dental, and other professional licensure or certifications, and Drug Enforcement Administration registration, with the date and number of each. (f) Specialty or subspecialty board certification, recertification and eligibility. (g) Physical or mental health impairments, if any, affecting the applicant’s ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully; Hospitalization or other institutionalizations for significant physical or mental health problems during the past five (5) year period; any continuing health problems requiring current therapy. (h) Professional liability insurance coverage or other evidence of financial responsibility
for professional liability, and information on malpractice claims history and experience (suits and settlements made, concluded and pending) during the past five (5) years, including the names of present and past insurance carriers. (i) The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of: license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state or national professional organizations; specialty or subspecialty board certification or eligibility; faculty membership at any medical or other professional school; Medical Staff membership status, prerogatives or clinical privileges at any other Hospital, clinic or health care institution, any restrictions or suspensions under Medicare or Medicaid programs. (j) Locations of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; names and locations of any other Hospital, clinic or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation. (k) Service assignment, Medical Staff category, and specific clinical privileges requested. (l) Any current felony criminal charges pending against the applicant and any past charges including their resolution. Failure, with good cause, to provide this information is deemed a voluntary resignation from the Medical Staff and results in automatic termination of membership at the expiration of the current term unless explicitly extended for not more than two thirty (30) day periods by action of the MEC. A Practitioner whose membership is so terminated is entitled to the procedural rights provided in Article X therein for the sole purpose of determining the issue of good cause.

The Chief Executive Officer shall verify this additional information and notify the Medical Staff member of any information, inadequacies, or verification problems. The Medical Staff member then has the burden of producing adequate information and resolving any doubts about the data.

4.4-2 FROM INTERNAL SOURCES

The Credentialing Coordinator shall collect from each Medical Staff member’s credentials file all relevant information regarding the individual’s professional and collegial activities, performance and conduct in this Hospital. Such information includes, without limitation: patterns of care as demonstrated in the findings of quality assessment & improvement activities; participation in relevant internal teaching and continuing education activities; physical and mental health status; attendance at required Medical Staff service meetings; service on Medical Staff, service and Hospital committees; timely and accurate completion of medical records; compliance with all applicable Bylaws, policies, Rules, Regulations and procedures of the Hospital and Medical Staff.

4.4-3 SERVICE ACTION

Each chairman of a service in which the Medical Staff member requests or has exercised privileges may review the member’s file and forwards to the MEC a written report, including a statement as to whether or not the knows of, or has observed or
been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the Practitioner’s ability to perform professional and Medical Staff duties appropriately and with recommendations for reappointment or nonreappointment for the Medical Staff category, service assignment and clinical privileges.

4.4-4 MEDICAL EXECUTIVE COMMITTEE ACTION

The MEC reviews the member’s file and service report, and any other relevant information available to it and defers action on the reappointment or prepares a written report with recommendations for reappointment or nonreappointment and for Medical Staff category, service assignment and clinical privileges.

4.4-5 FINAL PROCESSING AND BOARD ACTION

Final processing of reappointments follows the procedure set forth in Section 4.3-6, 4.3-7(a) through (c), 4.3-4, 4.3-10, 4.3-12, and 4.3-13. For purposes of reappointment, an “adverse recommendation by the MEC or an “adverse action by the Board as used in these sections means a recommendation or action to deny reappointment; to deny a requested change in, or to change without Medical Staff member’s consent, his/her Medical Staff category, service assignment, or to deny or restrict clinical privileges. The terms “applicant” and “appointment” as used in these sections shall be read respectively as “Medical Staff member” and “reappointment.” Reference therein to the masculine also includes the feminine.

4.4-6 BASIS FOR RECOMMENDATION AND ACTION

The report of each individual or group required to act on a reappointment shall state the reasons for each recommendation made or action taken, with specific reference to the Medical Staff member’s credentials file and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

4.4-7 TIME PERIODS FOR PROCESSING

Transmittal of the notice to a Medical Staff member and his/her providing updated information is to be carried out in accordance with Section 4.4-1. Thereafter and except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendations are transmitted to the MEC and in turn to the Board prior to the expiration date of Staff membership of the member whose reappointment is being processed.

The time periods specified are to guide the acting parties in accomplishing their tasks. If reappointment processing has not been completed by an appointment expiration date, through no fault of the staff member, the member maintains his/her current membership status and clinical privileges until the time that processing is completed, unless corrective action is taken with respect to all or any part thereof. If the delay is attributable to the Practitioner’s failure to provide information required by Section 4.4-1, his/her Staff membership terminates on the expiration date as provided in Section
4.4-1 unless explicitly extended as provided therein. An appointment extension is not to be deemed to create a right of automatic reappointment for the coming term.

4.4-8 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A Staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, service assignment or clinical privileges by submitting a written application to the Chief Executive Officer or Credentialing Coordinator. A modification application is processed in the same manner as a reappointment.

4.5 SYSTEMS AND PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES

4.5-1 CATEGORIES OF CLINICAL PRIVILEGES

Clinical privileges at this Hospital will be granted in the categories listed below to Practitioners demonstrating specific qualifications for the exercise of privileges in those categories.

4.5-2 CATEGORY III PRIVILEGES

Physicians with privileges in these procedures are expected to have documented training and/or experience and/or competence on a level commensurate with that provided by special training in the procedure. Such physicians may act as consultants to others and may in term be expected to request consultations when:

(a) Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;

(b) Unexpected complications arise which are outside this level of competence; and

(c) Specialized treatment or procedures beyond the level of expertise are contemplated.

4.5-3 CATEGORY II PRIVILEGES

Physicians with these privileges are expected to have documented training and/or experience and/or competence at a level which would qualify them to perform routine procedures to include general care and management of common complications and medical problems. Such physicians would be expected to request consultation from a physician with Category III privileges if:

(a) Diagnosis and/or management remain in doubt, especially in the presence of life-threatening illness;

(b) Unexpected complications arise which are outside this level of competence; and
(c) Specialized or unusual treatment or procedures are contemplated.

4.5-4 CATEGORY I PRIVILEGES

Physicians with these privileges may render emergency care of the most preliminary nature. Future management must be provided by appropriately qualified physician.

4.5-5 CONSULTATION

There may be attached to any grant of privileges in any category, in addition to requirements for consultation in specific circumstances provided by in the Bylaws, or in the Rules, Regulations and policies of the Medical Staff, any of its clinical units or the Hospital, special requirements for consultation as a condition to the exercise of particular privileges.

4.5-6 DEPARTMENTAL RESPONSIBILITIES

To implement this method of granting clinical privileges, each service must define, in writing, the various categories for the procedures, conditions and problems that fall within its clinical area. These definitions must be approved by the MEC and Board, must be periodically reviewed and revised, and must form the basis for service clinical privileges recommendations.

4.5-7 PROCEDURE FOR DELINEATING PRIVILEGES

(a) REQUESTS

Each application for appointment and reappointment to the Medical Staff contains a request for the specific clinical privileges desired by the applicant or Medical Staff member. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

(b) PROCESSING REQUESTS

All requests for clinical privileges will be processed according to the procedures outlined in Sections 4.2 and 4.4 of this manual, as applicable.

4.6 HISTORY AND PHYSICAL

A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission, but prior to surgery or procedure requiring anesthesia services. The medical history and physical exam must be placed in the patient’s medical record within 24 hours after admission but prior to surgery or procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient’s condition, when the medical history and physical examination are completed within 30 days before admission. Documentation of the updated examination must be placed in the patient’s medical record within 24
hours after admission but prior to surgery or procedure requiring anesthesia services. - CMS 482.22 5(i)(ii).

Patient assessment and reassessment data and information, the medical history and physical examination, and nutritional and functional screening are completed within the Hospital’s written time frames. These time frames are reflective of law and regulation where applicable. – PC.01.02.03, EP 1-8. The Hospital complies with its policy on timely entry into the medical record and the time frame for completion of the medical record (with equal to or less than 30 days from discharge being acceptable). RC.01.03.01, EP1-3

4.6-1 MEDICAL RECORDS COMPLETION

The attending physician is expected to complete the medical record of patients under his/her care within thirty (30) days of discharge unless pertinent lab or pathology reports remain outstanding. When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within 3 days (if possible given remote location) and the complete protocol is included in this record within 60 days unless the Medical Staff establishes exceptions for special studies. Charts not completed within this 30 day time requirement will be considered delinquent. Items requiring completion include, but are not limited to, the following: final diagnosis, discharge summary, history and physical, progress notes, orders and appropriate signatures. The items requiring completion will be specified on a list attached to the front of the chart by the Medical Records Department. The Medical Records Department will review charts for completeness just before each monthly Staff meeting and prepare a list of delinquent charts. It will be the responsibility of all members of the Medical Staff to obtain this list. If any charts on this list are not completed within seven (7) calendar days after the Staff meeting, the Chief Executive Officer will notify the responsible physician that sanctions will be imposed if the delinquent charts are not completed in an additional seven (7) calendar days. If the delinquent charts are not completed, the Chief Executive Office and Chief of Staff are directed to apply sanctions starting with suspension of privileges for elective admissions and procedures.

In the event that the delinquent records are not completed within two more weeks, the Chief Executive Officer and Chief of Staff are directed to suspend all privileges for admission to the Hospital and surgical procedures.

In any case where sanctions are being considered, consideration should be given to any justified reasons for delays in preparing records. If privileges have been restricted or suspended for delinquent medical records, they should be promptly reinstated when the records have been completed.

Justified reasons for delay in completing records include, without limitation:

(a) The Practitioner is ill or otherwise unavailable for a period of time due to circumstances beyond his/her control, or if within his/her control, then completion of the records prior to his/her unavailability was not reasonably possible for reasons beyond his/her control.
(b) The Practitioner is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis.

(c) The Practitioner has dictated reports and is waiting for Hospital personnel to transcribe them.

4.6-2 MEDICAL RECORDS PREPARATION

All portions of a Hospitalized patient’s medical record must be prepared within the timeframes provided in the Medical Staff Rules and Regulations. Unless a bona fide emergency as defined in the Medical Staff Bylaws exists, so certified in writing by the Practitioner, that requires him/her to immediately treat the patient, the Chief Executive Officer or Chief of Medical Staff, when informed of the delinquency, shall immediately give the practitioner written notice of it, advising him/her further that the sanctions provided in the Medical Staff Bylaws will be imposed if the portion of the record involved is not prepared with seven (7) days after receipt of the notice. If he/she deems it necessary for the welfare of the patient, the Chief of the Medical Staff may require the record to be prepared within any shorter time-span, or a summary suspension may be imposed by an appropriate authority. The Chief Executive Officer shall notify the applicable service chairman, the admitting office, the operating room and the emergency room when a suspension is imposed. Justified reasons for delay in preparing records may include, without limitation:

(a) The responsible Practitioner is unexpectedly ill or unavailable during the period of time involved due to circumstances beyond his/her control and the period remaining for timely preparation is too short to reasonably expect the covering physician to prepare the record.

(b) The record portion has been dictated but not transcribed.

