BYLAWS OF THE MEDICAL STAFF
EAST MORGAN COUNTY HOSPITAL
BRUSH, COLORADO

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BYLAWS OF THE MEDICAL STAFF OF EAST MORGAN COUNTY HOSPITAL BRUSH, COLORADO

PREAMBLE

WHEREAS, East Morgan County Hospital is operated by Banner Health**,** a nonprofit corporation organized under the laws of the State of Arizona;

WHEREAS, its purpose is to serve as a comprehensive primary care facility providing patient care; and

WHEREAS, it is recognized that the Medical Staff has the initial responsibility for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, the CEO and the Board of Directors are necessary to fulfill the Hospital's obligation to its patients.

THEREFORE, the Practitioners practicing in the Hospital are hereby organized into a Medical Staff in conformity with these Bylaws.

NAME

The name of this organization shall be the Medical Staff of East Morgan County Hospital.

ARTICLE I: PURPOSES

The purposes of the Medical Staff are:

1. To continually seek to provide quality patient care for all patients admitted to, or treated in, any of the facilities, departments or services of the Hospital.

2. To organize into committees in order to review the practices of Members for the purposes of reducing morbidity and mortality. Such review shall include assessment of, and formulation of recommendations concerning, the nature, quality and necessity of the care provided. These Bylaws have been adopted by the Medical Staff and approved by the Board of Directors, in order to provide a mechanism for such review which will be in accordance with applicable federal and state statutes and regulations relating to peer review and quality assurance. It is the intention of these Bylaws that the actions of the Medical Staff in conducting such review, including, without limitation, the actions of its officers, representatives, committees and consultants (including persons who are not Members, but who are requested by any duly authorized officer or committee of the Medical Staff to participate in such review) shall be afforded immunity from civil liability to the fullest

extent permitted by all applicable federal and state statutes and regulations. Furthermore, it is the intention of these Bylaws that the proceedings of the Medical Staff relating to such review (including, without limitation, reports of consultants, minutes of committees and transcripts of hearings) shall be held in strictest confidence and shall not be subject to discovery, production or subpoena except as is specifically compelled by applicable federal and state statutes and regulations.

3. To provide an educational setting which will maintain specific and medical standards and lead to continued advancement of professional knowledge and skill.

4. To initiate and maintain rules and regulations for governing the Medical Staff, which shall be binding on all Members and all Applicants, in accordance with these Bylaws and the policies of the Hospital and the Board of Directors.

5. To provide a means of communication among Members, the CEO and Board of Directors.

ARTICLE II:
DEFINITIONS

The following words, terms or phrases contained in these Bylaws shall be defined as follows:

1. Hospital: The term "Hospital" means East Morgan County Hospital, a primary care facility located in Brush, Colorado.

2. Medical Staff: The term "Medical Staff" means all Practitioners who hold a valid Colorado license and who have been appointed to membership on the Medical Staff and granted clinical privileges by the Board of Directors to attend patients at the Hospital.

3. Allied Health Personnel: The term “Allied Health Personnel” shall have the meaning ascribed to such term in Article XII below.

4. Board of Directors: The term "Board of Directors” means the governing body of Banner Health, or any subcommittee thereof, as may be designated by the governing body of Banner Health, unless otherwise specified.

5. CEO: The term "CEO" shall refer to the chief administrative officer of the Hospital.

6. Executive Committee: The term "Executive Committee" shall refer to the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Board of Directors.

7. Completed Application: The term "completed application" means and refers to an application for appointment or reappointment to the Medical Staff, in such form as the

Board of Directors may require, plus all documentation required by these Bylaws for consideration of an application for appointment or reappointment to the Medical Staff including, but not limited to, the documentation set forth in Article V, Section 2, Paragraph a, and Article V, Section 3.

8. Standards Required by These Bylaws: The phrase "standards required by these Bylaws" means and refers to (a) standards set forth in these Bylaws, (b) standards adopted by the Executive Committee and approved by the Board of Directors, such as those set forth in Article III, Section 2, Paragraph c, and (c) standards required by any policy and procedure statement formally adopted by the Board of Directors.

9. Medical Staff Year: The term "Medical Staff Year" means the period from January 1 to December 31.

10. Corporate Bylaws: The term "Corporate Bylaws" means the corporate bylaws of Banner Health.

11. Applicant: The term "Applicant" means any Practitioner who has applied for initial appointment to the Medical Staff or any Member who has applied for reappointment to the Medical Staff, additional clinical privileges or a change in Medical Staff category.

12. Member: The term "Member" means any Practitioner who has been appointed to membership on the Medical Staff by the Board of Directors.

13. Practitioner: The term "Practitioner" means a doctor of medicine, a doctor of osteopathy, a doctor of dental medicine, a doctor of dental surgery, a podiatrist, a nurse practitioner, a physician assistant, a psychologist, a licensed counselor, or a social worker.

14. Physician: The term "Physician" shall refer to a doctor of medicine or a doctor of osteopathy.

ARTICLE III:
MEDICAL STAFF MEMBERSHIP

Section 1. **Nature of Medical Staff Membership**

Membership on the Medical Staff is a privilege granted by the Board of Directors that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and the rules and regulations of the Hospital and the Medical Staff. Membership on the Medical Staff may be withdrawn at any time, in accordance with these Bylaws, if it is determined that the Member fails to meet the qualifications, standards and requirements of the Hospital. No Applicant shall be denied Medical Staff membership on the basis of sex, race, creed, or national origin, or on the basis of any other criterion lacking professional justification.

Section 2. **Qualifications for Membership**

a. Only Practitioners who can continually document their education, background, experience, training, physical and mental health, and demonstrated current clinical competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others for the cooperative delivery of quality medical care, shall be qualified for appointment and reappointment to the Medical Staff. No Practitioner shall be entitled to membership on the Medical Staff, or to the exercise of any particular clinical privileges, merely by virtue of being licensed to practice in the State of Colorado or in any other state, of being a member of any professional organization, or of having ever been granted such privileges at another hospital.

b. An Applicant shall have the burden of establishing, to the satisfaction of the appropriate committees of the Medical Staff and the Board of Directors, that he/she meets the qualifications, standards and requirements set forth in these Bylaws and the Corporate Bylaws, and that, if granted Medical Staff membership and clinical privileges, he/she would deliver quality medical care.

c. In order to qualify for appointment and reappointment to the Medical Staff and to be granted clinical privileges to practice at the Hospital, each Applicant must continually meet all of the following standards:

1. He/She must possess such credentials for Medical Staff appointment and reappointment and for the specific clinical privileges requested, as the Executive Committee shall, from time to time, establish, subject to final approval by the Board of Directors.

2. At a minimum, he/she possess the following:

A. Graduation from a medical school accredited at the date of graduation by the Liaison Committee on Medical Education, the Canadian Medical Association, or from a college of osteopathic medicine approved by the America Osteopathic Association; graduation from a foreign medical school and evidence of having passed parts I and II of the National Board of Medical Examiners examination or having obtained a permanent certificate from the Educational Council for Foreign Medical Graduates; or graduation from an accredited dental school.

B. An unrestricted license to practice in the State of Colorado issued by the Colorado Board of Medical Examiners, the Colorado Board of Osteopathic Examiners (Medicine and Surgery), the Colorado Board of Dental Examiners, the Colorado Board of Nursing Examiners, the Colorado Board of Optometry, the Colorado Board of Podiatry, or such other State of Colorado licensing board, whichever is applicable.

C. Insurance coverage as required by these Bylaws.

3. He/she must possess the requisite physical and mental health status, skill, proficiency and competency required for the careful practice of medicine, dentistry or other clinical discipline within the clinical privileges requested.

d. Establishing "standards" for Medical Staff membership and for clinical privileges involves an examination of several facets of the Applicant's education, training, experience, background and personal makeup. The "credentialing" process referred to as item 1 above involves an examination of the Applicant's formal education, training, experience and participation in medical societies, associations, groups or specialty organizations, as well as his/her experience at other hospitals and with licensing authorities. In addition, however, it is recognized by item 2 above that an individual Applicant may have received sufficient formal training as to "appear on paper" to be qualified for membership on the Medical Staff or to exercise specific clinical privileges, and yet, because of other factors, be unable to carefully practice that privilege. For example, certain clinical privileges require continued proficiency and skill with surgical instruments, or specialized equipment for diagnosis and treatment. The committees of the Medical Staff and the Board of Directors shall determine and consider the relevant factors for assessing an Applicant's ability to perform certain procedures, and practice within certain privileges. Additionally, an Applicant with proper credentials who, under pressure, stress, substance abuse or other personal circumstances, engages in erratic behavior which is dangerous or contrary to good patient care, shall not be qualified for continued Medical Staff membership or continued clinical privileges. Clinical responsibilities shall be construed to include direct medical care of patients and/or the supervision of the professional activities of non-Physician Practitioners.

e. Acceptance of an application for membership on the Medical Staff shall constitute an agreement that the Applicant will strictly abide by these Bylaws, the principles of Medical Ethics and the rules of the Judicial Council of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the code of Ethics of the American Dental Association, or the specific code of ethics for his/her professional organizations, whichever is applicable.

Section 3. **Conditions and Duration of Appointment**

a. All appointments and reappointments to the Medical Staff shall be made by the Board of Directors. The Board of Directors shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided, however, that, in the event of unwarranted delay on the part of the Medical Staff and after due notification to the appropriate committees of the Medical Staff and the Chief of Staff, the Board of Directors may act without such recommendations on the basis of documented evidence of the Applicant's professional and ethical qualification obtained from reliable sources. Prior to taking such action, however, the Board of Directors shall notify the Medical Staff of its intent and shall designate an action date prior to which the Medical Staff may still fulfill its responsibility.

b. Initial appointments to the Medical Staff shall be governed by the provisions of Article IV, Section 2. Reappointments to the Medical Staff shall be for a period not exceeding twenty-four (24) months and shall be determined in accordance with Article V, Section 3, of these Bylaws.

c. Appointments to the Medical Staff shall confer on the Member only such clinical privileges as have been granted by the Board of Directors in accordance with these Bylaws.

d. As a condition to membership on the Medical Staff, each Member shall acknowledge his/her obligation to provide continuous care and supervision of his/her patients, to abide by these Bylaws and the rules and regulation of the Hospital and the Medical Staff, to accept consultation assignment, and to participate in rotating staffing of the Emergency Room in accordance with established policies.

e. It shall be a condition of membership on the Medical Staff, and a condition to the exercise of any clinical privilege, that the Member shall have in full force and effect a policy or policies of professional liability insurance which are acceptable in form and amount to the Board of Directors, and that the Member has on file with the office of the CEO a certificate of insurance issued by an acceptable insurance carrier specifying the terms of coverage, the policy periods in effect, and the limits of coverage available, and further stating that notice shall be given to the Hospital prior to any termination, cancellation, revocation, lapse or modification of the terms or limits of coverage or any other material changes of any of said policies of insurance.