The Chief of the Medical Staff, or his/her designee, is responsible for certifying justified delays to the Medical Staff. The Medical Staff reviews each case in which the emergency exception is claimed to have been in effect and may recommend that corrective action be initiated against the practitioner when, in its determination, the record or the account of observers present at the time raises a question as to whether or not an emergency existed.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

A Medical Staff member may obtain a voluntary leave of absence by giving written notice to the Chief of the Medical Staff for transmittal to the applicable service chairman and the Chief Executive Officer. The notice must state the approximate period of time of the leave, which may not exceed two years except for military service. During the period of the leave, the Medical Staff member’s clinical privileges, prerogatives and responsibilities shall be suspended.
4.7-2 TERMINATION OF LEAVE

The Medical Staff member must, at least forty-five (45) days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to the MEC. The MEC makes a recommendation to the Board of Directors concerning reinstatement, and the procedures in Section 4.3-6, 4.3-7, 4.3-9, 4.3-10, 4.3-12, and 4.3-133, as applicable, are followed:

4.8 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICE

4.8-1 All Medical Staff members recognize and shall accept the Hospital’s policy that certain Hospital facilities will be used on an exclusive basis in accordance with contracts between the Hospital and qualified practitioners, such as other Medical Staff members must, except in emergency or life-threatening circumstances, adhere to this exclusivity policy in arranging for the care of their patients, applications for initial appointment or for clinical privileges related to those Hospital facilities and services in Section 4.8-2 will not be accepted for processing unless submitted in accordance with an existing or proposed contract with the Hospital and these Bylaws.

4.8-2 FACILITIES/SERVICES SUBJECT TO THE EXCLUSIVITY POLICY

The Hospital facilities/services listed in this Section, and such others as may from time to time be added by the Board, are subject to the exclusive contractual arrangements.

4.8-3 QUALIFICATIONS

A Practitioner who is or who will be providing specified professional services pursuant to a contract with the Hospital must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of his/her membership category as any other applicant or Medical Staff member.

4.8-4 EFFECT OF MEDICAL STAFF MEMBERSHIP TERMINATION

Because practice at the Hospital is always contingent upon continued Medical Staff membership and is also constrained by the extent of clinical privileges enjoyed, a Practitioner’s right to use Hospital facilities is automatically terminated when Medical Staff membership expires or is terminated. Similarly, the extent of his/her clinical privileges is automatically limited to the extent that pertinent clinical privileges are diminished.

4.8-5 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

(a) The effect of expiration or other termination of a contract upon a Practitioner’s Medical Staff membership status and clinical privileges will be governed solely by the terms of the Practitioner’s contract with the Hospital.
(b) If the contract is silent on the matter or if there is no written contract, then contract expiration or other termination alone will not affect the Practitioner’s Medical Staff membership status or clinical privileges, except that the Practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

4.9 EMPLOYED PHYSICIANS

The Hospital may, at its discretion, enter into an employment agreement with a Medical Staff member. The Hospital shall not (i) interfere with the professional judgment of a Practitioner employed by the Hospital; (ii) discriminate with respect to credentials or Staff privileges on the basis of whether the Practitioner is an employee of the Hospital; or (iii) offer financial incentives to an employed Practitioner to artificially increase or reduce the services provided to Hospital patients. In the event that any employed Practitioner reasonably believes that the Hospital has violated (i), (ii), or (iii) above, the Practitioner shall provide a written statement of the specifics of such violation to the Chief of Staff. The Chief of Staff shall investigate and review the matter. If the Chief of Staff finds evidence of violation, the Chief of Staff shall mediate a resolution to the problem between Hospital administration and the Practitioner.

4.10 PHYSICIAN PROVIDING SERVICES FROM REMOTE LOCATION

The Hospital is responsible for the safety and quality of the services provided by means of telemedicine in the Hospital. For the purposes of these Bylaws, “telemedicine” is defined as the use of interactive audio, interactive video or interactive data communication to provide and/or support health care when distance separates the participants. Credentialing for physicians who provide services by telemedicine shall be conducted as follows:

(i) Direct Care; Contracts for Services. Any physician who (1) has shared or total responsibility for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through telemedicine or (2) has entered into a contract with the Hospital for the regular provision of telemedicine services (e.g., physicians providing remote interpretation of imaging results) shall be subject to the credentialing and privileging processes of the Hospital, including, with respect to a physician under contract for the provision of telemedicine services, evidence of a license to practice medicine in the State of Colorado. The Hospital may accept the credentialing and privileging information from the facility at which the physician regularly practices (“Home Facility”) if such facility is accredited by the Joint Commission or certified by CMS. If the physician does not have a Home Facility, the physician must seek privileges at the Hospital. If the Hospital has an immediate clinical need and a physician can meet that need through a telemedicine link, the Hospital may grant temporary privileges to the physician. The Hospital will forward to the Home Facility any adverse performance assessment information it collects related to the services provided by the physician via telemedicine link.

(ii) Occasional Consultations. Any physician who provides only an occasional recommendation, consultation or test interpretation through telemedicine for a Medical Staff member who maintains total responsibility for patient care, treatment and services need not be subject to the full credentialing processes of the Hospital, at the discretion of the Hospital, but
shall provide evidence of a current license to practice medicine in the jurisdiction governing the physician's practice.

ARTICLE V. MEDICAL STAFF CATEGORIES

5.1 CATEGORIES

There are five categories of membership on the Medical Staff: Active, Courtesy, Consulting, Associate and Allied Health Professional.

5.2 ACTIVE STAFF

5.2-1 QUALIFICATIONS FOR ACTIVE STATUS

An Active Medical Staff member must:

(a) Be located closely enough (office and residence) to the Hospital to provide continuous care to his/her patients to be there within 30 minutes.

(b) Regularly admit patients to, or otherwise be regularly involved in, the care of patients in the Hospital.

(c) When called upon, must actively participate on a clinical and/or an administrative committee and fulfill the requirements for attendance on that committee.

(d) During the 1st year of the initial appointment to Active staff category, a Focused Professional Practice Evaluation (FPPE) will take place that consists of at least six cases that are peer reviewed by an Active Medical Staff member within the department for which the Practitioner has been granted privileges. If the Practitioner is assigned privileges in more than one department at least six cases are to be reviewed in each department.

(e) Upon completion of the peer reviewed cases, the department chair will make recommendation to the Medical Executive Committee regarding moving the Practitioner into an ongoing review process or continuing the FPPE.

5.2-2 PREROGATIVES OF ACTIVE STATUS

An Active Medical Staff member may:

(a) Admit patients without limitation, except as otherwise provided in the Medical Staff rules and regulations.

(b) Vote on all matters presented at general and special meetings of the Medical Staff and of the clinical service and committees to which he/she is a member, except as provided by resolution of the MEC and approved by the Board.
(c) Hold office at any level of the Medical Staff organization and sit on or be chairman of any committee, except as provided by the resolution of the Medical Executive Committee and approved by the Board.

(d) Exercise such clinical privileges as are granted to him.

(e) Physicians 65 years of age or older will not have to take ER call while still remaining on Active Staff. This is optional.

5.2-3 OBLIGATIONS OF ACTIVE STATUS

An Active Medical Staff member must, in addition to meeting the basic obligations set forth in Section 3.2:

(a) Retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

(b) Contribute to the organizational and administrative affairs of the Medical Staff, including service in MEC, faithfully performing the duties of any office or position to which elected or appointed.

(c) Participate in the performance improvement and utilization review activities required of the Medical Staff.

(d) Discharge the recognized functions of the Medical Staff membership by engaging in the Medical Staff’s continuing education programs, participating in the emergency services program of the Hospital, attending service or charity patients as required, giving consultation to other Medical Staff members consistent with his/her delineated privileges, supervising practitioners during provisional period, and fulfilling such other Medical Staff functions as may reasonably be required of Medical Staff members.

(e) Attend regular and special meetings of the Medical Staff and its committees of which he/she is a member and meet the attendance requirements of committees on which he/she services, which is fifty (50) percent of Medical Staff meetings and Medical Staff Committee meetings with unexcused absences.

5.3 COURTESY STAFF

5.3-1 QUALIFICATIONS FOR COURTESY STATUS

A Courtesy Medical Staff member must:

(a) Be in the same proximity to the Hospital as Active Medical Staff members or demonstrate arrangements that are satisfactory to the Medical Staff for alternative medical coverage for patients for whom he/she is responsible.
5.3-2 PREROGATIVES OF COURTESY STATUS

(a) A Courtesy Medical Staff member may admit patients in the same manner as an Active Medical Staff member, and may exercise such clinical privileges as are granted to him/her. At times of full Hospital occupancy or of shortage of Hospital beds or other facilities, as determined by the Chief Executive Officer, the elective patient admissions of Courtesy Medical Staff members shall be subordinate to those of Active Staff members. Anyone admitting more than six patients in six months shall apply for Active Staff membership pursuant to these Bylaws.

(b) Courtesy Medical Staff members are not eligible to hold office in the Medical Staff organization or to vote at meetings of the Medical Staff. The only exception will be the Emergency Medicine Director will be eligible to hold office and vote at meetings of the Medical Staff.

5.3-3 OBLIGATIONS OF COURTESY STATUS

(a) As provided in Section 3.2 and 5.2-3(a) and (e).

(b) Participate in Emergency Room specialty call as required by the MEC.

5.4 CONSULTING STAFF

5.4-1 QUALIFICATIONS FOR CONSULTING STAFF

(a) Possess specialized medical or surgical skills needed at the Hospital in a specific project or on an occasional basis in consultation when requested by a member of the Medical Staff. Unless the patient care contacts (consultation, procedures, etc.) of a Consulting Medical Staff member over any twelve (12) month period are occasional (as defined by the MEC), he/she shall be required to obtain Active Medical Staff status.

(b) Demonstrate active participation in the Active Medical Staff at another Hospital requiring quality assessment & improvement activities of a substance and character similar to those at this Hospital or agree to fulfill the obligations of Active Medical Staff membership in Sections 5.2-3(c) concerning participation in quality assessment & improvement and utilization review activities at this Hospital and in Sections 5.2-3(d) and (e) as they pertain to participation in clinical programs and attendance at clinical service and committee meetings.

5.4-2 PREROGATIVES OF CONSULTING STATUS

A Consulting Medical Staff member may exercise such clinical privileges as are granted to him/her. Consulting Medical Staff members are not eligible to admit patients to the Hospital, to hold office in the Medical Staff organization or vote at meetings of the Medical Staff, clinical service or committees.
5.4-3 OBLIGATIONS OF CONSULTING STATUS

As provided in Section 3.2 and 5.4(b).

5.5 ASSOCIATE STAFF

5.5-1 QUALIFICATIONS FOR ASSOCIATE STAFF

(a) The Associate Staff consists of practitioners who do not provide patient care in the Hospital, and are not retired.

5.5-2 PREROGATIVES OF ASSOCIATE STAFF

(a) Associate Staff shall not have admitting privileges.

(b) Associate Staff may vote in the Medical Staff committees but not in the general staff or department meeting.

5.5-3 OBLIGATIONS OF ASSOCIATE STAFF

(a) Associate Staff are not required to provide Emergency Department call coverage.

(b) Associate Staff are not required to attend meetings.

(c) Associate Staff may serve on and chair Medical Staff Committees.

5.6 ALLIED HEALTH PROFESSIONALS

5.6-1 DEFINED

An Allied Health Professional (AHP) is an individual other than a licensed physician who exercises independent judgment within the areas of his/her professional competence and who is qualified to render psychological, medical or surgical care. The following without limitation may be deemed AHPs for the purpose of his/her Section 5.6: Certified Nurse Anesthetists, Mental Clinical Psychologists, and podiatrists. AHPs serve on the Medical Staff and Hospital committees to the extent established by the Medical Staff. AHP may not hold elected Medical Staff positions. AHP may attend general and education meetings of the Medical Staff but without voting privileges. AHP may be granted clinical privileges based on the above noted AHPs contract delineating their own credentialing process and our medical staff and board of director’s acceptance of that process. Nurse Practitioners and Physician Assistants may be credentialed under the sponsorship of a member of the active Medical Staff.
5.6-2 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Only an AHP holding a license, certificate or such other credentials as may be required by Colorado law and who satisfy the basic qualifications required for Medical Staff membership are eligible to provide specified services in the Hospital. The Board may, in consultation with the Chief Executive Officer and the MEC, establish additional qualifications required of members of any particular category of AHP.

5.6-3 PROCEDURE FOR SPECIFICATION OF SERVICES

(a) Position Evaluations and Descriptions:

AHP contracts shall include the contractor’s responsibility to submit their delineation of privileges, current licensure/certification, background checks, yearly evaluations and any other requirements deemed necessary by the Hospital’s Administration, Medical Staff, and/or the Board of Directors. For each category of AHP’s such contract shall include, without limitation.

(i) Specification of the classes of patients that may be seen (e.g., only those of the employer-physician, only those referred by or from a particular clinical service, or any referred by a physician or other authorized Practitioner); and

(ii) A description of the services to be provided and procedures to be performed, including the equipment or special procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient’s medical record; and

(iii) Definition of the degree of assistance that may be provided to a practitioner in the treatment of patients on Hospital premises and any limitations thereon, including the degree of practitioner supervision required for each service.

5.6-4 PREROGATIVES OF ALLIED HEALTH PROFESSIONALS

The prerogatives of an AHP are to:

(a) Provide specifically designated patient care services under the supervision or direction of a Practitioner member of the Medical Staff and consistent with the limitations stated in Section 6.5 and protocols of these Bylaws.

(b) Write orders only to the extent specified in the Medical Staff Rules and Regulations or the position description required under Section 5.6-3(a) above, but not beyond the scope of the AHP’s license, certificate or other legal credential.

(c) Serve on Hospital committees where his/her special training and knowledge are desirable and with vote when so specified.
(d) Attend Medical Staff and Hospital education programs and clinical meetings related to his/her discipline.

(e) Exercise such other prerogatives as the MEC, with the approval of the Board, may accord AHPs in general or a specified category of AHP.

5.6-5 OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS

Each AHP shall:

(a) Meet the basic responsibilities required by Section 3.2 for Medical Staff members.

(b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange (or notify the principal attending practitioner of the need to arrange) a suitable alternative for such care and supervision.

(c) Participate as appropriate in quality assessment and improvement program activities, in supervising new appointees of his/her same profession during the focused practice evaluation period, and in discharging such other functions as may be required from time to time.

(d) Attend clinical meetings of the Medical Staff, clinical service of which he/she is a member when related to his/her discipline and meetings of the committee of which he/she is a member.

5.6-6 PROCEDURAL RIGHTS FOR ALLIED HEALTH PRACTITIONERS

An AHP is not entitled to the procedural rights provided in these Bylaws for denial of clinical privileges or any decision by the MEC to discipline, restrict, suspend or revoke one or more specific privileges for a quality of care reason (“Adverse Action”). The AHP is entitled to an informal meeting with the CEO and Chief of Staff to discuss any such Adverse Action. The AHP may request the informal meeting within fifteen (15) days of notice of the Adverse Action. The CEO will schedule the informal meeting for a time and date mutually agreeable to the parties but in no event later than twenty (20) days after receipt of the request, unless otherwise agreed by all parties. The AHP may continue to exercise all privileges during the review process unless otherwise determined by the CEO and Chief of Staff. The CEO will forward the findings and recommendations resulting from the informal meeting, and all supporting materials, to the Board within ten (10) days of the meeting. The Board must act on the findings and recommendations at its next regular meeting. The decision of the Board will be final. Nothing in this section is to be construed, however, as limiting the rights of the Hospital to terminate an employment or contractual relationship with an AHP in accordance with Hospital personnel policies or the contract with the AHP for reasons not relating to quality of care.
5.7 QUALIFICATIONS GENERALLY

Every Practitioner who seeks or enjoys Medical Staff membership must satisfy, at the time of appointment and continuously thereafter, the basic qualifications set forth in Section 3.1 as well as any additional qualifications that attach to the Medical Staff category to which he/she seeks appointment or of which he/she is a member.

5.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each Medical Staff category and for the AHPs in general in nature may be subject to limitation by special conditions attached to a Practitioner’s Medical Staff membership or to an AHP’s association with the Medical Staff, by other sections of these Bylaws and the related manuals, and by other policies of the Hospital. The prerogatives of dentist members of the Medical Staff and of AHPs are limited to those for which they have demonstrated the requisite level of medical education, training, experience and ability.

ARTICLE VI. DELINEATION OF PRACTICE PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

A Practitioner providing clinical services at this Hospital by virtue of Medical Staff membership or otherwise may, in connection with such practice and except as otherwise provided in Section 6.6, exercise only those clinical privileges specifically granted to him by the Board. Regardless of the level of privileges granted, each Practitioner must obtain consultation when necessary for the safety of his/her patient or when required by rules, regulations or other policies of the Medical Staff, any of its clinical units, or the Hospital.

6.2 BASIS FOR PRIVILEGES DETERMINATION

Privileges governing clinical practice are granted in accordance with prior and continuing education, training, experience and demonstrated current competence and judgment as documented and verified in each Practitioner’s credentials file and in accordance with the criteria set forth in Section 3.1-6. The basis for privileges determinations for current Medical Staff members in connection with reappointment or a requested change in privileges must include observed clinical performance and documented results of the Medical Staff’s quality assessment and improvement and utilization review program activities.

6.3 SYSTEM AND PROCEDURE FOR DELINEATING PRIVILEGES

The various levels of clinical privileges, the specific qualifications for the exercise of privileges at each level and the procedures by which requests for clinical privileges are processed are provided in Part III of Article IV of the Bylaws.

6.4 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges from dentists are processed in the manner specified in this Article. Surgical procedures performed by dentists are under the overall supervision of the chairman of surgical services. All dental patients shall receive a basis medical appraisal by a
physician member of the Medical Staff which shall be part of the medical records of the patient. A physician member of the Medical Staff shall also be responsible for the care of any medical problem that may be present at admission or that may arise during Hospitalization and shall advise on the risk and effect of any proposed surgical or special procedure on the total health status of the patient. When significant medical abnormality is present, the final decision on whether to proceed with the surgery must be agreed upon by the dentist and the physician consultant. The chairman of the surgery service will decide the issue in case of dispute. The dentist is responsible for performing dental history and dental physical examination of the patient which shall be part of the medical records of the patient.

6.5 EMERGENCY PRIVILEGES/DISASTER PRIVILEGES

a. In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of clinical service, Staff status or clinical privileges, shall be permitted to do everything reasonable possible to save the life of a patient or save a patient from serious harm. Once the emergency has passed or assistance has been made available, the practitioner shall refer to the patient’s attending physician.

b. Disaster privileges may be granted in accordance with medical staff policy entitled Credentialing Practitioners, which is incorporated herein, in the Event of a Disaster.

6.6 TEMPORARY PRIVILEGES

6.6-1 CONDITIONS

Temporary privileges may be granted only in the circumstances described in Section 6.6-2, only to an appropriately licensed physician, only when the information available reasonably supports favorable determination regarding the requesting Practitioner’s qualifications, ability and judgment to exercise the privileges requested, and only after the Practitioner has satisfied the professional liability insurance requirement, if any, of these Bylaws. Special requirement of consultation and reporting may be imposed by the clinical service chairman responsible for supervision. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, Rules, Regulations, and policies of the Medical Staff and Hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, said Bylaws, rules, regulations and policies control in all matters relating to the exercise of temporary privileges.

6.6-2 CIRCUMSTANCES

Upon the written concurrence of the Chief of the Medical Staff and the Chief Executive Officer, they may grant temporary privileges in the following circumstances:

(a) Pendency of Application: After receipt of an application for Medical Staff appointment including a request for specific temporary privileges, for an initial
period of sixty (60) days, with subsequent renewals, if any, not to exceed the pendency of the application.

(b) **Care of Special Patients:** Upon receipt of a written request for specific temporary privileges for the care of one or more specific patients from a Practitioner who is not an applicant for Medical Staff membership. Such privileges shall be restricted to the treatment of not more than two (2) patients in any 12-month period.

(c) **Locum Tenens:** Upon receipt of a written request for specific temporary privileges, to a Practitioner who is serving as a locum tenens for a member of the Medical Staff. Locum tenens privileges may be granted initially for a maximum period of thirty (30) days, and may be renewed for two successive periods of thirty (30) days each, but not to exceed the service as locum tenens, are limited to treatment of the patients of the Medical Staff member for whom the Practitioner is serving as locum tenens or in consultation with Medical Staff. Locum Tenens physicians must be appropriately licensed and be able to show documented competence. In the event that the physician performs subsequent locum tenens service within two years of the initial services, the Hospital may conduct a limited credentialing process, verifying current licensure status, NPDB status, OIG sanction status and requesting updates to any previously obtained credentialing information.

(d) **Residents:** Upon receipt of a written request for specific temporary privileges, a licensed physician enrolled in an approved post-graduate training program may be granted temporary privileges for the period of his/her rotation at this Hospital.

(e) **Telemedicine:** Upon receipt of a written request for specific temporary privileges and when the Hospital has a clinical need that can only be met by a Practitioner through the means of telemedicine, a licensed Practitioner may be granted temporary privileges. Temporary privileges for purposes of telemedicine may be granted initially for a maximum period of thirty (30) days, and are limited to treatment of the specific patients for whom temporary privileges were sought.

6.6-3 **TERMINATION**

The Chief Executive Officer and/or the Chief of the Medical Staff, preferably in consultation, on the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner’s professional qualifications or ability to exercise any or all of the temporary privileges granted, may terminate any or all of a Practitioner’s temporary privileges, provided that where the life or well being of a patient is determined to be endangered, the termination may be effectuated by any person entitled to impose summary suspension under these Bylaws. In the event of any such termination, the Practitioner’s patients then in the Hospital shall be assigned to another Practitioner by the Chief of the Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.
6.6-4 RIGHTS OF THE PRACTITIONER

A Practitioner is not entitled to the procedural rights afforded by the Bylaws and the Fair Hearing Plan because of his/her request for temporary privileges is refused or because of all or any portion of his/her temporary privileges are terminated or suspended.

ARTICLE VII. STAFF OFFICERS

8.1 GENERAL OFFICERS OF THE STAFF

8.1-1 IDENTIFICATION
The general officers of the staff are:

(a) Chief
(b) Vice Chief
(c) Secretary-Treasurer

8.1-2 QUALIFICATIONS

Each general officer must be a member of the active Medical Staff at the time of nomination and election, must remain a member in good standing continuously during his/her term of office, and must be willing and able to faithfully discharge the duties of the office held. The Chief and Vice Chief must have demonstrated executive ability and be recognized for their high level of clinical competence. No individual may hold two general Medical Staff offices concurrently.

8.2 TERMS OF OFFICE

The term of office of general Medical Staff officers will be for two Medical Staff years. Officers assume office on the first day of the Medical Staff year following their election or appointment, except that an officer elected to fill a vacancy assumes office immediately upon election. Each officer serves until the end of his/her term and until a successor is elected, unless the sooner resigns or is removed from office.

8.3 CHIEF, VICE CHIEF AND SECRETARY/TREASURER

8.3-1 Election: The Chief, Vice Chief and Secretary-Treasurer are chosen by election by majority vote cast by secret ballot or acclamation by those members of the Medical Staff who are eligible and qualified to vote for general officers and are present at the Medical Staff's annual meeting. If no candidate for an office receives a majority vote on the first ballot, a runoff election is promptly held between the two candidates receiving the highest number of votes.

8.3-2 The Chief of Staff shall appoint a nominating committee of up to three members of the Medical Staff who shall submit to the Medical Staff secretary before the annual
meeting one or more qualified nominees for each office. Nominations may be accepted from the floor of the annual meeting.

8.4 VACANCIES IN ELECTED OFFICES

Vacancies in offices, other than those of the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of Chief of Staff, the Medical Staff will elect a Chief at the next meeting to complete the remainder of the term.