Section 4. **Responsibilities of Each Member**

a. Each Member shall provide appropriate, timely, and continuous care of his/her patients. He/she is not responsible for the actions of other Members (unless under his/her sponsorship) or Hospital employees.

b. Each Member shall participate, if assigned, in relevant quality/performance improvement activities and in discharging other Medical Staff functions as may be required from time to time.

c. Each Member shall participate in the on-call coverage of the Emergency Room and other coverage programs as determined by the Executive Committee or, if necessary, the CEO.

d. Each Member shall abide by these Bylaws, the rules and regulations of the Medical Staff, and the applicable bylaws, rules, regulations, policies and procedures of the Hospital.

e. Each Member shall prepare and complete, in a timely fashion, according to these Bylaws and the Hospital's policies, the medical and other required records for all

patients to whom the Member provides care in the Hospital, or within its facilities, services or departments.

f. Each Member shall act in an ethical and professional manner, abiding by the principles and standards of ethics established by the applicable national professional association(s), including arranging for appropriate and timely medical coverage and caring for patients for whom he/she is responsible and obtaining consultation when necessary for the safety of those patients.

g. Each Member shall treat as confidential, any information discussed in executive session and use confidential information only as necessary for treatment, payment and healthcare operations in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the Hospital's business information that is designated as confidential by the Hospital or its representatives prior to disclosure.

h. Each Member shall refrain from disclosing confidential information to anyone unless authorized to do so.

i. Each Member shall protect access codes and computer passwords and to ensure confidential information is not disclosed.

j. Each Member shall treat Hospital employees, patients, visitors and other Members in a dignified and courteous manner.

k. Each Member shall demonstrate the ability to work cooperatively and professionally with the Hospital, Hospital staff, and other Members and shall refrain from disruptive behavior that has interfered or could interfere with patient care or the operation of the Hospital and/or the Medical Staff.

l. Each Member shall comply with a request from the Chief of Staff or the CEO to confirm current physical and mental capacity to practice medicine and his/her freedom from, or adequate control of, any physical, mental, or behavioral impairment, including substance and alcohol abuse.

m. Each Member shall promptly notify the CEO of any change in the status of liability coverage, licensure, DEA registration, or any other information on the application form.

n. Each Member shall immediately notify the CEO of his/her denial or loss of staff membership or denial, loss, curtailment, restriction of privileges at any hospital or other healthcare institution, of any adverse determination by a peer review organization concerning his/her quality of care; of the commencement of a formal investigation or the filing of charges by the United States Department of Health and Human Services, any law

enforcement agency, any regulatory agency of the United States, the State of Colorado, or any other state, or of the denial or loss of his/her right to participate in any federal or state program, including the Medicare and Medicaid programs.

Failure to meet these obligations may result in non-reappointment or the imposition of corrective action as provided in Article VII.

Section 5. **Medical Director Role**

a. A medical director is a Member engaged by the Hospital or the Medical Staff, either full or part-time, in an administrative capacity, whose activities may include clinical responsibilities such as direct patient care, research or supervision of the patient care activities of other Members under the medical director's direction.

b. When provided for by contract, a medical director's responsibilities shall include assisting the Medical Staff and/or Banner Health's Care Management Council to carry out its peer review and quality improvement activities. Such medical director may serve as an ex-officio member of all committees of the Medical Staff, without vote, consistent with the scope of his/her responsibility.

Section 6. **Cooperativeness**

Demonstrated ability to work with, and relate to, others in a cooperative, professional manner is essential for maintaining an environment appropriate to quality and efficient patient care. It is the policy of the Hospital and the Medical Staff, that all individuals within its facility be treated courteously, respectfully, and with dignity. The Medical Staff prohibits and shall not tolerate abuse or harassment by Members. This includes verbal or physical behavior that a reasonable person would regard as hostile, intimidating, disrespectful, or offensive. Should claims about such behavior occur, the situation shall be investigated. If inappropriate behavior is determined to have occurred, the situation shall be judged on the nature and severity of the behavior, as well as patterns of behavior.

In order to effectively and expeditiously address complaints from Hospital staff concerning Member conduct and/or behavior (other than quality of care issues), each complaint shall be submitted, and shall be processed, in accordance with the Medical Staff Disruptive Practitioner Policy. The Medical Staff and the Hospital shall, to the extent permitted by law, protect the identity of complainants and the confidentiality of the information, ensuring an environment of fairness for all involved.

As appropriate, Hospital administration shall adopt policies and procedures consistent with the policy and these Bylaws, to inform Hospital personnel about the mechanisms and processes for lodging complaints about Member conduct.

Complaints of sexual harassment also shall be handled in accordance with the Banner Health Sexual Harassment Policy and Procedure A-601.

ARTICLE IV:
CATEGORIES OF THE MEDICAL STAFF

Section 1. **Staff Categories**

The Medical Staff shall be divided into the following categories: Active Medical Staff, Associate Medical Staff, Courtesy Medical Staff, Honorary Medical Staff and Telemedicine Staff.

a. Active Medical Staff: The Active Medical Staff shall consist of those Members who practice primarily at the Hospital and have demonstrated a special interest in the Hospital by regularly admitting, treating and/or performing consultations for patients cared for at the Hospital and by taking an active role in Medical Staff affairs by accepting and fulfilling committee assignments, serving as Medical Staff officers, and otherwise contributing to the accomplishment of the Medical Staff purposes. Members of the Active Medical Staff shall have delineated clinical privileges and shall be eligible to vote, to hold office and to serve on Medical Staff committees; provided, however, that the non-Physician members of the Active Medical Staff may not vote on specified matters or hold specified offices for which specific professional education, training and experience are deemed prerequisites for making an informed judgment thereon or for carrying out the duties thereof.

Physician members of the Active Medical Staff may admit patients as provided in these Bylaws. A non-Physician member of the Active Medical Staff may co-admit a patient with a Physician member of the Active Medical Staff, provided it is demonstrated at the time of admission that the Physician member of the Active Medical Staff has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problems that may be present or may arise during hospitalization.

b. Associate Staff: The Associate Staff shall consist of those Members who meet the requirements of one of the following categories: (1) they are Hospital-based Practitioners who do not practice primarily at the Hospital; or (2) they are locum tenens Practitioners who provide services at the Hospital for an extended period of time.

Members of the Associate Staff who are Hospital-based Practitioners or locum tenens Practitioners may serve as attending or admitting physicians and as surgeons of record.

The members of the Associate Staff shall hold such other clinical privileges, with appropriate limitation, if any, as are approved by the Board of Directors in accordance with these Bylaws. In addition, the members of the Associate Staff are not eligible to vote or to hold medical staff offices. Members of the Associate Staff shall be eligible to serve on Medical Staff committees, if directed to do so by the Chief of Staff, or his/her designee.

Members of the Associate Staff must have at least two (2) patient management contacts within the last two (2) years in order to be eligible for reappointment to the Associate Staff. Practitioners who qualify for membership on the Active Staff are not eligible to apply for membership on the Associate Staff.

c. Courtesy Medical Staff: The Members assigned to the Courtesy Medical Staff shall consist of those Members who only occasionally admit patients to the Hospital (less than thirty (30) per year), who act primarily as consultants, or whose primary inpatient practice is elsewhere than in Brush, Colorado. If they wish, such Members may apply to be members of the Active Medical Staff if they are willing to accept the obligations thereof. Members of the Courtesy Medical Staff shall have full privileges of admitting patients, within the scope of their respective licensure, and may serve as members of special, ad hoc or standing Medical Staff committees. Members of the Courtesy Medical Staff shall not be eligible to hold medical staff offices or vote. Members of the Courtesy Medical Staff shall have specifically delineated clinical privileges.

d. Community-Based Provider Staff: The Community-Based Provider Staff shall consist of Members who do not treat patients at Hospital but who request services from Hospital for their patients, who have no clinical privileges at Hospital and who are exempt from computerized physician order entry training.

A member of the Community-Based Provider Staff may:

1. Order outpatient diagnostic services for patients;

2. Make courtesy visits to patients;

3. Be appointed to Medical Staff committees unless otherwise provided by these Bylaws or another Medical Staff Document;

4. Vote on matters presented to any Medical Staff committee to which he/she has been appointed, unless otherwise limited by these Bylaws or by another Medical Staff Document;

5. Attend, but not vote at, meetings of the Medical Staff;

6. Attend continuing medical education programs at Hospital; and

7. Provide information and/or ongoing support to admitting Members regarding the care of patients.

Members of the Community-Based Provider Staff are not allowed to admit, treat or consult on patients who are admitted to Hospital or to write orders for such patients while they are admitted to Hospital. Members of the Community-Based Provider Staff shall not be eligible to hold elected office.

Notwithstanding anything contained in any Medical Staff Document to the contrary, members of the Community-Based Provider Staff are not entitled to due process rights under these Bylaws or the Corrective Action/Fair Hearing Plan. An Applicant who believes he/she was wrongly denied membership on the Community-Based Provider Staff or a member of the Community-Based Provider Staff who believes his/her membership was wrongly terminated may submit information to the Medical Executive Committee demonstrating why such denial or termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission. The Applicant or Member shall have no appeal or other rights in connection with the Medical Executive Committee's decision.

e. Honorary Medical Staff: The Honorary Medical Staff shall consist of Members not active in medical/clinical practice but who, because of outstanding reputation, service, or recognition, may be appointed to the Honorary Medical Staff. They shall not be eligible to vote, hold medical staff offices, or serve on standing committees, and they may not admit patients. The term of appointment for members of the Honorary Medical Staff shall be indefinite.

f. Telemedicine Staff: The Telemedicine Staff category shall consist of practitioners who remotely practice privileges granted and do not physically treat patients in the Hospital. The Telemedicine Staff category is for members who provide diagnostic treatment delivered through a telemedicine medium. Specific delineation of privileges for Telemedicine shall define the ability to write orders and/or manage direct patient care. Members of the Telemedicine Staff shall not serve as the attending, admitting, or surgeon of record for any patient. As Members of the Medical Staff, Telemedicine Staff shall be fully credentialed and when a telemedicine practitioner is providing services from a different State, licensure will be verified for both Colorado and the State where the practitioner is located. Telemedicine Staff members are subject to focused professional practice evaluation and ongoing professional practice evaluations.

1. Prerogatives: Members of the Telemedicine Staff may practice privileges granted from a remote location through electronic communication. Telemedicine Staff shall not be eligible to vote or hold office within the Medical Staff organization. Telemedicine Staff may attend educational events, Department meetings, or any other meetings of the Medical Staff unless otherwise specified elsewhere.

2. Obligations: Each member of the Telemedicine Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide unassigned patient call or perform any other duties for which on site clinical privileges are required, they shall pay all required Medical Staff dues and assessments in a timely manner; participate in the training and subsequent use of the electronic medical record system, including computerized physician order entry; and perform such further duties as may be required under these Bylaws or Rules and Regulations.

Section 2. **Initial Appointment**

All initial appointments to the Medical Staff are subject to the following conditions:

a. A period of monitoring as shall be determined by the Executive Committee and as more particularly set forth in the Banner Health Medical Staff Focused Professional Practice Evaluation (FPPE) Policy. FPPE is a time-limited process whereby the Executive Committee evaluates the privilege-specific competency of the Member or the Member's ability to provide safe, high quality patient care. These requirements may be waived or reduced by the Executive Committee, as long as approved by the Board of Directors. Such waiver may be considered in the case of a Member who is an extensively experienced practitioner or in such other circumstances as may be appropriate.

b. The FPPE monitoring shall be performed by at least one (1) physician with appropriate experience who is appointed by the Chief of Staff. In the event that there are no physicians on the Medical Staff with appropriate qualifications, or when otherwise deemed advisable, the Chief of Staff may appoint a qualified physician from outside the Medical Staff to perform the FPPE monitoring function. While preferable that the outside physician directly observe the Member, the outside monitoring physician may perform the FPPE monitoring by review of a required number of medical records.

c. The required monitoring under FPPE shall be completed within the time frame established by the Executive Committee but in no event longer than twelve (12) months from the Member's initial appointment. The Executive Committee may, due to inadequate caseload or other good cause, extend the period for completion of monitored cases up to a maximum of twenty-four (24) months. A written report shall be submitted by each physician monitoring the subject Member to the Executive Committee. Until the Executive Committee acts upon the reports received, the FPPE monitoring shall continue. Once approved, the Member shall be subject to reappointment at the end of the Medical Staff year in which other members are subject to reappointment.

d. In the event of concerns regarding the Member's patient care activity or the monitored/proctored cases, or if the Member does not successfully complete the FPPE process, or whenever an extension is denied, the Chief of Staff will provide him or her with special notice of the adverse result and of his or her entitlement to the procedural rights provided in the Hospital's Fair Hearing Plan.