8.5 RESIGNATION AND REMOVAL FROM OFFICE

8.5-1 RESIGNATION

Any general Medical Staff officer may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.

8.5-2 REMOVAL

Removal of a general Medical Staff officer may be effected by the Board acting upon its own initiative or by a two-thirds vote by secret ballot of members of the Medical Staff eligible and qualified to vote for Medical Officers, such vote being taken at a special meeting. Permissible basis of removal of a general Medical Staff officer includes, without limitation:

(a) Failure to perform the duties of the position held in a timely and appropriate manner.

(b) Failure to continuously satisfy the qualifications for the position.

8.6 DUTIES OF OFFICERS

8.6-1 DUTIES OF THE CHIEF OF STAFF

As the primary Medical Staff officer, the Chief of the Medical Staff has the following primary responsibilities.

(a) AS STAFF’S REPRESENTATIVE TO OTHERS

(i) Transmit to the Board and to the Chief Executive Officer the views and recommendations of the Medical Staff and the MEC on matters of Hospital policy, planning, operations governance, and relationships with external agencies, and transmit the views and decisions of the Hospital’s Board and Chief Executive Officer to the MEC and the Medical Staff membership.

(ii) Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual
matters affecting Hospital operations to the Board and the Chief Executive Officer.

(iii) Oversee compliance on the part of the Medical Staff with the procedural safeguards and rights of individual Medical Staff members in all stages of the Hospital’s credentialing process.

(iv) The Chief of Staff will represent the physicians in a non-Director position and will attend Board meetings to report to the Board any information from the physicians and will be responsible to report to the physicians any actions taken at the Board meetings. The Chief of Staff will serve in an ex-officio position.

(b) AS THE CHIEF ADMINISTRATIVE OFFICER

(i) Direct the efficient operation and organization of the administrative policy-making and representative aspects of the Medical Staff organization, assist the Chief Executive Officer in coordinating these with Administration, nursing, support, and other personnel and services, enforce compliance with the provisions of the Bylaws, Rules, Regulations, policies and procedures of the Medical Staff and the Hospital related to these matters and with regulatory and accrediting agencies’ requirements, and periodically evaluate the effectiveness of the organization.

(ii) Preside at, and be responsible for the agenda of, all general and special meetings of the Medical Staff and the MEC.

(iii) Appoint Medical Staff members to, and the Chairman of Medical Staff committees formed, to accomplish Medical Staff administrative, environmental or representation functions, and serve as ex-officio member without vote of all other standing Medical Staff committees.

(iv) Review and endorse compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community the Hospital serves.

(c) AS THE CHIEF CLINICAL OFFICER

(i) Supervise the clinical organization of the Medical Staff, coordinate the delivery of services among the clinical services and assist the Chief Executive Officer in coordinating activities of administration, nursing, support and other personnel and services with Medical Staff clinical units.

(ii) Advise the Board, the Chief Executive Officer and the MEC on matters impacting on patient care and clinical services, including the need for
new or modified programs and services, for recruitment and training of professional and support staff personnel, for staffing patterns.

8.6-2 DUTIES OF THE VICE CHIEF OF STAFF

As the second ranking Medical Staff officer, the Vice Chief has the following responsibilities and authority:

(a) Assume all of the duties and responsibilities and exercise all of the authority of the Chief of Staff when the latter is unable – temporarily or permanently – to accomplish the same by reason of illness, absence, other incapacity or unavailability or refusal.

(b) Serve as an ex-officio member of the MEC.

(c) Perform such additional duties as may be assigned by the Chief of the Medical Staff, the MEC or the Board.

8.6-3 DUTIES OF THE SECRETARY-TREASURER

(a) Review and sign Medical Staff minutes.

(b) Handle financial matters, if any, of the Medical Staff.

(c) Act as Chief if the Chief and Vice Chief are not available.

ARTICLE VIII. CLINICAL SERVICES

9.1 ENUMERATION

9.1-1 CLINICAL SERVICES

(a) The Surgery Service Committee shall deal primarily with medical care for the patients whose problems require operative treatment. The Surgery Service Committee shall also be responsible for and supervise care provided in the area of anesthesia, transfusions and blood bank, histological studies of tissues removed at surgery, and other Medical Staff and support service functions which relate to surgical patients.

(b) The Medical Service Committee shall deal primarily with medical care for patients who are over the age of 14 and whose problems are not obstetrical or immediately amenable to surgical care. The Medicine Service Committee shall also be responsible for and supervise care provided in the areas of respiratory therapy, physical therapy, radiology and in other areas which provide support services to patients with medical problems. This committee shall also be responsible for review of the quality, scope and timeliness of laboratory services provided to patients in the Hospital.
(c) The Emergency Room Service Committee shall deal primarily with patient care which is provided on the Hospital premises to patients who have not yet been admitted as inpatients.

9.1-2 FUTURE CLINICAL SERVICES OR DEPARTMENTS

The Medical Staff will periodically restudy this structure and recommend through the MEC to the Board what action is desirable or necessary in creating new services or in departmentalizing the Medical Staff for better organization efficiency and improved patient care.

9.2 AFFILIATION WITH SERVICES

(a) To facilitate appointment and reappointment of service chiefs and certain Medical Staff committees, every Medical Staff member must designate at the time of his/her appointment and/or reappointment a primary affiliation with the service of his/her choice. A Practitioner may be granted clinical privileges in one or more services in this exercise of privileges within his/her jurisdiction of any services always subject to the rules and regulations of that service and the authority to the service chief.

(b) In addition to those members of a Clinical Service Committee appointed as provided therein, any member of the Medical Staff may attend and vote at the committee meetings of any clinical service of which he/she has been granted privileges so long as he/she maintains the same attendance standards as are required for appointed members of the Service committee.

9.3 SIZE OF CLINICAL SERVICE COMMITTEE

Each Clinical Service Committee shall have no fewer than three (3) members including the Chairman, depending on the size of the Medical Staff and expertise, as a Committee of the Whole.

9.4 FUNCTIONS OF SERVICE COMMITTEES

The Service Committees shall function to monitor patient care provided by the Hospital Medical Staff and physicians for patients whose problems fall in the general area of each individual Service Committee purview. The Service Committee shall perform the following specific functions:

(a) Review applications for appointment and reappointment to the Medical Staff for those physicians requesting clinical privileges in the area of the specific Service Committee, such review to be performed in addition to the review performed by the Service Committee Chief on such matters. The Service Committee shall review the applicant’s credentials, documented results of his/her prior training and practice both in this institution and elsewhere, and whatever other facts the committee fees are necessary for its rendering a well-informed opinion regarding the applicant’s request for membership and clinical privileges.
(b) Maintain and periodically update a list of those clinical privileges which are appropriate to be performed at the Hospital under the supervision of that clinical service and establish minimum requirements for the clinical privileges that may be exercised within the service and monitor the exercise of privileges actually delineated.

(c) Perform random chart audits to maintain a continuing familiarity of the committee and the nature of care provided by all Medical Staff members with clinical privileges in its area.

(e) Develop mechanisms such as audits, “generic screens”, etc., in order to maintain a continuing assessment of level of care provided by the Hospital, for patients whose care falls under the general area of that Service Committee and to use this information in cooperation with the Quality Assessment & Improvement Committee to identify suboptimal areas in patient care, to develop plans for improving such areas of patient care, and to monitor and to ensure improvement in such patient care.

(e) Convey to the Medical Staff needs which it identifies for educational programs for the Medical Staff and other Hospital personnel.

(f) Monitor and evaluate care provided in and develop clinical policy for the operating rooms, the recovery rooms, medical surgery intensive care units, and other special area units, inpatient care support services such as respiratory therapy, physical therapy, pathology, radiology, etc., and which fall under the purview of the specific Service Committee.

(g) Cooperate with other Medical Staff committees in developing and maintaining policies and practices for specific areas of concern.

(h) Coordinate the care provided by Practitioners within the purview of each Service Committee for patients who require Hospital treatment, but have not previously had a physician on the Medical Staff.

(i) Other duties and functions of the Service Committees shall be as delineated elsewhere in this document, in the Medical Staff Rules and Regulations, in the Credentials Manual and in other formal documents of the Medical Staff.

ARTICLE IV. OFFICERS OF CLINICAL SERVICES

10.1 DESIGNATION AND QUALIFICATIONS OF SERVICE CHIEFS

Each clinical service will have a Chairman who must be a member of the Active Medical Staff and of the clinical service he/she is to head and remain in good standing through his/her term, and must be willing and able to faithfully discharge the functions of his/her office. Each clinical service shall also have a Vice-Chairman who will perform the duties of the Chairman in the event of the Chairman’s absence or in the performance of specific duties where in the opinion of two or more members of the Service Committee the Chairman may not be able to act in an objective manner.
10.2 SELECTION

The Chief of Staff shall appoint one service chief for each clinical service with the approval of the MEC.

10.3 TERM OF OFFICE

A service chief shall serve a one-year term commencing on his/her appointment. He/she shall serve until his/her successor is chosen, unless he/she shall resign or be removed from office.

10.4 RESIGNATION AND REMOVAL

A service chief of a clinical service may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent on formal acceptance, shall take effect on the date of receipt or at any later time specified in it. Removal of a service chief of a clinical service may be effected by the Board action upon its initiative, by a two-thirds majority vote of the MEC and subject to the approval of the Board. Permissible grounds for removal include, without limitation: (a) failure to perform the duties of the position held in a timely and appropriate manner; and (b) failure to continuously satisfy the qualifications for the position.

10.5 RESPONSIBILITIES AND AUTHORITY OF SERVICE CHIEFS

In assuring the accomplishment of the functions of the clinical services as provided in the Medical Staff Bylaws and in meeting his/her responsibility for the professional and administrative activities within the service, a service chief has three specific responsibilities and authority:

(a) Participating on a continuous basis in managing the service through cooperation and coordination with the nursing and other patient care services and Hospital management on all matters affecting patient care.

(b) Communication and, as directed, implementation within the service actions taken by the MEC, and the Board.

(c) Give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding the service to the MEC, Hospital management, and the Board.

(d) Maintain continuing review of patient care and the professional performance of Practitioners and allied health professionals with clinical privileges or specific services in the service and report regularly in writing to the MEC and other Staff or Hospital committees or officials when appropriate or required.

(e) Prepare and transmit to the appropriate authorities as required by the Medical Staff Bylaws recommendations concerning appointment, reappointment, delineation of clinical privileges, and corrective action with respect to Practitioners in the service.

(f) Enforce the Hospital and Medical Staff Bylaws, rules, policies, procedures, and regulations with the service including initiating corrective action and investigation of
clinical performance and ordering consultations to be provided or sought when necessary.

(g) Appoint ad hoc committees of the service as necessary to perform functions of the service and designate a chairman and secretary of each.

h) Perform such other duties commensurate with the office as are set forth in the Medical Staff Bylaws and any other related manuals and, where applicable, in a contract with the Hospital and as may from time to time be reasonably requested by the Chief of the Medical Staff, the MEC, or the Board.

**ARTICLE X. FUNCTIONS AND COMMITTEES**

11.1 **FUNCTIONS OF THE STAFF**

The required functions of the Medical Staff are as specified in this Section and as more fully described in Section 11.2. They shall be accomplished as indicated in these Bylaws and through assignment to the Medical Staff as a whole, to clinical services committees, to Medical Staff officers, or other individual Medical Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members.

(a) Govern, direct and coordinate the Staff organization and its various functions.

(b) Plan, conduct, coordinate and evaluate the Medical Staff components of the Hospital’s quality assessment & improvement program.

(c) Conduct, coordinate and evaluate the effectiveness of monitoring activities, including tissue, blood usage, mortality, morbidity and antibiotics and other drug use reviews; analysis of autopsy reports, analysis of unexpected clinical occurrences; fulfillment of consultation requirements; and compliance with the Bylaws, Rules, Regulations, policies and procedures of the Medical Staff and Hospital.

(d) Conduct, coordinate and evaluate the effectiveness of, or oversee the conduct of, utilization review activities.

(e) Conduct, coordinate and evaluate the effectiveness of special studies of the inputs, processes and outcomes of care.

(f) Monitor and evaluate care provided in and develop clinical policy for: medical-surgical intensive care units, and patient care support services, such as respiratory therapy, physical therapy, pathology, radiology and anesthesiology.

(g) Conduct, coordinate and act on credentials investigations and recommendations regarding Medical Staff membership, grants of clinical privileges, corrective action and specified services for allied health professionals.

(h) Provide and evaluate continuing education opportunities responsive when appropriate to quality assessment & improvement and utilization review program findings and to new state-of-the-art developments pertinent to clinical practice in the Hospital.
(i) Supervise the Hospital’s professional library services.

(j) Develop and review policies and practices on, and maintain surveillance over the completeness, timeliness, and clinical pertinence of patient medical and related records.

(k) Develop and maintain surveillance over drug utilization policies and practices.

(l) Prevent, investigate and control Hospital-acquired infections and monitor the Hospital’s infection control program.

(m) Participate in planning for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.

(n) Direct Staff organizational activities, including Medical Staff Bylaws review and revision, the Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review the maintenance of Hospital accreditation.

(o) Coordinate the care provided by Practitioners with the care provided by the nursing and support services and with the activities of other Hospital patient care and administrative services.

11.2 DESCRIPTION OF FUNCTIONS OF THE STAFF

11.2-1 GOVERNANCE, DIRECTION, COORDINATION AND ACTION (EXECUTIVE)

(a) Receive, coordinate and act upon the written reports and recommendations from clinical services, committees, and other assigned activity groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities.

(b) Coordinate the activities of and policies adopted by the Medical Staff, clinical services, other clinical units, and committees.

(c) Account to the Board and to the Medical Staff by timely reports for the overall quality and efficiency of patient care in the Hospital.

(d) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted.

(e) Make recommendations on medical-administrative and Hospital management actions.

(f) Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.
(g) Meet at least monthly with a permanent record kept of the proceedings and actions.

11.2-2 QUALITY ASSESSMENT & IMPROVEMENT PROGRAM

(a) Adopt and modify, subject to the approval of the MEC and the Board, and supervise the conduct of specific programs and procedures for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital.

(b) Implement the programs and procedures required under (a).

(c) Formulate recommendations for action to correct identified problems.

(d) Act upon recommendations to correct problems.

(e) Follow-up on action taken.

(f) Coordinate the Staff’s quality assessment and improvement activities with those of other health care disciplines.

(g) Send quarterly written reports to the next higher authority in the organizational structure on the results (including findings, action taken and follow-up) and progress of the quality assessment and improvement activities.

(h) Participate in annually evaluating the overall quality assessment and improvement program for its comprehensiveness, integration, effectiveness and cost efficiency.

11.2-3 MONITORING ACTIVITIES

(a) Adopt, modify, supervise and coordinate the conduct and findings of the patient care monitoring activities.

(b) Conduct monthly review of mortalities, including analysis of autopsy reports when available.

(c) Conduct monthly surgical case review, including tissue review, evaluation and comparison to preoperative and post-operative diagnosis, indications for surgery, actual diagnosis of tissue removed, and situations in which no tissue was removed.

(d) Conduct blood utilization studies at least quarterly, including comparisons of the use of whole blood versus blood components, review of each actual or suspected transfusion reaction, and review of the amount of blood requested, the amount used and the amount of wastage.

(e) Review and evaluate the clinical (prophylactic and therapeutic) use of antibiotics in the Hospital on at least a quarterly basis.
(f) Review on a continuous basis other general indicators of quality of care and of clinical performance, including unexpected clinical occurrences.

(g) Review on a continuous basis and enforce or coordinate compliance with consultation requirements and other established policies and protocols relating to clinical practice in the Hospital.

(h) Those responsible for conducting any of these monitoring activities shall submit written reports or minutes of results and progress as required by the frequency of activity to the Quality Assessment & Improvement Committee.

11.2-4 UTILIZATION REVIEW

(a) Develop a utilization review plan for approval by the Medical Staff, Hospital administration and the Board. The plan must apply to all patients regardless of payment source, outline the confidentiality and conflict of interest policy and include provisions for at least:

(i) Review of the appropriateness and medical necessity of admissions, continued Hospital stays and supportive services;

(ii) Discharge planning;

(iii) Data collection and reporting.

(b) Review and monitor that the utilization review plan is in effect, known to the Medical Staff members and functioning at all times.

(c) Prepare written evaluations of the utilization review activities on a continuous basis, including a determination of their effectiveness in allocating resources.

(d) Conduct studies, take actions, submit reports and make recommendations as required by the utilization review plan.

11.2-5 SPECIAL STUDIES

(a) Conduct any special studies of the inputs, processes or outcomes of care that may be required to determine the appropriateness of Practitioner performance in the Hospital.

(b) Send written monthly reports on the progress and results of such studies to the Quality Assurance & Improvement Committee.

11.2-6 CREDENTIALS REVIEW

(a) Review, evaluate and transmit written reports as required by the Medical Staff Bylaws on the qualifications of each applicant or member for appointment and
for clinical privileges, and of each allied health professional for the performance of specified services.

(b) Initiate, investigate, review and report on corrective action matters and on any other matters involving clinical, ethical or professional conduct of any Practitioner assigned or referred by:

(i) The Chief of the Medical Staff.
(ii) The Service Chief.
(iii) The MEC.
(iv) The Board.

(c) Submit timely reports monthly to the MEC and the Board on the status of pending applications or other credentials matters, including the specific reasons for any inordinate delay in their processing.

(d) Maintain a credentials file for each member of the Medical Staff (and allied health professionals), including records of participation in Staff activities and results of quality assessment & improvement activities, or disciplinary action.

11.2-7 EDUCATION

(a) Develop, plan, implement and evaluate programs of, and requirements for, continuing education that are relevant to the type of scope of patient care services delivered in the Hospital, designed to keep the Medical Staff informed of significant new developments and new skills in medicine, and responsive to quality assessment & improvement findings.

(b) Coordinate the various education activities of the clinical services.

(c) Supervise the Hospital’s medical library services.

(d) Maintain a written record of education activities and participation in them.

11.2-8 MEDICAL RECORDS

(a) Review and evaluate medical records to determine that they:

(i) Properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and

(ii) Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the Hospital. Findings are reported to the MEC.

(b) Provide liaison with Hospital administration, nursing services and medical records professionals in the employ of the Hospital on matters relating to medical records practices.
(c) Submit a written report at least quarterly to the MEC on the progress and results of the activity.

11.2-9 PHARMACY AND THERAPEUTICS

(a) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.

(b) Advise the Medical Staff and the Hospital’s pharmaceutical department on matters pertaining to the choice of available drugs.

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(d) Develop and review periodically a formulary for use in the Hospital, prescribe the necessary operating rules and regulations for its use, and assure that said rules and regulations are available to and observed by all Medical Staff members.

(e) Review all unexpected drug reactions.

(f) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(g) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(h) Submit written reports at least quarterly to the MEC concerning drug utilization policies and practices in the Hospital.

11.2-10 INFECTION CONTROL

(a) Maintain surveillance over the Hospital infection control program.

(b) Develop a system for reporting, identifying and analyzing the incidence and cause of all infections.

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.

(d) Develop, evaluate and review preventive, surveillance and control policies and procedures relating to all phases of the Hospital’s activities, including:

- operating rooms, delivery rooms, special care units, central supply, housekeeping and laundry, sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures, prevention for cross-infection by
anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management, and other situations as requested.

(e) Coordinate action on findings from the Medical Staff’s review of the clinical use of antibiotics.

(f) Conduct on a periodic basis statistical/prevalence studies of antibiotic usage and susceptibility/resistance trend studies.

(g) Submit written reports at least quarterly to the Quality Assessment & Improvement Committee and to the MEC.

11.2-11 DISASTER PREPAREDNESS

(a) Assist in developing and periodically reviewing, in cooperation with the Hospital administration, a written plan that is designed to safeguard patients at the time of an internal disaster and requires all key personnel to rehearse fire and other types of disaster drills at least four (4) times a year for each shift.

(b) Assist in developing and periodically reviewing, in cooperating with the Hospital administration, a written plan for the care, reception and evaluation of mass casualties that is coordinated with the inpatient and outpatient services of the Hospital, that adequately relates to other available resources in the community and coordinates the Hospital’s role with other agencies in the event of disasters in the Hospital, or nearby communities, and that is rehearsed by all personnel involved at least twice yearly.

11.2-12 PLANNING

(a) Participate in evaluating on an annual basis existing programs, services and facilities of the Hospital and Medical Staff and recommend continuation, expansion, abridgement or termination of each.

(b) Participate in evaluating the financial, personnel and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment and assess the relative priorities of service and needs and allocation of present and future resources.

(c) Submit written reports as necessary or required to relevant staff organizational components and to the Board or appropriate committees thereof with findings and recommendations for action.

11.2-13 BYLAWS REVIEW AND REVISION

(a) Conduct at least a biannual review of the Bylaws, Rules and Regulations, procedure manuals, and forms promulgated in connection with the.
(b) Conduct at least a biannual review of the clinical policies, rules and regulations.

(c) Submit written recommendations to the MEC and the Board for changes in the documents.

11.3-13 PRINCIPLE GOVERNING COMMITTEES

11.3-1 MEDICAL EXECUTIVE AND OTHER COMMITTEES

There will be a Medical Executive Committee and such the standing and special committees, responsible to the MEC or to a designated staff official, as are necessary and desirable to perform any of the functions listed in Section 11.1 and 11.2 and elsewhere in the Bylaws. The composition and purpose of any standing committees, in addition to the MEC, that exist at any given time, are set forth in the Bylaws.

11.3-2 SUBSTITUTION

The MEC may, at any time it deems necessary and desirable for the proper discharge of the functions required of the Medical Staff by these Bylaws and the Bylaws and policies of the Hospital, by resolution and upon approval of the Board, establish, eliminate or merge standing or special Medical Staff committees, change the function of a Medical Staff committee, or assign the function to the Medical Staff as a whole.

11.3-3 REPRESENTATION ON HOSPITAL COMMITTEES

Staff functions and responsibilities relating to liaison with the Board and the Hospital administration, Hospital accreditation, disaster planning, facility and service planning, financial management, and functional and physical plant safety which require participation of, the than direct oversight by, the Staff may be discharged in part by various officers and organizational components of the Medical Staff as described in the Bylaws and in part by Medical Staff representation on Hospital committees established to perform such functions.

11.3-4 ACTION THROUGH SUBCOMMITTEES

Any standing committee may elect to perform any of its specifically designated functions by constituting any number of its members as a subcommittee for that purpose, reporting such action to the MEC in writing. Any such subcommittee may include individuals in addition to members of the standing committees. Such additional members are appointed by the committee chairman after consultation with the Chief of the Medical Staff and with the Chief Executive Officer for his/he designee when administrative staff appointments are to be made.
11.3-5 COMPOSITION

A Medical Staff committee established to perform one or more of the Medical Staff functions required by the Bylaws shall be composed of members of the active Medical Staff and may include, the appropriate, representation from Hospital administration, nursing services, medical records service, pharmaceutical service and such other Hospital departments as are appropriate to the function(s) to be discharged. Hospital representatives may serve with or without vote as provided in the composition of the committee.