ARTICLE V:
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

Section 1. **Appointment**

a. It shall be the responsibility of each Applicant to supply all information reasonably required by the Medical Staff committees and Board of Directors in order to make an informed judgment as to the Applicant's qualifications and compliance with the standards required by these Bylaws. To that end, it shall be the responsibility of the Applicant to supply all information requested by the appropriate committees of the Medical Staff, the officers of the Medical Staff, the CEO, and/or the Board of Directors, and the Applicant's duty to supply such information is not necessarily fulfilled simply by completing the application form. The Applicant shall have the burden of establishing to the satisfaction of the appropriate Medical Staff committees and the Board of Directors that the standards set by these Bylaws, the rules and regulations of the Hospital and the Medical Staff, and any applicable policies of the Board of Directors are met. In the event that the information supplied by the Applicant to the committees of the Medical Staff and the Board of Directors is not sufficient to permit an informed decision on the matter or if any requested information is not obtained from the Applicant within thirty (30) days after written to the Applicant of the request for same, then the application for appointment to the Medical Staff and for clinical privileges will be deemed withdrawn from consideration and no further action will be taken on it.

b. All Applicants shall complete, sign and file with the CEO, or the CEO's designee, such application or reappointment forms as the Board of Directors may require. Such forms shall require full and complete disclosure by the Applicant of all information required by this Article V, Section 1, Paragraph a, including, without limitation, the following matters:

1. Education: The form shall require a full disclosure of all the institutions of higher learning attended by the Applicant (meaning all institutions attended after graduation from high school), including dates of attendance, areas of study and degrees awarded.

2. Training: The form shall require a complete listing of all training programs of two (2) or more months in duration, which are medically or health care related, in which the Applicant has participated, and as to those programs completed by the Applicant, the date of completion.

3. Professional Qualifications: The form shall require a full disclosure of all factors bearing upon the Applicant's professional qualifications. This shall include a listing of at least one (1) professional who is personally acquainted with the Applicant and has extensive experience in observing and working with the Applicant, and is in a position to provide adequate references pertaining to the Applicant's current professional competence, ethical character and compliance with the standards required for appointment to the Medical Staff as set forth in this

Article V, Section 1, Paragraph a. The form shall require the Applicant to identify all specialty boards to which he/she has applied for certification and dates of certification, if any. As to those Applicants who are not board certified in any field of practice, but who consider themselves to the "board eligible," the Applicant shall provide information concerning the date upon which he/she first became board eligible and the basis upon which board eligibility is claimed.

4. Organizational Experience: The form shall require a complete listing of all medical, surgical or health related organizations to which the Applicant currently belongs and the status of the Applicant's membership. This includes not only specialty organizations, but professional societies and other professional organizations of every type.

5. Hospital Experience: The form shall require a complete listing of every hospital facility or other acute care facility, including governmentally owned or operated facilities, at which the Applicant has applied for and/or received medical staff or other patient care privileges. This shall require full disclosure by the Applicant of action by any such health care facility to deny, revoke, limit, suspend or take corrective action concerning the Applicant's privileges or medical staff appointment.

6. Peer Review Information: The form shall require a full disclosure of all peer review information from hospitals or professional societies and organizations (including, without limitation, specialty boards) in which any form of disciplinary or corrective action was taken, recommended or requested.

7. Insurance Experience: The form shall require a full disclosure of the Applicant's insurance and malpractice claims experience, including a certificate of insurance by a reliable insurance carrier indicating that the Applicant has, in full force and effect, valid and collectible insurance with coverages and policy limits in such amounts as the Board of Directors may, from time to time, determine. The Application shall require a full disclosure of all claims made against the Applicant involving allegations of professional negligence or malpractice and shall identify the person making the claim, the current status of all pending claims and the ultimate disposition of all closed claims.

8. Licensing Experience: The form shall require full disclosure of the Applicant's experience with regard to any licensing agency of any federal, state of local government, including all licenses granted, denied, suspended or revoked relating to the privilege of practicing any health care profession.

9. Felony Information: The form shall require full disclosure of any current felony criminal charges pending against the Applicant and any past charges including their resolution.

10. Exclusion Information: The form shall require full disclosure of any pending or current action against the Applicant that may exclude him/her from participation in Medicare and/or any other federally-supported healthcare program.

11. Physical and Mental Health Status: The form shall require full disclosure of any physical or mental condition which could affect the Applicant's ability to exercise the clinical privileges requested, or which would require an accommodation in order for the Applicant to exercise the privileges requested, safely and competently. Regardless of the nature of the response, all applications will be processed in the usual manner. If an Applicant answers this question affirmatively and is found to be professionally qualified for Medical Staff membership and the clinical privileges requested, the Applicant will be given an opportunity to meet with the Executive Committee to determine what accommodations may be necessary or feasible to allow the Applicant to practice safely.

c. By making application for appointment or reappointment to the Medical Staff, the Applicant acknowledges the responsibility to give full, complete and accurate information. Any failure to give true, complete and accurate information concerning the matters required by these Bylaws, including the making of untrue statements in the application for appointment or the failure to make materially true statements in said application, shall be sufficient grounds for denial of the application for appointment or for automatic suspension of privileges already granted.

d. By making application for appointment or reappointment to the Medical Staff, the Applicant agrees to submit to such physical or mental examination(s), solely at Applicant's expense, as the Executive Committee or the Board of Directors may require.

e. The forms shall include a statement that the Applicant has received and read these Bylaws and the rules and regulations of the Hospital and the Medical Staff, and that the Applicant agrees to be bound by the terms thereof without regard to whether or not the Applicant is granted membership and clinical privileges.

f. Qualified Applicants in administrative or employed positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other Applicants for membership or privileges.

Section 2. **Appointment Process**

The application for appointment to the Medical Staff shall be processed in the following manner:

a. Review and evaluation of an application for appointment to the Medical Staff shall not commence until the Applicant has delivered, or caused to be delivered to the CEO, or the CEO's designee, all of the following documentation: a completed application

form, a completed clinical privilege application, copies of professional degrees and certificates of completion, copies of current licensure, copies of insurance policies and certificates of insurance, responses to letters of inquiry from the CEO, or the CEO's designee, a response from the National Practitioner Data Base and any other information which has been requested by the Medical Staff or the Board of Directors and is within the scope of the provisions of Article V, Section 1. Upon receipt by the CEO, or the CEO's designee, of all of the foregoing documentation, review and evaluation of the application shall be commenced. For purposes of these Bylaws, all of the documentation referred to in this Article V, Section 2, Paragraph a and Article V, Section 1 shall be referred to as the "completed application."

b. The completed application shall be reviewed and evaluated by the Medical Staff in accordance with this Article V, Section 2, Paragraph b, and the Medical Staff shall formulate recommendations to the Board of Directors concerning the Applicant's compliance with the standards required by these Bylaws.

1. The completed application shall be referred to the Executive Committee. The Executive Committee shall review the Applicant's qualifications and measure them against the standards required by these Bylaws**.** The Executive Committee may elect to conduct an interview.

In special situations where there are no Members on the Executive Committee with the appropriate qualifications to review the Applicant's qualifications and requested privileges, the Chief of Staff can appoint one (1) or more Members, if possible, or one (1) or more Practitioners from outside the Medical Staff, to serve as a consultant to the Executive Committee for the specific purpose of helping the Executive Committee make a recommendation on the Applicant.

2. Upon approval of the Applicant by the Executive Committee and the Chief of Staff, the Applicant may request temporary privileges as provided in Article VI, Section 2 of these Bylaws.

3. The Executive Committee shall take action on the matter. The forms of action available to the Executive Committee include: (a) referral of the matter to a subcommittee for further determination of specified issues, for clarification or recommendations, or for the gathering of additional information; (b) approval of the application for appointment and the formulation of a recommendation to the Board of Directors concerning the granting of Medical Staff membership and delineated clinical privileges; or (c) recommendation against appointment to the Medical Staff, and/or recommendation against granting of any or all of the clinical privileges requested by the Applicant.

4. The committees of the Medical Staff shall use best efforts to complete their review process as outlined above within ninety (90) days of receiving a completed application.

c. In the event of a favorable recommendation by the Executive Committee, such recommendation shall be forwarded to the Board of Directors to take action on the matter.

d. In the event it is the initial recommendation of the Executive Committee that the Applicant be denied appointment to the Medical Staff, or that appointment be made to the Medical Staff but with fewer privileges than had been requested, then the following procedures shall apply:

1. The CEO shall send notice of the unfavorable recommendation to the Applicant at the address shown on the application.

2. The Applicant shall have thirty (30) days from the date such notice is received within which to make a written request for a hearing pursuant to the Fair Hearing Plan. Failure to make a timely request for a hearing shall constitute a waiver of any hearing or appeal otherwise available under the Fair Hearing Plan, and shall constitute a consent to the taking of final action by the Board of Directors.

3. In the event of a timely request by the Applicant for a hearing, the proceedings provided for in the Fair Hearing Plan shall be completed and the Hearing Committee shall report its findings and recommendations to the Executive Committee.

4. The findings and recommendations of the Hearing Committee shall be advisory, and the Executive Committee shall have the authority and power to make the final recommendation, based on the record of the proceeding, of the Medical Staff.

5. The Executive Committee's final recommendation shall be forwarded to the Board of Directors for action. If the Executive Committee's final recommendation is unfavorable, the Applicant shall receive notice of said recommendation, and shall have the right to make a request for an appeal to the Board of Directors pursuant to the Fair Hearing Plan. Failure to make a timely, proper request for appellate review shall constitute a waiver of any appellate review and shall be a consent to the taking of final action by the Board of Directors.

6. Following completion of the Medical Staff hearing and Board appeal as are available under these Bylaws and the Fair Hearing Plan, the Board of Directors shall take action on the matter.

e. In taking action on the final recommendation of the Executive Committee, the Board of Directors may:

1. adopt the recommendations of the Executive Committee, in whole or in part, and act accordingly;

2. refer the matter back to any committee of the Medical Staff, including the Executive Committee or the Hearing Committee for gathering additional information or for clarification of prior recommendations;

3. grant Medical Staff membership and clinical privileges as may appear, in the judgment of the Board of Directors, appropriate under the circumstances and with such limitations and qualifications as the Board of Directors may impose; or

4. deny appointment to the Medical Staff and/or deny some or all of the requested clinical privileges. The Board of Directors may grant clinical privileges conditioned upon the performance of certain acts by the Applicant, including, but not limited to, monitoring, special education or training, or such other provisions as may, in the judgment of the Board of Directors, be advisable for proper patient care.

f. In the event the final recommendation of the Executive Committee is favorable to the Applicant, and the Board of Directors votes to deny the Applicant membership on the Medical Staff and/or to deny the Applicant the requested Medical Staff privileges, then notice of such decision shall be given the Applicant in writing by the CEO. Failure to make a timely request for a hearing shall constitute a waiver of any further review by the Board of Directors or any other committee of the Medical Staff, and shall constitute consent by the Applicant to final action by the Board of Directors. If a timely request for a hearing is made, final action by the Board of Directors shall be delayed until after completion of the fair hearing process as provided under the Fair Hearing Plan.

g. When the decision of the Board of Directors is final, it shall send notice of such decision through the CEO to the Vice Chief of Staff, to the Chief of Staff; and, by certified mail, return receipt requested, to the Applicant.

h. The time periods set forth in this Article V, Section 2 are guidelines and do not create any right to have an application processed within a specified period of time. If an Applicant is entitled to any procedural rights provided in the Fair Hearing Plan, the time requirements contained therein will govern the subject proceedings.