11.3-6 APPOINTMENT

Unless otherwise specifically provided, the Chief of the Medical Staff appoints, subject to the approval of the MEC, the members, chairman and vice chairman of any Medical Staff committee formed to accomplish Medical Staff administrative, environmental or representational functions. Non-Medical Staff appointees are subject to the approval of the Chief Executive Officer.

11.3-7 TERM AND PRIOR REMOVAL

Unless otherwise specifically provided, a Medical Staff committee member shall continue as such until the end of his/her normal period of Medical Staff appointment and until his/her successor is elected or appointed, unless the shall sooner resign or be removed by the committee. A Medical Staff committee member, other than one serving ex-officio, may be removed by a majority vote of the MEC. An administrative staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until his/her successor is elected or appointed, unless the shall sooner resign or be removed by the committee. An administrative staff committee member may be removed by action of a majority vote of the MEC or by the Chief Executive Officer.

11.3-8 VACANCIES

Unless otherwise specifically provided, vacancies on any Medical Staff committee shall be filled in the same manner in which the original appointment to such committee is made.

11.3-9 MEETINGS

A Medical Staff committee established/shed to perform one or more of the Medical Staff functions required by he/these Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly.
11.4 MEDICAL EXECUTIVE COMMITTEE

11.4-1 PURPOSE

The MEC is empowered to act for the Medical Staff and to coordinate all activities and policies of the Medical Staff and its clinical services and committees, so long as it acts in a manner that is not inconsistent with the Medical Staff Bylaws. He/the MEC is empowered to take actions that might not be specifically articulated in the Medical Staff Bylaws, subject to a general constraint of a consistent purpose. It meets on an as-needed basis and communicates its discussions and actions that affect or define Medical Staff policies, rules or positions by written summary reports made available to all active and provisional members of the Medical Staff, including in these reports abstracts of department (or service and/or other clinical unit designations as applicable) and committee reports submitted to it, together with the actions taken by any of said groups and whether such actions were approved, modified or rejected by the MEC.

11.4-2 COMPOSITION

The MEC shall consist of the Chief, Vice Chief, Secretary-Treasurer and Chief Executive Officer.

The Chief of the Medical Staff is chairman and presiding officer. The Vice Chief is vice chairman to act in the chairman’s absence and the Secretary-Treasurer is secondary and recording officer. The Chief Executive Officer serves as an ex-officio member without vote.

11.4-3 CONFLICTS

If there is a conflict between the MEC and the Medical Staff regarding actions taken by the MEC, the Medical Staff can override the MEC action at any general or special meeting of the Medical Staff where a quorum is present by a majority vote of the voting members present.

ARTICLE XI. CORRECTIVE ACTION

SECTION 1

PROCEDURE

(a) Whenever the activities or professional conduct of any Practitioner with clinical privileges are considered to be lower than the standards of the Medical Staff, or to be disruptive to the operation of the Hospital, corrective action against such practitioner may be requested by any Officer of the Medical Staff, by the Chairperson or any clinical department, by the Chairperson of any standing committee or sub-committee of the Medical Staff, by the Chief Executive Officer or his/her designee, or by the Board. All requests for corrective action shall be in writing to the Medical Executive Committee (MEC) and shall be supported by reference to the specific activities or
conduct, which constitutes the grounds for the request. The Medical Staff will adopt and update as necessary the policies and procedures for impaired/disruptive Medical Staff members.

(b) Action by the Officer of the Inspector General to exclude the practitioner from federal and federally supported programs shall initiate an automatic investigation for potential correction action by a committee appointed by the President of the Medical Staff. During the investigation, the practitioner will be removed from Emergency Department call, be prohibited from providing any services for patients on federally funded programs in the Hospital and from providing services for the Hospital. If the investigation results in an action adverse to the Practitioner, he/she may exercise his/her right to a hearing as provided in Article XI of these Bylaws. If the results of the Hearing and Appeal results in suspension of clinical privileges, he/she will be eligible to have privileges reinstated when the exclusion expires or is cleared.

(c) Whenever the corrective action could be a reduction or suspension of the clinical privileges or a suspension or expulsion from the Medical Staff and the provisions of Section 2 herein are not utilized, the Medical Executive Committee shall forward such request to the Practitioner and to the Chairperson of the Department where the Practitioner has such privileges. Upon receipt of such request, the Chairperson of the Department shall immediately appoint an Ad Hoc Committee of at least three (3) persons, not in economic competition with the Practitioner, to investigate the matter.

(d) Within 14 days after the Chairman’s receipt of the request for corrective action, the Ad Hoc Committee shall make a report of its investigation to the Medical Executive Committee. Prior to the making of such report, the Practitioner against whom the corrective action has been requested shall have an opportunity for an interview with the departmental Ad Hoc Committee. At such interview, he/she shall be informed of the charges against him/her, and shall be invited to discuss, explain or refute them. This interview shall not constitute a Hearing and shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to the hearing shall apply thereto. Minutes of such interview shall be taken.

(e) Within 14 days following receipt of the report from the Ad Hoc Committee following the investigation of a request for corrective action involving reduction of suspension of clinical privileges, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, the Practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to it taking action on such request. This appearance shall not constitute a Hearing and shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to Hearing shall apply thereto. The Medical Executive Committee shall make minutes of such appearance.

(f) Except for those instances which are governed by Section 2A of this Article, an adverse recommendation by the Medical Executive Committee shall entitle the affected Practitioner to the procedural rights provided in Article XI of these Bylaws.

(g) The Chairperson of the Medical Executive Committee (President of the Medical Staff) shall promptly notify the Chief Executive Officer in writing of all requests for
corrective action received by the Medical Executive Committee and shall continue to keep the Chief Executive Officer or his/her designee fully informed of all action taken in connection therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be provided in these Bylaws.

SECTION 2

PRECAUTIONARY SUSPENSION

(a) The Chief of the Medical Staff, on recommendation of the Medical Executive Committee, shall have the authority whenever action must be taken immediately in the best interest of patient care in the Hospital, to cautiously suspend all or any portion of the clinical privileges of a Practitioner, and such suspension shall become effective immediately upon imposition. Such Precautionary Suspension shall be deemed an interim precautionary step (not reportable to the National Practitioner Data Bank) in the professional review activity related to the ultimate professional review action in and of itself. It shall not imply any final finding of the responsibility for the situation that caused the suspension.

A Precautionary Suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the Medical Executive Committee by the Chief of the Medical Staff and shall remain in effect, or until modified by the Chief of the Medical Staff and the Medical Executive Committee.

(b) Immediately upon the imposition of a suspension, the Chairperson of the Medical Executive Committee or the responsible Department Chairperson shall have the authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner.

(c) A review of the matter resulting in Precautionary Suspension shall be completed within a reasonable time period not to exceed thirty (30) days or reasons for the delay shall be transmitted to the Board so that the Board may consider whether the suspension should be lifted or extended. In the event the suspension is not lifted at that time, the Board shall bring an action under the provisions of Article XI.

SECTION 3

AUTOMATIC SUSPENSION

(a) INCOMPLETE MEDICAL RECORDS:

Physicians may be suspended for any delinquent records. Delinquent records for inpatient, observation, and same day surgery are defined as those records that are not completed within 15 days after patient discharge. Suspension is defined as a temporary suspension of admitting privileges from the date the suspension list is created the day following the last Wednesday of the current month. The physician
shall not admit new patients to in patient, observation, or same day surgery status under his/her name or any other physician name. The physician shall not schedule surgical or endoscopic procedures if he/she is on the suspension list. Previously scheduled surgical or endoscopic procedures will remain scheduled. Upon completion of the delinquent medical records by the physician, Health Information Services will remove him/her from the suspension list. This immediately reinstates the physician to the Medical Staff and full admitting or scheduling privileges are granted to the physician. Refer to Medical Staff Rules & Regulations for specific policies on completion of medical records and suspension.

The HIM Director shall contact the Emergency Room, Admissions Office, Department of Surgery (OP), Same Day Surgery and other Departments contacted at the time of suspension.

(b) MANDATORY MEETINGS

Whenever a Practitioner fails to attend a meeting to which he/she was given notice that attendance was mandatory, and no postponement was granted, automatic suspension will occur.

(c) STATE BOARD ACTION

Action by the State Board of Medical Examiners, revoking or suspending a “Practitioner’s” license, shall automatically revoke or suspend all his/her Hospital privileges.

(d) DEA ACTION

Action by the DEA reducing, revoking or suspending a DEA certificate will automatically and correspondingly trigger a review of the Practitioner with a possibility of reduction, revocation, or suspension of his/her privileges at the Hospital.

ARTICLE XII. HEARING AND APPELLATE REVIEWS (FAIR HEARING PLAN)

SECTION 1

RIGHT TO HEARING AND APPELLATE REVIEWS

(a) Recommendation or Actions

The following recommendations or actions shall, if deemed adverse pursuant to Section 1(b) of this Article, entitle the practitioner affected thereby to a hearing:

1. Denial of initial staff appointment
2. Denial of reappointment
3. Suspension of staff membership
4. Revocation of staff membership
5. Denial of requested advancement in staff category
6. Reduction in staff category
7. Limitation of right to admit patients
8. Denial of requested department/service/section affiliation
9. Denial of requested clinical privileges
10. Suspension of clinical privileges
11. Reduction in clinical privileges
12. Revocation of clinical privileges
13. Terms of probation

14. A finding that the Practitioner in question is lacking in qualifications
15. A finding that the Practitioner has provided substandard or inappropriate patient care
16. A finding that the Practitioner has exhibited inappropriate professional conduct

Admonitions, reprimands and warnings, whether verbal or written, are not considered to be adverse actions and the recipients thereof, while entitled to interviews, are not entitled to Hearings or Appellate Reviews. A recommendation or action listed in Section 1(a) of this Article shall be deemed adverse only when it has been:

1. Recommended by the Medical Executive Committee;
2. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to hearing existed; or
3. Taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

(b) NOTICE OF ADVERSE RECOMMENDATIONS OR ACTIONS

A practitioner against whom an adverse recommendation or action has been taken pursuant to Section 1(b) of this Article shall promptly be given special written notice of such action. Such notice shall be delivered in person or by certified mail and shall:
1. Advise the Practitioner of his/her right to a Hearing pursuant to the provisions of the Medical Staff Bylaws and the reasons for the proposed action;

2. Specify the number of days (not more than 30 days) following the date of receipt of notice within which a request for a hearing be submitted. Such requests shall be delivered to the Chief Executive Officer of the Hospital in person or by certified mail;

3. State the failure to request a Hearing within the specified time period shall constitute a waiver of rights to a Hearing and to an appellate review on the matter; and

4. State that upon receipt of his/her Hearing Request, the Practitioner will be sent another notice that indicates the date, time and place of the hearing, which cannot be held earlier than 30 days after the second notice. A list of witnesses expected to testify at the hearing against the Practitioner shall be provided.

(c) WAIVER BY FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a Hearing within the time and in the manner specified in Section 1(b) waives any right to such a Hearing and to any Appellate Review to which he/she might otherwise have been entitled. Such waiver in connection with:

1. An adverse action by the Board shall constitute acceptance of this action, which shall thereupon become effective as the final decision by the Board.

2. An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the committee’s recommendation at its next regular meeting following the waiver. In its deliberation, the Board shall review all relevant information received from any source. If the Board’s action on the matter is in accord with the Medical Executive Committee’s recommendation, such action shall constitute a final decision of the Board. The Chief Executive Officer shall promptly send the Practitioner a notice informing him/her of each action taken pursuant to this Section and shall notify the President of the Medical Staff and the Medical Executive Committee of each action.