Section 3. **Reappointment Process**

a. In order to be granted continuing Medical Staff membership and clinical privileges, it shall be the responsibility of the Applicant to supply the appropriate committees of the Medical Staff and the Board of Directors with updates of all the current information required for initial appointment to the Medical Staff under the provisions of Article V, Section 1. The Applicant must specifically address whether the Applicant's license to practice his/her profession has ever been voluntarily or involuntarily limited, diminished, or revoked. After submission of such information, the committees of the Medical Staff and the Board of Directors shall determine whether the Applicant continues to meet all of the standards required by these Bylaws. In order to secure the continuation of

the Medical Staff membership and privileges, the Applicant must complete, sign and file with the CEO, or the CEO's designee, an application for reappointment in such form as the Board of Directors may require. It shall also be the responsibility of the Applicant to supply such other information as may be reasonably requested by representatives of the Executive Committee and/or Board of Directors, within fifteen (15) days of receiving the request therefore, in order that each may make an informed judgment as to the Applicant's compliance with the standards required by these Bylaws. If any requested information is not obtained from the Applicant within thirty (30) days after written notice to the Applicant of the request for same, the subject application shall be deemed withdrawn from consideration and no further action shall be taken on such application.

b. The reappointment process shall be commenced prior to the expiration of the Member's current Medical Staff appointment as follows:

1. At least one hundred twenty (120) days prior to the expiration of the Member's current Medical Staff appointment, the CEO, or the CEO's designee, shall cause to be mailed to the Member at the most recent business address found in the Hospital records, or shall hand deliver to the Member, a reappointment form.

2. The Applicant shall complete the form, sign it, and file it with the CEO, or the CEO's designee.

3. The completed reapplication form, and such other information as may be requested by the Medical Staff or the Board of Directors, shall be forwarded to the Executive Committee. The Executive Committee shall take action thereon and shall make recommendations to the Board of Directors concerning renewal of the Applicant's Medical Staff membership and renewal, extension, or curtailment of his/her clinical privileges.

In special circumstances where there are no Members on the Executive Committee with the appropriate qualifications to review the Applicant's reapplication form, the Chief of Staff can appoint one (1) or more Members, if possible, or one (1) or more Practitioners from outside the Medical Staff, to serve as a consultant to the Executive Committee for the specific purpose of helping the Executive Committee make a recommendation on the Applicant.

4. The committees of the Medical Staff shall use best efforts to complete their review process as outlined above within ninety (90) days.

c. In the event the recommendation of the Executive Committee is favorable to the Applicant, the recommendation shall be forwarded to the Board of Directors for action.

d. In the event the initial recommendation of the Executive Committee is adverse to the Applicant, in that the Executive Committee recommends against continuation of the Applicant's Medical Staff membership or recommends against the granting of any or

all clinical privileges, then notice of such recommendation shall be given the Applicant in writing by the CEO, and the following process shall apply:

1. The Applicant shall have thirty (30) days from the date of receipt of said notice within which to request a hearing pursuant the Fair Hearing Plan. Failure to request a hearing within said time shall constitute a waiver of all further proceedings by the Medical Staff, and shall constitute a consent to final action by the Board of Directors.

2. In the event the Applicant makes a timely request for a hearing, the proceedings provided for in the Fair Hearing Plan shall be completed, and the Hearing Committee shall report its findings and recommendations to the Executive Committee.

3. The findings and recommendations of the Hearing Committee shall be advisory, and the Executive Committee shall have the authority and power to make the final recommendation, based on the record and proceeding, of the Medical Staff.

4. The Executive Committee's final recommendation shall be forwarded to the Board of Directors for action. If the Executive Committee's final recommendation is unfavorable, the Applicant shall receive notice of said recommendation, and shall have the right to make a request for an appeal to the Board of Directors pursuant to the Fair Hearing Plan. Failure to make a timely, proper request for appellate review shall constitute a waiver of any appellate review, and shall be a consent to the taking of final action by the Board of Directors.

5. Following completion of the hearing and the Board appeal as are available under these Bylaws and the Fair Hearing Plan, the Board of Directors shall take action on the matter.

e. In taking action upon the final recommendation of the Executive Committee, the Board of Directors may:

1. adopt the recommendations of the Executive Committee, in whole or in part, and act accordingly;

2. refer the matter back to a committee of the Medical Staff**,** to be appointed by the Chief of Staff, including the Executive Committee or the Hearing Committee, for gathering of additional information or for clarification of prior recommendations;

3. grant Medical Staff reappointment and clinical privileges as may appear, in the judgment of the Board of Directors, appropriate under the circumstances and with such limitations and qualifications as the Board of Directors may impose; or

4. deny reappointment to the Medical Staff, and/or any, some or all of the requested clinical privileges. The Board of Directors may grant privileges conditioned upon the performance of certain acts by the Applicant, including, but not limited to, monitoring, special education or training, or other such provisions as may, in the judgment of the Board of Directors, be advisable for proper patient care.

f. In the event the final recommendation of the Executive Committee is favorable to the Applicant, and the Board of Directors votes to deny the Applicant reappointment to the Medical Staff and/or to deny the Applicant any or all Medical Staff privileges requested, then notice of such decision shall be given the Applicant in writing by the CEO. Failure to make timely request for a hearing shall constitute a waiver of any further review by the Board of Directors or any other committee of the Medical Staff, and shall constitute consent by the Applicant to final action by the Board of Directors. If a timely request for a hearing is made, final action by the Board of Directors shall be delayed until after completion of a hearing under the Fair Hearing Plan.

g. The time periods set forth in this Article V, Section 3 are guidelines and do not create any right to have an application processed within a specified period of time. If an Applicant is entitled to any procedural rights provided in the Fair Hearing Plan, the time requirements contained therein will govern the subject proceedings.

Section 4. **Leaves of Absence**

a. A Member may be granted a voluntary leave of absence by the CEO, upon the recommendation of the Executive Committee, and subject to the approval of the Board of Directors, to enter military service, to pursue specialized studies in medical or related scientific fields, for other educational purposes, for emergency situations or for other personal reasons, including medical reasons. Such leave of absence shall be for a specified period of time, not to exceed two (2) years.

b. The Member must submit a request in writing to the Executive Committee (except in an emergency situation, when a verbal request may be directed to the CEO or the Chief of Staff, or their respective designees), explaining the reason for the request and the expected time of return to the community to resume practice. The Executive Committee shall consider such request and shall make a recommendation regarding same to the CEO, and the CEO shall forward such recommendation to the Board of Directors for final action.

Upon request and for such purposes as it deems appropriate, the Executive Committee may extend the period of a previously granted leave of absence to a maximum of two (2) years. Absence for longer than the period of time granted for a leave shall constitute voluntary resignation of Medical Staff membership and clinical privileges.

c. During the duration of a leave of absence, the clinical privileges, prerogatives, and responsibilities of the Member who has been granted such leave of absence shall be suspended.

d. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that a Member has not demonstrated good cause for a leave, or where a request for extension of a leave of absence is not granted, the determination shall be final, with no recourse to a hearing and appeal.

e. If such leave does not extend beyond the Member's current appointment term, then the Member may be reinstated by the Board of Directors upon:

1. Written request;

2. The submission of a statement of the Member's professional activities during the leave of absence as well as evidence of current licensure, DEA registration (if applicable), and liability insurance coverage; and

3. A recommendation of approval from the Executive Committee.

In acting upon a request for reinstatement, the Executive Committee may recommend reinstatement either in the same or a different Medical Staff category, and may recommend limitation or modification of the Member's clinical privileges. Furthermore, the Executive Committee may evaluate the Member's statement of professional experience during the leave of absence, and shall have the discretion to determine whether the Member continues to meet the qualifications for membership required by these Bylaws and whether he/she continues to demonstrate the proficiency required for the clinical privileges that he/she has requested. The Member requesting reinstatement shall provide such other information as may be requested by the Executive Committee.

If the recommendation of the Executive Committee is adverse to the Member, such recommendation shall be processed in accordance with the Fair Hearing Plan.

f. If such leave of absence extends beyond the Member's current appointment term, upon return, the Member must make formal application for reappointment to the Medical Staff and shall, upon applying for reappointment, supply the Hospital with all pertinent information concerning activities during the leave of absence, including certification of military service, letters of reference from commanding officers, directors of specialized training, and/or such other information as the Executive Committee may request.

g. If the leave of absence was for medical reasons, the Member requesting reinstatement shall submit to the Executive Committee a report from his/her Practitioner indicating that the Member is physically and mentally capable of exercising those clinical privileges that have been requested.

Section 5. **Requests for Modification of Appointment**

A Member may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category or clinical privileges by submitting a

written application to the CEO, or the CEO's designee, on the prescribed form. Such application shall be processed in substantially the same manner as provided in Article V, Section 3 for reappointment.

ARTICLE VI:
CLINICAL PRIVILEGES

Section 1. **Clinical Privileges Restricted**

a. Every Member shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors, except as provided in Article VI, Section 2 and Article VI, Section 3.

b. The following must be successfully completed, **as applicable**, prior to exercising Privileges at the Hospital:

1. Banner Health's electronic medical record/computerized physician order entry (CPOE) training; and

2. Banner Health's electronic New Provider Orientation (NPO).

c. Every application for Medical Staff appointment and reappointment must contain a request for specific clinical privileges desired by the Applicant on such form as the Board of Directors may require. The evaluation of such requests shall be based upon the Applicant's compliance with the standards required by these Bylaws. The Applicant shall have the burden of establishing qualifications and current clinical competency in the requested clinical privileges.

d. Privileges granted to non-Physician Members shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of diagnoses and procedures that each non-Physician Member may perform shall be specifically delineated and granted in the same manner as all other privileges. All patients of non-Physician Members shall receive the same basic medical appraisal as patients admitted to other surgical services by a Physician Member. A Physician Member shall be responsible for the care of any medical problem that may be present at the time of admission, or that may arise during hospitalization.

e. In the event a request for clinical privileges is submitted for a procedure for which no criteria have been created, the request shall be tabled for a reasonable period of time during which the Board of Directors shall, after consultation with the Executive Committee, formulate the necessary criteria unless it is determined that such a procedure shall not be performed at the Hospital. Once objective criteria have been established, the original request shall be processed as described herein.

Section 2. **Temporary Privileges**

a. Upon receipt of a completed application for Medical Staff membership, including, without limitation, written evidence of current state licensure, required insurance coverage and DEA certificate, from an appropriately licensed Applicant, and with the approval of the Chief of Staff, or his/her designee, the CEO may grant temporary admitting and clinical privileges to the Applicant for up to sixty (60) days; provided, however, that in exercising such privileges, the Applicant shall act under the supervision of the Member whom the Chief of Staff assigns to monitor the Applicant's practice.

b. Temporary clinical privileges may also be granted by the CEO for the care of a specific patient to Practitioners who do not intend to become Members under the following terms and conditions: The Applicant for temporary clinical privileges shall advise the Chief of Staff, or his/her designee, of the Applicant's qualifications and the extent to which the Applicant complies with the standards required by these Bylaws, and shall furnish proof of licensure and proof of adequate professional liability insurance coverage. Under such circumstances, and upon the recommendation of the Chief of Staff, or his/her designee, the CEO may grant temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than two (2) inpatients in any six (6) month period.

c. A Practitioner may be permitted to serve as a locum tenens for a Member or for the Hospital under the following conditions:

1. The Member desiring to utilize a locum tenens Practitioner shall advise the CEO of the name and address of the proposed locum tenens Practitioner and the period of time during which the Member will be absent from the community. Such notification shall be made at least three (3) weeks prior to the Member's scheduled departure. It is the responsibility of the Member to insure that the proposed locum tenens Practitioner complies, in all respects, with the provisions of these Bylaws. The CEO shall advise the Chief of Staff of the name and address of any proposed locum tenens Practitioner that the Hospital desires to utilize.

2. The locum tenens Practitioner shall complete and sign an application for appointment to the Medical Staff and request specific privileges. The application will not be processed for review, but appropriate licensure, DEA/controlled substances registration, and adequate professional liability insurance coverage will be confirmed, the National Practitioner Databank will be queried, and a complete written reference specific to the requested privileges will be obtained. By signing the application, the locum tenens Practitioner agrees to be bound by these Bylaws and the rules and regulations of the Hospital and the Medical Staff.

3. Upon receipt of a written request, an appropriately licensed Practitioner, who is serving as a locum tenens for a Member or the Hospital may, without applying for membership on the Medical Staff, be granted temporary privileges for an initial period of sixty (60) consecutive days. Such privileges may be renewed for one additional period of sixty (60) days, not to exceed his/her services

as locum tenens. A Practitioner serving as a locum tenens may not be granted temporary privileges more than once in any twelve (12) month period.

4. The CEO may permit the locum tenens Practitioner to care for patients in the Hospital only with the approval of the Chief of Staff.

d. Temporary privileges also may be granted to a Practitioner to teach and/or proctor a procedure or treatment, to a potential applicant for Medical Staff membership during his or her site visit, or to a Member to be proctored for a new procedure or treatment that he or she wishes to add.

e. Special requirements or conditions may be imposed by the Chief of Staff or the CEO on any Practitioner granted temporary privileges. The CEO may, at any time and without notice, revoke temporary privileges, and shall revoke the temporary privileges of a Practitioner when requested to do so in writing by the Chief of Staff. Revocation of temporary privileges shall not be subject to review by any committee of the Medical Staff or the Board of Directors, and such termination shall not be the subject of any proceedings under the Fair Hearing Plan. Where appropriate or necessary, the Chief of Staff shall arrange for the continued care of patients who have been admitted by a Practitioner whose temporary privileges have been terminated.

f. Upon the recommendation of the Chief of Staff or another member of the Executive Committee, the CEO, or his/her designee, may grant temporary privileges to a Practitioner who is volunteering in the event of a mass disaster when the emergency management plan of the Hospital has been activated and the Hospital is unable to meet immediate patient needs, but only after the identity of the Practitioner has been verified. The minimum acceptable sources of identification for the Practitioner providing emergency care include a valid license or a passport and at least one (1) of the following: (1) a current picture hospital identification card that clearly identifies the volunteer Practitioner's professional designation; (2) a current license to practice medicine in the United States; (3) identification indicating that the volunteer Practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized Federal or State organization or group; or (4) identification indicating that the volunteer Practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a Federal, State, or municipal entity). Whenever possible, Practitioners who are volunteering will be assigned to a Member by the Chief of Staff, or his/her designee, for oversight of the care provided, which oversight may be done by direct observation and/or clinical record review. Such temporary privileges shall last for the duration of the disaster or for ninety (90) days, whichever occurs first. Verification of the credentials of any Practitioner granted disaster privileges will begin as soon as the immediate situation is under control and will be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, if possible. If extraordinary circumstances, such as no means of communication or lack of resources, prevent the primary source verification from being completed within seventy-two (72) hours, the CEO, or his/her designee, shall document (i) the reason for the delay, (ii) evidence

of a demonstrated ability on the part of the volunteer Practitioner to provide adequate care, treatment and services, and (iii) all attempts to rectify the situation as soon as possible. The Hospital shall make a decision, based on the information obtained regarding the professional practice of the volunteer Practitioner, within seventy-two (72) hours related to the continuation of the disaster privileges initially granted to such volunteer Practitioner. The verification process will be the same as described in this Article VI, Section 2. Furthermore, notwithstanding any existing delineation of privileges or scope of authority, Members, Hospital employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or the public health during a mass disaster.

Section 3. **Emergency Medical Situations**

In the event of a medical emergency, any Member, to the degree permitted by his/her license and regardless of service or Medical Staff status, shall be permitted to do everything reasonably possible to save the life of a patient, using every available facility of the Hospital. When an emergency situation no longer exists, such Member must request the privileges necessary if he/she desires to continue to treat the patient. In the event such privileges are denied or not desired, the patient shall be assigned to an appropriate Member by the Chief of Staff or designee. For the purpose of this Article VI, Section 3, an "emergency" is defined as a condition in which serious permanent harm or death would result to a patient, and any delay in administering treatment would add to that danger.

ARTICLE VII:
PROFESSIONAL REVIEW PROCEDURES AND CORRECTIVE ACTION

Section 1. **Nature of Professional Review Procedures**

a. Resolution of any controversy or request for further review of a Member's compliance with these Bylaws shall, if possible, be accomplished by an informal, intra professional review procedure by the appropriate Medical Staff committee.

b. Initiation of Professional Review Procedures

1. Whenever a matter which may merit Medical Staff committee review comes to the attention of any Member, the CEO, or the Board of Directors, a request for a professional review procedure shall be made to the Chief of Staff, or, in the case of absence or inability of the Chief of Staff to act, the Vice Chief of Staff. The allegations shall be supported by reference to specific activities or conduct. No anonymous or oral requests shall be considered.

2. The Chief of Staff (or the Vice Chief of Staff) shall arrange for a confidential informal review of the matters raised in the request, by a committee of not less than two (2) Members. The Chief of Staff also shall notify the CEO of the

informal review. If possible, the members of the reviewing committee shall not be in direct economic competition with the Member in question.

3. If preliminary review by the committee indicates that the matter does not merit serious attention, the committee shall report to the Chief of Staff ***and*** the CEO through written recommendation, and the review shall be discontinued without further action. A copy of this report shall be retained in the quality/peer review file of the Member in question.

4. If the preliminary review indicates that the matter merits more detailed analysis, the Chief of Staff shall promptly notify the Member and give the Member an opportunity to meet informally with the reviewing committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the Member shall be informed of the general nature of the evidence supporting the review requested and shall be invited to discuss, explain, or refute it. The Member may also be allowed to present any written information he or she feels is relevant for the ad hoc committee to review. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws or the Fair Hearing Plan shall apply. If the matter can be resolved to the satisfaction of the reviewing committee, it shall be dismissed with an appropriate notation made in the committee records. A copy of the documentation also shall be retained in the quality/peer review file of the Member in question.

5. If the reviewing committee and/or the Chief of Staff recommends that corrective action be initiated at any time during these procedures, the recommendation shall be in the form of a written report that is forwarded to the Executive Committee, along with supporting documentation.

6. Informal review is not a prerequisite to initiating a corrective action, but is encouraged when appropriate. At any time during the corrective action, if it is deemed appropriate to initiate further review, it may be requested pursuant to this Article VII.

c. CEO's Option: When the Executive Committee has rejected a request for corrective action and reported to the CEO as set forth in Article VII, Section 2, the CEO may either appoint an ad hoc review committee, or direct an appropriate Member to appoint an review committee, to review further the activities or conduct, and to submit a written report of the review to the CEO. Such report may be submitted by the CEO to the Executive Committee for action in accordance with Article VII, Section 2 below.

d. Board of Director's Option: When the Executive Committee, after review of the reviewing committee's report, or after review of precautionary suspension imposed pursuant to Article VII, Section 4 below, determines that no corrective action be taken, the CEO shall report such determination to the Board of Directors. The Board of Directors, in its discretion, may appoint a committee to conduct an investigation of the conduct that

served as the basis for the request for corrective action and, after receipt of the report of the investigation, take any such action as is set forth in Article VII, Section 2 below.

Section 2. **Corrective Action**

a. If it appears that a Member does not meet the standards required by these Bylaws for Medical Staff membership, or for specific clinical privileges which have been granted, or otherwise appears to have engaged in a course of conduct or practice which is, or may be, detrimental to patient safety, or a substantial hindrance to the delivery of quality patient care by others, is disruptive to the Hospital's operations, or is an impairment to the community's confidence in the Hospital or the Medical Staff, a corrective action proceeding may be initiated by any of the following persons: any officer of the Medical Staff, the chair of any standing committee of the Medical Staff, the CEO, or the Board of Directors.

b. A corrective action proceeding may be initiated only in the following manner:

1. A written request for corrective action must be submitted to the Chief of Staff, or, in case of absence or inability to act, the Vice Chief of Staff. A copy of such request shall also be submitted to the CEO.

2. The request for corrective action must specify the type of action requested, and shall give a general description of the basis upon which action has been requested.

c. Decision and course of action by the Executive Committee

1. All requests for corrective action shall be reviewed by the Executive Committee within thirty (30) days of receipt.

2. The Executive Committee may:

(A) Determine that the request is without merit and recommend no action be taken.

(B) Determine that more information is needed and request an investigation pursuant to Article VII, Section 1 above.

(C) Determine that sufficient information exists to make a recommendation for corrective action.

d. If a recommendation for corrective action is made by the Executive Committee, the CEO shall send to the Member, a written preliminary statement of the general nature of the charges, the recommendation, and a course of action to be followed.

e. If the recommendation for corrective action is non-reviewable, the Executive Committee shall consider its implementation and so advise the Member in writing.

f. If the recommendation for corrective action is reviewable, then the Member shall have thirty (30) days from the date of receipt of such notice within which to make a written request for hearing pursuant to the Fair Hearing Plan. Failure to make a timely request for hearing shall constitute a waiver of any further hearing before any committee of the Medical Staff or appeal or other review by the Board of Directors, and shall constitute consent by the Member to final action by the Executive Committee and Board of Directors.

g. In the event the Member makes a timely, proper request for hearing pursuant to the Fair Hearing Plan, final action of the Medical Staff shall be delayed until the completion of procedures provided for in the Fair Hearing Plan.

h. Upon completion of the hearing procedures required by the Fair Hearing Plan, the findings and the recommendations of the Hearing Committee shall be forwarded to the Executive Committee. Such findings and recommendations of the Hearing Committee shall be advisory, and the authority and power to make the final recommendations of the Medical Staff shall be retained by the Executive Committee. Authority to make the ultimate decision in the matter is retained by the Board of Directors.

i. In acting upon the request for corrective action and the findings and recommendations of the Hearing Committee, if any, the Executive Committee shall have authority, in its discretion and where it deems appropriate, to develop a program of corrective action which will exercise reasonable care to protect patients' safety and, when appropriate, provide an opportunity for the Member to correct professional deficiencies or to bring qualifications up to the level of the standards required by these Bylaws. Such actions may include, but are not limited to, a program of individual monitoring of professional practices, the requirement of additional formal, practical, clinical or other training or education, the issuance of a warning, a letter of admonition, a letter of reprimand, or a requirement for consultation. Where appropriate, the Executive Committee may recommend the imposition of probation; the reduction, suspension, modification or revocation of clinical privileges, or may recommend that the Member's Medical Staff membership be suspended or revoked. The Executive Committee shall also have authority to refer the matter back to the Hearing Committee appointed under the Fair Hearing Plan, for further hearing or clarification of any issues which, in the discretion of the Executive Committee, are in need of resolution prior to the final action of the Medical Staff by the Executive Committee.

j. The final recommendation of the Executive Committee shall be in writing, shall state the reasons for the recommendations made by the Executive Committee, and shall be forwarded to the CEO and mailed or delivered to the Member. If the final recommendation of the Executive Committee is adverse to the Member, the Member shall have the right to request, in writing, an appellate review by the Board of Directors as provided in the Fair Hearing Plan. Failure to make a timely request for appellate

review pursuant to the Fair Hearing Plan shall constitute a waiver of any appeal before the Board of Directors and a consent that the Board of Directors take final action in the matter.

k. After final action of the Medical Staff by the Executive Committee, and upon conclusion of all appellate rights provided for and requested under the Fair Hearing Plan, the Board of Directors shall take action on the request for corrective action. In acting upon the Executive Committee's report and recommendation, the Board of Directors shall have all the power it would have in making the initial decision; and the authority to make the ultimate decision on the matter is retained by the Board of Directors. In taking final action on the request, the Board of Directors shall have authority to (1) deny any form of corrective action; (2) impose such form of corrective action as, in the judgment of the Board of Directors, appears appropriate under the circumstances; or (3) refer the matter back to the Executive Committee (and, if necessary, to the Hearing Committee) for clarification of recommendations or further consideration of questions raised by the Board of Directors.