SECTION 2

REQUEST FOR HEARING

(a) NOTICE OF TIME AND PLACE FOR HEARING OTHER THAN FOR PRECAUTIONARY SUSPENSION

Upon receipt of a timely request for such hearing, the Chief Executive Officer of the Hospital shall deliver such request to the Chief of the Medical Staff or to the Board depending on whose recommendation or action prompted the request for hearing. At
least thirty (30) days prior to the Hearing, the Chief Executive Officer shall send the Practitioner special notice of the time, place, and date of the hearing. The Hearing date shall not be less than thirty (30) days or not more than forty-five (45) days from the date of receipt of the request of Hearing unless otherwise agreed to by the Parties.

(b) STATEMENT OF ISSUES AND EVENTS

The notice of Hearing required by these Bylaws shall contain the following:

1. The time date and place of the hearing;

2. The witnesses the Medical staff or Board will call to testify on its behalf (this shall not be construed to preclude additional witnesses not on the list from the Hearing. However, if additional witnesses are necessary, the Practitioner may be granted additional time for adequate preparation for such witnesses);

3. A concise statement of the Practitioner’s alleged acts or omissions, a list of the specific or representative patient records, by number, in question and/or the other reasons or subject matter forming the basis for the adverse recommendation, action, or finding which is the subject of the hearing;

4. The identity of the members of the hearing committee;

5. That the right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear;

6. That the Practitioner shall have the right to representation by an attorney or other person of the Practitioner’s choice (notice of the exercise of this right must be given within seven (7) days of receipt of the Notice of Hearing); have a record made of the proceedings (both parties shall equally share in the expenses associated with the preparation thereof); call, examine, and cross-examine witnesses; present evidence determined to be relevant by the hearing committee, regardless of its admissibility in a court of law; and submit a written statement at the close of the hearing;

7. That upon completion of the hearing, the Practitioner involved has the right to receive the written recommendation of the hearing panel, including a statement of the basis for the recommendation and receive a written decision of the Medical Staff or Board (as applicable), including a statement of the basis for the decision;

8. That if the Practitioner waives appellate review by the Board, the Board is not bound by the adverse recommendation, action or finding that the Practitioner has accepted by virtue of the waiver but may take any action, whether more or less severe, that it deems warranted by the circumstances.
(c) APPOINTMENT OF HEARING COMMITTEE/HEARING OFFICER

A Hearing occasioned by an adverse Medical Executive Committee or by the g Board recommendation pursuant to these Bylaws shall be conducted by a Hearing Officer appointed by the Chief of the Medical Staff who is not in direct economic competition with the Practitioner or a committee of three physicians not in direct economic competition with the Practitioner involved. One of the panel so appointed shall be designated as Chairperson by the Chief of the Medical Staff.

A Medical Staff or Board member shall be disqualified from serving on the Hearing Committee or as a Hearing Officer if the has significantly participated in initiating or investigating the underlying matter at issue. A Hearing Officer may be from outside the Hospital. Anytime “Hearing Committee” is mentioned herein the term “Hearing Officer” is automatically included.

(d) PREHEARING CONSIDERATIONS

The Practitioner shall submit a list of his/her probable witnesses at least seven (7) days prior to the hearing. However, additional witnesses may be called by either party, provided that notice has been sent. Other relevant matters which arise that were not known at the time of Notice of Hearing may also be added to the matters to be determined at the hearing. In such cases, additional time for preparation may be granted to the other party if requested. In cases of initial appointment, the matters to be considered at the hearing shall include, but not be limited to, all information, records, and references in the credentials or application file of the Practitioner.

SECTION 3

CONDUCT OF HEARING

(a) PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her right in the same matter and with the same consequences as provided in Section 1(d).

(b) PRESIDING OFFICER

In the event that a panel of three (3) physicians is named to hear the matter, the Chairperson of the hearing Committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings of matters of law, procedure and admissibility of evidence.
(c) REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a person of his/her choice, including an attorney. The Medical Executive Committee or the Board, depending on whose recommendation or action prompted the Hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action and to examine witnesses.

(d) RIGHTS OF PARTIES

During a Hearing, each of the parties shall have the right to:

1. Call and examine witnesses
2. Introduce exhibits
3. Cross-examine any witness on any matter relevant to the issues
4. Impeach any witness
5. Rebut any evidence
6. Be called and examined as if under cross-examination by the individual presenting the matter
7. Both parties have the right to provide a written statement at the conclusion of the Hearing
8. The Hearing Committee’s or Hearing Officer’s decision must be in writing and shall include Findings of Fact which are the basis on which this decision is made.
9. Any decision in the matter by the Medical Executive Committee or Board must be in writing and shall include the basis on which the decision was made.

(e) PROCEDURE AND EVIDENCE

A record of the Hearing shall be made by use of a court reporter or an electronic recording unit. The Hearing need not be conducted strictly according to rules of law relating to the examination of witness or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The Hearing Committee/Hearing Officer shall also be entitled to consider all other information that can be considered, pursuant to the Medical Staff Bylaws, in reappointment to the Medical Staff and for Clinical Privileges. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the Hearing record.
(f) OFFICIAL NOTICE

In reaching a decision, the Hearing Committee/Hearing Officer may take official notice, either before or after accepted technical or scientific matter relating to the issues under consideration and of any facts that may be Judicially Noticed by the Colorado Courts. Parties present at the Hearing shall be informed of the matters to be noticed and those matters shall be noted in the Hearing record. Any party shall be given opportunity, on a timely request, to request that a matter be Officially Noticed and to refute the Officially Noticed matters by evidence or by written or oral presentation of authority. The matter of such refutation is to be determined by the Hearing Committee/Hearing Officer.

(g) BURDEN OF PROOF

When a Hearing relates to Section 1(a-1), (8) or (9), the Practitioner who requested the Hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendations or action lacks substantial factual basis or that such basis or conclusions drawn therefrom are either arbitrary or capricious.

(h) POSTPONEMENT

Request for postponement of a Hearing shall be granted by the Hearing Committee/Hearing Officer only upon a showing of good cause and only if the request therefore is made as soon as is reasonably practical.

(i) PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the Hearing Committee shall constitute a quorum. If a committee member is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

(j) RECESSES AND ADJOURNMENT

The Hearing Committee/Hearing Officer may recess the Hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence of consultation. Upon conclusion of the presentation of oral and written evidence and summation if desired and permitted, the Hearing shall be closed. The Hearing Committee/Hearing Officer shall thereupon, at a time convenient to itself, conduct its deliberations, outside the presence of the parties. Upon conclusion of its deliberations, the Hearing shall be declared finally adjourned.

(k) HEARING COMMITTEE/HEARING OFFICER REPORT

The Hearing Committee/Hearing Officer shall make a written report of its findings of fact and recommendations in the matter and shall forward the same, together with the hearing record to all other documentation considered by it, to the Body whose adverse recommendation or action caused the Hearing.
SECTION 4

ACTION OF HEARING COMMITTEE/HEARING OFFICER REPORT

(a) CONSIDERATION OF HEARING COMMITTEE/HEARING OFFICER REPORT

Within twenty-one (21) days after receipt of the report of the Hearing Committee/Hearing Officer the Medical Executive Committee or the Board as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the Hearing Committee/Hearing Officer and all other documentation considered, to the Chief Executive Officer.

(b) NOTICE, EFFECT AND RESULT

1. NOTICE

The Chief Executive Officer shall promptly send a copy of the result to the Practitioner, to the Chief of the Medical Staff, to the Medical Executive Committee and to the Board.

2. EFFECT OF FAVORABLE RESULT

a. ADOPTED BY THE BOARD

If the Board’s result, pursuant to Section 4(a), is favorable to the Practitioner, such result shall become the final decision of the Board.

b. ADOPTED BY THE MEDICAL EXECUTIVE COMMITTEE

The Chief Executive Officer shall promptly forward Medical Executive Committee’s decision together with all documentation, to the Board for its final action.

The Board shall take action thereupon by adopting or rejecting the Medical Executive Committee’s result in whole or part, or by referring the matter back to the Medical Executive Committee for further consideration. Any referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that any additional hearing be conducted by the Medical Executive Committee to clarify issues that are in doubt. After receipt of such subsequent recommendation, the Board shall take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section 4(b)2b. Favorable action shall become the final decision of the Board. If the Board’s action is adverse in any of the respects listed in Section 1(a) of this Article, the notice shall
inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 5(a) of this Article.

3. **EFFECT OF ADVERSE RESULT**

   If the result of the Medical Executive Committee or if the Board continues to be adverse to the practitioner in any of the respects listed in Section 1(a) of this Article, the notice required by Section 4(b)1 shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 5(a) of this Article.

**SECTION 5**

**APPEAL TO THE BOARD**

(a) **REQUEST FOR APPELLATE REVIEW**

   Practitioner shall have seven (7) days following his/her receipt of notice pursuant to Section 4(b)2b or 4(b)3 to file a written request for an Appellate Review. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail and may include, to the extent he/she has not previously been given it, a request for a copy of the report and record of the Hearing Committee/Hearing Officer and all other exhibits, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse action or result.

(b) **WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW**

   A Practitioner who fails to request an Appellate Review within the time and in the manner specified in Section 5(a) above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 1(e) of this Article.

(c) **NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW**

   Upon receipt of a timely request for Appellate Review, the Chief Executive Officer shall deliver such request to the Board. As soon as practical, the Board shall schedule and arrange for an Appellate Review which shall commence no more than twenty-one (21) days from the date of receipt of the Appellate Review request provided, however, that an Appellate Review for a Practitioner who is under suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, if possible not later than seven (7) days from the date of receipt of the request for review. At least five (5) days prior to Appellate Review, the Chief Executive Officer shall send the Practitioner notice of the time, place and date of the review. The time for the Appellate Review may be extended by the Appellate Review Body for good cause if the request therefore is made as soon as is reasonably practical.
(d) **APPELLATE REVIEW BODY**

Appellate Review shall be by the Appeals Committee of the Hospital

(e) **NATURE OF PROCEEDING**

The proceedings by the Appellate Review Body shall be in the nature of an Appellate Review based upon the record of the Hearing before the Hearing Committee/Hearing Officer, the Committee’s/Hearing Officer’s report, and all subsequent action thereon. The Appellate Review Body shall also consider the written statements, if any, submitted pursuant to Section 5(f) of this Article and such other material as may be presented and accepted under Section 5(h) and 5(i) of this Article.

(f) **WRITTEN STATEMENTS**

The Practitioner seeking the Review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Body through the Chief Executive Officer at least seven (7) days prior to scheduled date of the Appellate Review, except if the Appellate Review Body waives such time limit. A written statement in reply may be submitted by the Medical Executive Committee or by the Board and if submitted, the Chief Executive Officer shall provide a copy thereof to the Practitioner at least two (2) days prior to the scheduled date for the Appellate Review.

(g) **PRESIDING OFFICER**

The Chairperson of the Appellate Review Body shall be Presiding Officer. He/she shall determine the order of the procedure during the review, make all required rulings and obtain decorum.

(h) **ORAL STATEMENT**

The Appellate Review Body, in its sole discretion, may allow the parties and their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put by him/her by any member of the Appellate Review Body.

(i) **CONSIDERATION OF NEW OR ADDITIONAL MATTERS**

New or additional matters or evidence, not raised or presented during the original Hearing or in the Hearing report and not otherwise reflected in the record, may be introduced at the Appellate Review only with permission of the Appellate Review Body following an explanation by the Party requesting the consideration of such matters or evidence as to the extraordinary reasons it was not presented earlier and comments by the opposing Party, if any.
(j) **POWERS**
The Appellate Review Body shall have all powers granted to the Hearing Committee and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

(k) **PRESENCE OF MEMBERS AND VOTE**
A majority of the Appellate Review Body shall constitute a quorum. If a member of the Review Body is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

(l) **RECESSES AND ADJOURNMENT**
The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside those deliberations, and the appellate review shall be declared finally adjourned.