Section 3. **Nonreviewable Form of Corrective Action**

a. Not every form of requested corrective action entitles the Member to a formal hearing and/or appeal pursuant to the Fair Hearing Plan before it is implemented. For example, precautionary suspensions may be implemented immediately under the terms set forth in Article VII, Section 4. In addition, the following types of corrective action are not deemed to be a reduction, suspension or revocation of clinical privileges or Medical Staff membership and therefore may be imposed by the Executive Committee without affording the Member the procedural steps provided for in the Fair Hearing Plan:

1. Imposition of a program of individual monitoring of professional practices, by such committee of the Medical Staff as the Executive Committee may direct, provided that such program of individual monitoring does not exceed one hundred eighty (180) days in length;

2. The requirement of additional formal, practical, clinical or other training or education;

3. The issuance of a warning or letter of admonition;

4. Issuance of a letter of reprimand;

5. The requirement for consultation provided the Member is permitted to make decisions about his/her patients' course of treatment without the agreement of the consulting Practitioner; or

6. The granting of conditional appointment or appointment of a limited duration to the Medical Staff.

b. The forms of corrective action which, when requested, entitle the Member to hearing and review are those forms of corrective action which would constitute a reduction, suspension or a revocation of clinical privileges as identified in Section 1-1 of the Fair Hearing Plan or the imposition of probation, termination, suspension or revocation of the Member's Medical Staff membership.

Section 4. **Precautionary Suspension**

a. Criteria and Initiation: Whenever a Member willfully disregards or grossly violates these Bylaws, the rules and regulations of the Hospital or the Medical Staff, or other Hospital policies, whenever his/her conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of serious injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or whenever the conduct of the Member materially disrupts the operations of any department or unit of the Hospital, the Chief of Staff, the CEO, or the Executive Committee shall have the authority to precautionarily suspend the Medical Staff appointment or all or any portion of the clinical privileges of such Member. The Member may be given an opportunity to refrain voluntarily from exercising clinical privileges pending an investigation.

The officer or committee that imposes the suspension shall notify the CEO of such action. Such precautionary suspension shall become effective immediately upon imposition, and the CEO shall promptly give notice of the suspension to the Member and to the Executive Committee if the Executive Committee did not impose the suspension.

b. Executive Committee Action: Upon the written request of the suspended Member, a meeting of the Executive Committee shall be convened as soon as reasonably possible after the imposition of such precautionary suspension to review and consider the action taken. Otherwise, the review and consideration of the action shall occur at the next regularly scheduled meeting of the Executive Committee. The Executive Committee shall recommend to the Board of Directors modification, continuation or termination of the terms of the precautionary suspension and the action to be taken by the Member to have the suspension lifted, if any.

c. Procedural Rights: Unless the Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Member shall be entitled to the procedural rights as provided in this Article VII, and the suspension shall be processed in accordance with the provisions of the Fair Hearing Plan. The terms of the precautionary suspension as sustained by the Executive Committee shall remain in effect pending a final decision by the Board of Directors.

If the Executive Committee recommends termination of the suspension and cessation of all further corrective action, the suspension shall be lifted until the Board of Directors has reviewed the recommendation and taken action. If the Board of Directors, after such review, decides to continue the suspension, the Member shall be entitled to the procedural rights as provided in this Article VII, and the suspension shall be processed in accordance with the provisions of the Fair Hearing Plan.

If the Executive Committee recommends less restrictive terms of suspension, the original suspension shall remain in effect until the Board of Directors has reviewed the recommendation and taken action to terminate the suspension. If the Board of Directors, after such review, decides to continue the suspension, either original or as modified, the Member shall be entitled to the procedural rights as provided in this Article VII, and the suspension shall be processed in accordance with the provisions of the Fair Hearing Plan.

Section 5. **Automatic Suspension**

a. License: If a Member's license to practice his/her profession in the State of Colorado is revoked or suspended, or the licensing agency imposes terms of probation or limitation of practice on the Member, such Member shall immediately and automatically be suspended from practicing in the Hospital.

When the licensing agency has imposed terms of probation or limitation of practice on the Member, the Executive Committee shall treat the matter as a request for corrective action, and the procedures in Article VII, Section 2 and in the succeeding sections shall be followed.

When the action of the licensing agency has been to revoke or suspend the Member's license, any subsequent request for the opportunity to practice at the Hospital after the Practitioner has regained his/her license shall only be by application for appointment to the Medical Staff.

b. Drug Enforcement Administration (DEA) Number: A Member whose DEA number is revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. The Executive Committee shall treat the matter as a request for corrective action, and the procedures in Article VII, Section 2 and in the succeeding sections shall be followed.

c. Medical Records: An automatic suspension after warning of delinquency shall be imposed for failure to complete medical records in timely fashion. All discharge summaries shall be completed within thirty (30) days of patient discharge. Regarding a Member's absence, all charts shall be cleared from the Member's box prior to the time he/she leaves. If the Member has not dictated all charts available prior to going on vacation, any of those charts which become due during his/her absence shall cause an automatic suspension until the charts are dictated. Upon return from his/her absence, the Member shall have seven (7) days in which to dictate the charts which accumulated during his/her absence. If these requirements are not met, the Member will be suspended until all charts are dictated. Any failure to complete medical records shall result in a suspension until the charts are completed.

A medical record is ordinarily considered complete when the required contents, including any required clinical resume of final progress note, are assembled and authenticated, and when all final diagnoses and any complications are recorded, without use

of symbols or abbreviations. Completeness implies that the content of any dictated record has been transcribed and inserted into the medical record. Hospital policy defines when those individuals charged with the medical record committee function are otherwise allowed to declare any medical record complete for purposes of filing.

In the event a Member is suspended, his/her emergency room coverage shall be assigned to another Member by the Chief of Staff. However, the suspended Member shall then have to make-up the time covered by the other Member(s). Substandard records shall be referred to the Executive Committee for review and action.

Medical Records reports on inpatient or outpatient procedures and surgical procedures will be completed within twenty-four (24) hours of the procedure or surgery (with the exception of Holter monitors). If this requirement is not met, the Member will be suspended until the procedures are dictated.

Any Member guilty of three (3) suspensions in one (1) year for delinquent medical records will be referred to the Executive Committee to discuss the problem and take appropriate action. Reinstatement of privileges will only be made by medical Records Personnel during regular working hours.

Suspension will be counted on an annual basis beginning with the beginning of the Medical Staff Year. The suspensions will apply to admitting privileges, including Emergency Room coverage and scheduling of Physician-conducted outpatient procedures. The suspended Member shall continue to care for previously admitted patients.

For purposes of enforcing this Article VIII, Section 5, Paragraph c, justified reasons for delay in completing medical records may include, without limitation:

1. The attending Member or any other individual contributing to the record is ill or otherwise unavailable for a period of time due to circumstances beyond his/her control.

2. A Member is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis.

3. A Member has dictated reports and is waiting for Hospital personnel to transcribe them.

d. Failure to Practice Actively: When a Member has not admitted a patient to the Hospital or has not provided professional services to any patient in the Hospital for one hundred eighty (180) days, he/she shall be given special notice that in ninety (90) days, his/her staff appointment will be automatically revoked unless the Member either admits a patient to the Hospital or provides services to a patient in the Hospital during such ninety (90) day period. This rule may be suspended for good cause at the discretion of the Chief of Staff upon written petition by the Member.

e. State Licensing Agencies: Final action taken by the applicable State of Colorado licensing agency placing a Member on probation may be cause for automatic suspension of all of the Member's Hospital privileges, or other corrective action in accordance with the provisions of Article VII, Section 2 of these Bylaws.

f. Malpractice Insurance: Termination of a Member's malpractice insurance coverage shall result in an automatic suspension of the Member's Medical Staff membership and clinical privileges. An affected Member may request reinstatement during a period of sixty (60) calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such Member shall be deemed to have voluntarily resigned from the Medical Staff and must reapply for Medical Staff membership and clinical privileges.

g. False Statements: By making application for reappointment to the Medical Staff, the Applicant acknowledges his/her responsibility to give full, complete and accurate information. Any failure to give true, complete and accurate information, including the making of untrue statements or failure to make materially true statements shall be sufficient ground for automatic suspension of privileges already given, or other corrective action in accordance with the provisions of Article VII, Section 2 of these Bylaws.

h. Conviction of a Felony: Conviction of a felony may be cause for automatic suspension of all of a Member's Hospital privileges, or other corrective action in accordance with the provisions of Article VII, Section 2 of these Bylaws.

i. Exclusion from Participation: The clinical privileges of any Member who has been excluded from participation in the Medicare/State programs shall be automatically suspended to ensure that the excluded Member does not provide or order items or services for patients enrolled in Medicare/State programs.

j. Procedural Rights

1. With respect to an automatic suspension or revocation, the Member shall be entitled to a hearing only with respect to whether the suspension or revocation was imposed in error.

2. The imposition of a corrective action, other than an automatic suspension for matters described under this Article VII, Section 5 shall be conducted pursuant to the corrective action process in these Bylaws.

k. It shall be the duty of each Member to cooperate with the CEO in enforcing all automatic suspensions.

Section 6: **Continuity of Patient Care**

Upon the imposition of a precautionary suspension or the occurrence of an automatic suspension, the Chief of Staff shall provide for alternative coverage for the

patients of the suspended Member's patients in the Hospital. The wishes of the patient shall be considered, where feasible, in choosing a substitute Member. The suspended Member shall confer with the substitute Member to the extent necessary to safeguard the patient.

Section 7. **Confidentiality**

a. All proceedings conducted pursuant to this Article VII shall be privileged and confidential pursuant to applicable federal and state laws, rules and regulations. Such proceedings and final action by the Board of Directors pursuant to these Bylaws shall not be disclosed except in accordance with reporting requirements imposed by applicable federal and state laws, rules and regulations.

b. All Members participating in the proceedings outlined in this Article VII acknowledge that confidentiality is required.

Section 8. **Reporting**

The Hospital shall comply with any reporting requirements applicable under the Health Care Quality Improvement Act of 1986, including required reporting to the National Practitioner Data Bank, and under the Colorado Revised Statutes. The Hospital also shall comply with the Banner Health Sharing of Information Policy.

ARTICLE VIII: OFFICERS

Section 1. **Officers of the Medical Staff**

The officers of the Medical staff shall be:

a. Chief of Staff;

b. Vice Chief of Staff; and

c. Secretary.

Section 2. **Qualifications of Officers**

Officers must be Physician members of the Active Medical Staff at the time of nomination and election and, as a condition of holding office, they must remain Members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 3. **Election of Officers**

Officers shall be elected by the members of the Active Medical Staff in accordance with Article XI of these Bylaws at the December meeting of the Medical Staff.

Section 4. **Term of Office**

The term of office for all officers of the Medical Staff shall be a period of one (1) year, commencing with the first (1st) day of January following the officers' election, and continuing for one (1) year thereafter or until a successor is elected and qualified; provided, however, that the Chief of Staff may decide to extend his/her term of office for one (1) additional year, in which event the term of office of Vice Chief of Staff shall be similarly extended. No officer of the Medical Staff shall be permitted to serve more than two (2) consecutive years in the same office. The Vice Chief of Staff shall automatically succeed to the office of the Chief of Staff at the end of the Chief of Staff's term of office.

Section 5. **Vacancies in Office**

An office of the Medical Staff shall be deemed "vacant" if the person elected to the official position (a) resigns or is removed from membership of the Medical Staff; (b) becomes disabled to the extent that he/she cannot fulfill the duties of office; or (c) dies.

In the event the office of Chief of Staff becomes vacant, the Vice Chief of Staff shall immediately succeed to the position of the Chief of Staff.

In the event the office of Vice Chief of Staff should become vacant with three (3) months or less left in the term, the Chief of Staff shall appoint a Vice Chief of Staff who shall serve the remainder of the term. If more than three (3) months remain, the Chief of Staff shall call a special election within thirty (30) days of the occurrence of the vacancy. In the event any other office of the Medical Staff shall become vacant, it may be filled by the Executive Committee, with the person so appointed to hold office until the end of the applicable Medical Staff Year. If an office is filled by the Executive Committee, it shall, prior to the end of the applicable Medical Staff Year, cause an election to be held as provided in Article XI for the purpose of filling the vacancy. The term of persons so elected shall commence on the first day of the Medical Staff Year following their election and expire on the same date as provided for the other Medical Staff officers.

Notwithstanding the provisions set forth above, in the event a vacancy is created by removal of any Medical Staff officer other than the Chief of Staff, the Executive Committee may, at its discretion, choose to leave the office vacant on an interim basis and by resolution require the holding of an election to fill the vacancy as provided in Article XI hereof.

Section 6. **Duties of Officers**

a. Chief of Staff: The Chief of Staff shall serve as the highest elected official of the Medical Staff to:

1. act in coordination and cooperation with the CEO in all matters of mutual concern with the Hospital;

2. call, preside at, and be responsible for the agenda of all regular and special meetings of the Medical Staff;

3. call, serve as a member of, preside at, and be responsible for all meetings of the Executive Committee;

4. serve as ex-officio member of all other Medical Staff committees, without vote;

5. be responsible for the enforcement of these Bylaws and the rules and regulations of the Medical Staff, for implementation of sanctions where they are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Member;

6. appoint members to all standing, special, and multi-disciplinary Medical Staff committees except the Executive Committee, provided that all appointments to standing committees shall be subject to approval of the Executive Committee;

7. represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and to the CEO;

8. receive and interpret the policies and requests of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

9. be responsible or designate responsibility for the educational activities of the Medical Staff;

10. be the spokesman for the Medical Staff in its external professional and public relations; and

11. appoint a Medical Staff representative to the Joint Conference Committee.

b. Vice Chief of Staff: The Vice Chief is a member of the Executive Committee. In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. In the absence of a secretary, the Vice Chief of Staff shall keep accurate and complete minutes of all Medical Staff and Executive Committee meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office.

Section 7. **Removal of Medical Staff Officers**

Any officer of the Medical Staff may be removed prior to the expiration of the term of office in the following manner:

a. Special Meeting. A special meeting of the Active Medical Staff shall be called as provided in Article X, Section 2, for the purpose of considering and acting upon a written request that any one or more officers of the Medical Staff be removed. In order to be effective, the notice of said special meeting must state that the purpose of said special meeting is to consider and act upon a request for the removal of one or more designated Medical Staff officers.

b. Quorum. Fifty percent (50%) of the members of the Active Medical Staff shall constitute a quorum for the purpose of conducting a special meeting held pursuant to the provisions of this Article VIII, Section 7.

c. Required Vote. Upon the vote of two-thirds (2/3) of those members of the Active Medical Staff in attendance at said special meeting, any officer of the Medical Staff may be removed.

d. Effective Date. Removal of a Medical staff officer shall be effective upon such vote of the Medical Staff.

ARTICLE IX:
COMMITTEES AND FUNCTIONS OF THE MEDICAL STAFF

Section 1. **Committees of the Medical Staff**

a. The following committees, unless otherwise designated by these Bylaws, shall be appointed by the Chief of Staff, subject to approval by the Executive Committee.

1. Executive Committee; and

2. Service Area Committees:

(A) Surgical Services (including Surgery, Anesthesia, Laboratory and Pathology);

(B) Medicine/Hospitalists (including oversight responsibilities for Rehab Services, e-ICU, Radiology and Respiratory Therapy);

(C) Emergency Room/Trauma; and

(D) OB/GYN.

b. The Chief of Staff, or his or her designee, shall be an ex-officio member of all Medical Staff committees, unless otherwise specifically designated as a committee member. In addition, the Administrator, or his or her designee, shall be an ex-officio member without voting privileges of all Medical Staff committees, unless otherwise specifically designated as a committee member. In addition to the Administrator or his or her designee, the Quality Manager will serve as an ex-officio member without voting privileges on all Service Area Committees. In addition, special committees may be appointed for specific purposes by the Chief of Staff, and their appointments will cease upon the accomplishment of their purposes. They shall report to the Executive Committee.

Section 2. **Executive Committee**

a. The Medical Staff, acting as a whole, shall have the Executive Committee as a standing committee. The Executive Committee's functions, size and composition shall be determined by the Medical Staff, as approved by the Governing Board. The Medical Staff delegates to the Executive Committee broad authority to oversee the operations of the Medical Staff. The Executive Committee shall be composed of not less than the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, and the Secretary. The CEO or his/her designee and the Chief Facility Medical Director shall be ex-officio members. Executive Committee meetings shall be held at least monthly at a mutually agreeable date and time. The duties of the Executive Committee shall be:

1. to represent and act on behalf of the Medical Staff, in accordance with the duties and powers granted by the Medical Staff and these Bylaws;

2. to coordinate the activities and general policies of the Medical Staff;

3. to receive and act upon all committee reports and reports of the Medical Staff in carrying out the various functions as set forth in this Article IX;

4. to make and implement policies of the Medical Staff;

5. to provide liaison among the Medical Staff, the CEO, and Board of Directors;

6. to recommend action to the CEO on matters of a medical-administrative nature, and to advise concerning implementation of new departments, services, and other medical-administrative matters;

7. to make recommendations on Hospital management matters (for example, long range planning) to the Board of Directors, through the CEO;

8. to fulfill the Medical Staff's accountability to the Board of Directors of the medical care rendered to all patients in the Hospital;

9. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;

10. to review the credentials of all Applicants and to make recommendations for Medical Staff membership and delineation of clinical privileges;

11. to review periodically all information available regarding the performance and clinical competence of Members and other Practitioners with clinical privileges, and as a result of such review, to make recommendations for reappointments and renewal or changes in clinical privileges;

12. to take all reasonable steps to continue professionally ethical conduct and competent clinical performance on the part of all Members, including the initiation of, and/or participation in, Medical Staff corrective action or review measures when warranted; and to participate as required by these Bylaws and the Fair Hearing Plan in peer review proceedings;

13. to report at each Medical Staff meeting;

14. to review and act upon all appointments to committees made by the Chief of Staff;

15. to participate in the adoption of all overall hospital quality assurance program, for approval by the Board of Directors, which program will be designed to include:

(A) identification of important or potential problems or related concerns, in maintaining a safe patient environment and reduction of liability.

(B) objective assessment of the cause and scope of problems or concerns, including the determination of priorities of both investigating and resolving problems. Ordinarily, priorities shall be related to the degree of impact on patient care that can be expected if the problem remains unresolved.

(C) implementation, through appropriate officers of the Medical Staff, of the decisions or actions that are designed to eliminate, insofar as is reasonably possible, identified problems.

(D) monitoring activities designed to ensure that the desired results have been achieved and sustained.

(E) documentation that reasonably substantiates the effectiveness of the overall program to enhance patient care, to assure sound clinical performance.

16. to appropriately involve the Medical Staff in quality activities that are designed to improve patient care.

17. to propose policies and procedures for adoption by the Board of Directors which are intended to achieve the foregoing goals.

18. to review these Bylaws and the rules and regulations of the Medical Staff for consideration of revisions and amendments, and act upon any proposals for same that may originate from a member of the Active Medical Staff.

Meetings shall be held regularly at a date and place, which shall be determined by the Chief of Staff, upon notice to all members of the Executive Committee.

Section 3. **Service Committees.**

a. Surgical Services Committee

1. Composition:

The Surgical Services Committee shall consist of Members whose scope of practice includes surgical, anesthesia, laboratory and pathology services. Allied Health Professionals whose special expertise and training is in surgery and/or, anesthesia may serve on the Surgical Services Committee, but without voting privileges. The focus of the Surgical Committee shall be peer review and oversight responsibilities of the surgical, anesthesia, laboratory and pathology services provided at the Hospital. The Surgical Services Committee shall also oversee blood usage at the Hospital as set forth in Article IX, Section 4. Others Members may attend in a non-voting capacity. The Chair of the Surgical Services Committee shall be appointed by the Chief of Staff and whose appointment shall be approved by the Executive Committee. A Vice-Chair may be elected by majority vote of the committee members, and in the event of a tie vote, shall be determined by the Chief of Staff. The appointment term for members of this committee shall be two (2) years.

2. The duties of the Surgical Services Committee are as follows:

(A) To develop and implement a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of

care and treatment provided to surgical patients including peer review of applicable cases.

When developing and using the above plan, it is anticipated that the medical record will be the primary item, though not necessarily the only item, used to evaluate objectively the appropriateness and quality of the care given. Such review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.

(B) To review quarterly, the findings from the monitoring and evaluation as delineated above and perform certain functions as set forth in Article IX, Section 4. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges. When such review(s) identifies an important issue(s), the Surgical Services Committee shall formulate a plan for improving care and monitoring the intervention outcome.

(C) To make recommendations on Hospital matters (i.e., long range planning, areas of improvement, equipment needs, staffing issues, policies etc.) to the Executive Committee for its use in making similar recommendations to the Medical Staff and the Board of Directors.

(D) The findings and conclusions of the above patient care monitoring, evaluating and issue-solving activities shall be documented in writing and reported quarterly to the Executive Committee.