(m) **ACTION TAKEN**
The Appellate Review Body may recommend that the Board affirm, modify or reverse. The Board pursuant to section 4(a) or 4(b)2b or, in its discretion, may refer the matter back to the Hearing Committee for further review and further recommendations to be returned to it within a reasonable time and in accordance with its instructions. Within fourteen (14) days after receipt of such recommendations after referral, the Appellate Review Body shall make its recommendations to the Board as provided in this Section 5(m).

(n) **CONCLUSION**
The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided therein have been completed or waived. If the final decision is to recommend termination of Medical Staff membership, the Practitioner will be notified by certified letter.

SECTION 6

**FINAL DECISION BY BOARD**

(a) **BOARD’S ACTION**
At its next regular meeting after the conclusion of the Appellate review, unless otherwise postponed for good cause, the Board shall render its final decision in the
matter in writing and shall send notice thereof to the Practitioner by special notice, to the Chief of the Medical Staff, and to the Medical Executive Committee.

SECTION 7

HEARING SPECIFICATIONS

(a) ATTORNEYS

If the affected Practitioner desires to be represented by an attorney, whether or not a physician, at a hearing or at any Appellate Review appearance, his/her initial request for the hearing must state his/her wish to be so represented at either or both such proceedings in the event they are held. If, and only if, the Practitioner gives notice at the time that he/she shall be represented by an attorney, shall the Medical Executive Committee or Board be allowed representation by an attorney. The foregoing shall not be deemed to deprive the Practitioner, the Medical Executive Committee, or the Board of the right to legal counsel in connection with the preparation for a Hearing or an Appellate Review or give advice to the representatives of the Practitioner or Medical Executive Committee or the Board at the Hearing.

(b) NUMBER OF HEARINGS AND REVIEWS

Not withstanding any other provision of the Medical Staff Bylaws or of this Article, no Practitioner shall be entitled, as a right, to more than one evidentiary hearing and one Appellate Review with respect to an adverse recommendation or action.

(c) RELEASES

By requesting a Hearing or Appellate Review under this Article, a Practitioner agrees to be bound by the provisions of Article XIII in the Medical Staff Bylaws relating to immunity from liability in all matters relating thereto.

(d) WAIVER

If at any time after receipt of special notice of an adverse recommendation, action, or result a Practitioner fails to make a required request or appearance or otherwise fails to comply with this Article or to proceed in this matter, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all right to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Article with respect to the matter involved.

ARTICLE XIII. MEETINGS

12.1 MEDICAL STAFF YEAR

For the purpose of the business of the Medical Staff, the business year will commence on January 1 and expire on December 31 of that year.
12.2 MEDICAL STAFF MEETINGS

12.2-1 REGULAR MEETINGS

Regular meetings of the staff will be held at least bi-monthly. The regular staff meeting immediately prior to the end of each Medical Staff year is the annual staff meeting.

12.2-2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called at any time by the Board, the Chief, the MEC, or not less than 50% of the members of the Active Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except for stated in the meeting notice.

14.3 CLINICAL SERVICE AND COMMITTEE MEETINGS

14.3-1 REGULAR MEETINGS

Clinical services and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is then required. Clinical Services must hold regular meetings at least monthly.

14.3-2 SPECIAL MEETINGS

A special meeting of any Clinical Service, section or committee may be called by the chairman or chief thereof, and must be called by the chairman or chief thereof, and must be called by the chairman or chief at the written request of the Board, the Chief of Medical Staff or by one-third of the group’s current members but not less than two.

14.4 ATTENDANCE REQUIREMENTS

14.4-1 GENERALLY

Each member of the staff shall continuously maintain a 70% attendance at clinical service and staff committee meetings, based on the annual number of meetings for that committee, required for members in his/her staff category and the meetings of committees on which he/she serves, unless excused by reason of illness, absence from the city, or a medical or personal emergency. Failure to meet the attendance requirement over a rolling six-month period will result in loss of voting rights at all Medical Staff activities. If the attendance requirement is then not met over the next four months, the status of the physician as an Active staff member of the Medical Staff will be reviewed by the MEC who will have the option of possible further disciplinary action.

Resignation from a committee may be accomplished without sanctions only with the approval of the Chief of Staff.
14.4-2 SPECIAL APPEARANCE OR CONFERENCES

(a) A Practitioner whose patient’s clinical course of treatment is scheduled for discussion at a Staff, clinical service or committee meeting should be so notified and invited to present the case in person or in writing.

(b) Whenever a Staff or Clinical Service education program is prompted by findings of quality assessment & improvement program activities, the Practitioners whose performance prompted the program will be notified of the time, date and place of the program, of the subject matter to be covered, and of its special applicability to the practitioner’s practice. Except in unusual circumstances, they will be required to be present.

(c) Whenever a pattern of apparent or suspected deviation from standard clinical practice is identified within a practitioner’s practice, the applicable Clinical Service Chief may require the practitioner to confer with him/her or with a standing or ad-hoc committee that is considering the matter. The Practitioner will be given special notice of the conference at least five (5) days prior to it, including the date, time, and place, a statement of the issue involved, and that the Practitioner’s appearance is mandatory. Failure of a Practitioner to appear at any such conference, unless excused by the MEC upon a showing of good cause, will result in an automatic suspension of all or such portion of the Practitioner’s clinical privileges as the MEC may direct. A suspension under this Section will remain in effect until the matter is resolved by subsequent action of the MEC and the Board or through corrective action, if necessary.

14.5 NOTICE OF MEETINGS

Written notice of any regular general staff meeting, or of any regular committee, clinical service meeting not held pursuant to resolution must be delivered personally, email or by mail to each person entitled to be present thereat, not less than five (5) days or more than fifteen (15) days before the date of such meeting and must be posted. Notice of any special meeting of the staff, clinical service or a committee must be given in writing at least 72 hours prior to the meeting and must be posted. Personal attendance at a meeting constitutes a waiver of notice of such meeting except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened. No business shall be transacted at any special meeting except that stated in the meeting notice.

14.6 QUORUM

14.6-1 GENERAL STAFF MEETING

The presence of fifty (50) percent of the qualified voting members of the Active Medical Staff at any regular or special meeting constitutes a quorum for the transaction of any business under these Bylaws.
14.7 ORDER OF BUSINESS AT REGULAR STAFF MEETING

The order of business at a regular Staff meeting is determined by the Chief of Staff. The agenda includes at least:

(a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.

(b) Administrative reports from the Chief of the Medical Staff, the Chief Executive Officer, services and committees.

(c) The election of officers and of representatives to the Staff and Hospital committees, when required by these Bylaws.

(d) Reports by responsible officers, clinical services, and committees on the fulfillment of the other required staff functions.

(e) New business.

14.8 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present is the action of the group.

14.9 MINUTES

Minutes of all meetings are prepared by the secretary of the meeting and include a record of attendance and the vote taken on each matter. Copies of said minutes must be signed by the presiding officer, approved by the attendees and made available to any member of the staff upon request. A permanent file of the minutes of each meeting shall be maintained.

14.10 PROCEDURAL RULES

Meetings of the staff, services and committees will be conducted according to the then current edition of Roberts’ Rules of Order. In the event of conflict between the Rules and any provision of the Medical Staff Bylaws or any of its related manuals, the latter are controlling.

ARTICLE XIV. CONFIDENTIALITY, IMMUNITY AND RELEASES

15.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

(a) INFORMATION means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations,
(b) **MALICE** means the dissemination of a knowing falsehood or of information with a reckless disregard for whether or not in its true or false.

(c) **REPRESENTATIVE** means a Board of a Hospital and any director or committee thereof; a Hospital chief executive officer or his/her designee; registered nurses and other employees of a Hospital; a medical staff organization and any member, officer, clinical unit or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

(d) **THIRD PARTIES** mean both individuals and organizations providing information to any representative.

15.2 **AUTHORIZATION AND CONDITIONS**

By submitting an application for Staff membership or by applying for or exercising clinical privileges or providing specified patient care services in this Hospital, a Practitioner:

(a) Authorizes representatives of the Hospital and the medical staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications.

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions of his/her application for, or acceptance of, staff membership and the continuation of such membership and to his/her exercise of clinical privileges or provisions of specified patient services at this Hospital.

15.3 **CONFIDENTIALITY OF INFORMATION**

Information with request to any Practitioner submitted, collected or prepared by any representative of his/her or any other health care facility or organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative nor be used in any way except as provided therein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient’s record.
15.4 IMMUNITY FROM LIABILITY

15.4-1 FOR ACTION TAKEN

No representative of the Hospital or Medical Staff shall be liable to a Practitioner for damages or other relief of any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

15.4-2 FOR PROVIDING INFORMATION

No representative of the Hospital or Medical Staff and no third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a Practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this Hospital, provided that such representative or third party acts in good faith and without malice and provided further that such information is related to the performance of the duties and functions of the recipient and its reported in a factual manner.

15.5 ACTIVITIES AND INFORMATION COVERED

15.5-1 ACTIVITIES

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility’s or organization’s activities concerning, but not limited to:

(a) Application for appointment, clinical privileges, or specified services.

(b) Periodic reappraisals for reappointment, clinical privileges or specified services.

(c) Corrective or disciplinary action.

(d) Hearings and appellate reviews.

(e) Quality Assessment & Improvement Program activities.
(f) Utilization reviews.

(g) Claims reviews.

(h) Profiles and profile analysis.

(i) Malpractice loss prevention.

(j) Other Hospital and staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

15.5-2 INFORMATION

The information referred to in this Article may relate to a practitioner’s professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

15.6 RELEASES

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of such releases is not a prerequisite to the effectiveness of this Article.

15.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by law not in limitation thereof.

ARTICLE XV. GENERAL PROVISIONS

16.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these Bylaws. The procedures outlined in Article X of these Bylaws shall be followed in the adoption and amendments of the rules and regulations, procedural manuals and other documents.

The Medical Staff, acting as a Committee of the Whole, may perform all the functions and take for itself all of the responsibilities as set forth in these Bylaws, Rules and Regulations, the Fair Hearing Plan, and the Credentialing Procedure Manual.
16.2 CLINICAL SERVICE

Subject to the approval of the MEC and the Board, each clinical service may formulate its own written policies for the conduct of its affairs and the discharge of its responsibilities.

16.3 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine and feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE XVI. ADOPTION AND AMENDMENT

17.1 ACTION REQUIRED

The Organized Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner. Medical Staff Bylaws shall be reviewed at least biannually and may be adopted, amended or repealed by the following combined action:

(a) The affirmative vote of two-thirds of the Medical Staff appointees eligible to vote on this matter who are present at a meeting at which a quorum is present, provided at least ten (10) days written notice accompanied by the proposed Bylaws and/or alterations or amendments, has been given of the intention to take such action.

(b) The affirmative vote of a majority of the Board provided, however, that in the event that the Medical Staff shall fail or refuse to exercise its responsibility and authority as required, and after notice to the Medical Staff from the Board, the Board may resort to its own initiative in formulating or amending the Medical Staff Bylaws, including the Credentialing Procedures Manual, the Rules and Regulations and the Fair Hearing Plan.
BYLAWS OF THE MEDICAL STAFF
OF
MT. SAN RAFAEL HOSPITAL

Adopted by the Medical Staff of Mt. San Rafael Hospital, Trinidad, Colorado

290A14
Date

Chief of Medical Staff

Approved by the Board of Mt. San Rafael Hospital of Trinidad, Colorado

10-20-14
Date

TAHA Board President