(E) Meetings shall be held quarterly at minimum at a date and place determined by the chair upon notice to all committee members.

b. Medicine/Hospitalist Committee

1. Composition:

The Medicine/Hospitalist Committee shall consist of Members whose scope of practice includes hospitalist services, rehabilitation services, radiology, e-ICU and respiratory therapy. The focus of the Medicine/Hospitalist Committee shall be peer review and oversight responsibilities for the Hospitalist Program, Rehabilitation Services, e-ICU, Radiology and Respiratory Therapy. Others Members may attend in a non-voting capacity. The Chair of the Medicine/Hospitalist Committee shall be appointed by the Chief of Staff and whose appointment shall be approved by the Executive Committee. A Vice-Chair may be elected by majority vote of the committee members, and in

the event of a tie vote, shall be determined by the Chief of Staff. The appointment term for members of this committee shall be two (2) years.

2. The duties of the Medicine/Hospitalist Committee are as follows:

(A) To develop and implement a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of care and treatment provided to patients specifically by the Hospitalists, Radiologists, Respiratory Therapists, e-ICU providers etc. including peer review of applicable cases.

When developing and using the above plan, it is anticipated that the medical record will be the primary item, though not necessarily the only item, used to evaluate objectively the appropriateness and quality of the care given. Such review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.

(B) To review quarterly, the findings from the monitoring and evaluation as delineated above and perform certain functions as set forth in Article IX, Section 4. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges. When such review(s) identifies an important issue(s), the Medicine/Hospitalist Committee shall formulate a plan for improving care and monitoring the intervention outcome.

(C) To make recommendations on Hospital matters (i.e., long range planning, areas of improvement, equipment needs, staffing issues, policies etc.) to the Executive Committee for its use in making similar recommendations to the Medical Staff and the Board of Directors.

(D) The findings and conclusions of the above patient care monitoring, evaluating and issue-solving activities shall be documented in writing and reported quarterly to the Executive Committee.

(E) Meetings shall be held quarterly at minimum, at a date and place determined by the chair upon notice to all committee members.

c. Emergency Room/Trauma Committee

1. Composition:

The Emergency Room/Trauma Committee shall consist of Members whose scope of practice includes emergency and trauma care. Allied Health Professionals whose special expertise and training is in trauma or emergency medicine may serve on the Emergency Room/Trauma Committee, but without voting privileges. Other Members may attend in a non-voting capacity. The Chair of the Emergency Room/Trauma Committee shall be appointed by the Chief of Staff and whose appointment shall be approved by the Executive Committee. A Vice-Chair may be elected by majority vote of the committee members, and in the event of a tie vote, shall be determined by the Chief of Staff. The appointment term for members of this committee shall be two (2) years.

2. The duties of the Emergency Room/Trauma Committee include the following:

(A) To develop and implement a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of care and treatment provided to patients in the Emergency Room including peer review of applicable cases.

When developing and using the above plan, it is anticipated that the medical record will be the primary item, though not necessarily the only item, used to evaluate objectively the appropriateness and quality of the care given. Such review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.

(B) To review quarterly, the findings from the monitoring and evaluation as delineated above and perform certain functions as set forth in Article IX, Section 4. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges. When such review(s) identifies an important issue(s), the Emergency Room/Trauma Committee shall formulate a plan for improving care and monitoring the intervention outcome.

(C) To make recommendations on Hospital matters (i.e., long range planning, areas of improvement, equipment needs,

staffing issues, policies etc.) to the Executive Committee for its use in making similar recommendations to the Medical Staff and the Board of Directors.

(D) The findings and conclusions of the above patient care monitoring, evaluating and issue-solving activities shall be documented in writing and reported quarterly to the Executive Committee.

(E) Meetings shall be held quarterly at minimum, at a date and place determined by the chair upon notice to all committee members.

d. OB/GYN Committee

1. Composition:

The OB/GYN Committee shall consist of Members whose scope of practice includes obstetrics and gynecology care. Allied Health Professionals whose special expertise and training is in obstetrics, gynecology, and newborn care may serve on the OB/GYN Committee, but without voting privileges. Other Members may attend in a non-voting capacity. The Chair of the OB/GYN Committee shall be appointed by the Chief of Staff and whose appointment shall be approved by the Executive Committee. A Vice-Chair may be elected by majority vote of the committee members, and in the event of a tie vote, shall be determined by the Chief of Staff. The appointment term for members of this committee shall be two (2) years.

2. The duties of the OB/GYN Committee include the following:

(A) To develop and implement a plan of action for use in the ongoing monitoring and evaluation of the appropriateness and quality of care and treatment provided to patients in the OB area and the GYN procedures performed including peer review of applicable cases.

When developing and using the above plan, it is anticipated that the medical record will be the primary item, though not necessarily the only item, used to evaluate objectively the appropriateness and quality of the care given. Such review of the medical record may well be designed to insure that the record contains sufficient information to identify the patient, the patient's diagnosis, support the Member's diagnosis, justify the treatment, and document the results accurately.

(B) To review quarterly, the findings from the monitoring and evaluation as delineated above and perform certain functions as set forth in Article IX, Section 4. This review, at a minimum, shall specifically relate to both the overall care of patients as a group, as well as to the specific clinical performance of Members with clinical privileges. When such review(s) identifies an important issue(s), the OB/GYN Committee shall formulate a plan for improving care and monitoring the intervention outcome.

(C) To make recommendations on Hospital matters (i.e., long range planning, areas of improvement, equipment needs, staffing issues, policies etc.) to the Executive Committee for its use in making similar recommendations to the Medical Staff and the Board of Directors.

(D) The findings and conclusions of the above patient care monitoring, evaluating and issue-solving activities shall be documented in writing and reported quarterly to the Executive Committee.

(E) Meetings shall be held quarterly at minimum, at a date and place determined by the chair upon notice to all committee members.

Section 4. **Functions of the Medical Staff**

a. Unless otherwise designated by these Bylaws, the following functions shall be performed by Members, who shall be appointed by the Chief of Staff subject to approval by the Executive Committee and certain approved functions may be accomplished through delegation to the above-mentioned Service Area Committees. The Chief of Staff or his/her designee shall be a participant ex-officio in all functions.

b. The functions of the Medical Staff shall be:

1. Peer Review Functions

(A) Clinical Services Review;

(B) Surgical Case Review;

(C) Medical Record Review;

(D) Blood Usage Review;

(E) Drug Usage Evaluation; and

(F) Pharmacy and Therapeutics.

2. Monitoring and Evaluation of Hospital Services

(A) Diagnostic Radiology;

(B) Emergency Care;

(C) Ambulatory Care;

(D) Pathology and Medical Laboratory;

(E) Rehabilitation Services;

(F) Respiratory Care;

(G) Special Care Units; and

(H) Swing Bed Care.

3. Other Review Functions

(A) Risk Management;

(B) Infection Control;

(C) Internal and External Disaster Plans;

(D) Hospital Safety; and

(E) Utilization Review.

c. Peer Review Functions: The Medical Staff shall provide effective mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all Practitioners with delineated clinical privileges. Important problems in patient care are identified and resolved, and opportunities to improve care are addressed, through the functions set forth in Article IX.

1. Clinical Services Review: Clinical Services Review shall be performed monthly. Predetermined clinically valid criteria will be approved and used for screening medical records for quality and appropriateness of patient care and clinical performance. Screening may be completed by non-Physician personnel. Review functions shall include:

(A) The monitoring and evaluation of the quality and appropriateness of patient care provided by all Practitioners with clinical privileges, to encompass all major clinical services. Medical Staff monitoring and evaluation includes the following:

i. objective written clinical criteria and thresholds approved by the Medical Staff, reflective of current knowledge and clinical experience;

ii. routine collection of information about important aspects of patient care provided by the Medical Staff and clinical performance of the Members;

iii. periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care; and

iv. When problems in patient care and clinical performance, or opportunities to improve care are identified, actions are taken and the effectiveness of the actions taken is evaluated.

(B) A summary of the variations will be reviewed monthly by the Executive Committee. The Executive Committee or its designate will then document conclusions, recommendations, actions taken, and results of actions.

2. Surgical Case Review: This function shall include review of all surgical and invasive diagnostic procedures performed at the Hospital in order to determine the acceptability and appropriateness of the procedure; and, as to surgical procedures, the agreement or disagreement among the preoperative, postoperative and pathological diagnoses. This function may include consults with individual Members and requests for written justification of the treatment performed. Failure to give an adequate response to the request may be the basis for suspension of Medical Staff privileges. If a procedure does not meet acceptable standards, the findings and recommendations resulting from this function shall be reported to the Executive Committee.

Surgical case review shall be performed quarterly by either the Executive Committee or the Surgical Services Committee to help assure that surgery performed in the Hospital is justified and of appropriate quality. Predetermined clinically valid criteria which have been approved by the Medical Staff will be used for screening medical records for surgical case review. Screening may be completed by non-Physician personnel. Cases not meeting the criteria will be reviewed by the appointed Member(s).

(A) Review is conducted for each case, whether or not a tissue or non-tissue specimen was submitted. This review includes:

i. operations performed in the Operating Room, ambulatory surgery, and Emergency Room;

ii. tissue cases;

iii. non-tissue cases;

iv. tissue exempt from pathology review;

v. major invasive diagnostic procedures;

vi. all cases in which a major discrepancy exists between preoperative and postoperative (including pathologic) diagnoses.

vii. Additional screening mechanisms based on predetermined criteria may be developed to identify types of cases that may be excluded from review, and to identify other cases for more intensive evaluation.

(B) A summary of the screening and peer review findings will be reviewed monthly by the Executive Committee. The Executive Committee or its designate will then document conclusions, recommendations, actions taken, and results of actions.

3. Medical Record Review: The medical record review functions may be carried out by an appointed Member, Committee, the Medical Record Director, representatives of nursing, administration, and other departments as appropriate. Predetermined clinically valid criteria, which have been approved by the Medical Staff, will be used for screening medical records for medical records review. Screening can be completed by non-Physician personnel. Cases not meeting criteria will be reviewed by the appointed Member. Review functions shall include:

(A) Clinical Pertinence: This review function assures that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-Hospital progress of the patient, and the condition of the patient at discharge.

(B) Timely Completion: Medical records are screened for timeliness of entries and timeliness of completion against the provisions of Hospital policies and Medical Staff Rules and Regulations.

(C) Maintenance of Records: This function also includes taking necessary action to insure maintenance of the records at the standards set by the Board of Directors. It includes reporting to the Executive Committee any Members who are persistently delinquent in completion of their medical records.

(D) The medical record review function also includes recommending the format of the medical records, the forms used in the medical record, and the use of electronic data processing and storage systems for medical record purposes.

(E) This function will be performed monthly, and a quarterly summary of findings of the peer review in written form will be provided to the Medical Staff as a whole. The Medical Staff will then document conclusions, recommendations, actions taken, and results of actions.

4. Blood Usage Review: Blood usage review shall be performed quarterly by Surgical Services Committee to evaluate the appropriateness of blood therapy in all cases that receive transfusions of whole blood, blood components, or blood derivatives. Predetermined clinically valid criteria, which are approved by the Medical Staff, will be used for screening medical records for blood usage review. Screening can be completed by non-Physician personnel. Cases not meeting the criteria will be reviewed by the appointed Member. Functions of blood usage review include the following:

(A) the evaluation of the appropriateness of all cases in which patients were administered transfusion, including the use of whole blood and blood components;

(B) the evaluation of all confirmed transfusion reactions;

(C) the development or approval of policies and procedures relating to the distribution, handling, use, and administration of blood and blood components;

(D) the review of the adequacy of transfusion services to meet the needs of patients;

(E) the review of ordering practices for blood and blood products.

(F) A summary of the screening and peer review findings will be reviewed by the Executive Committee monthly. The

Executive Committee or its designee will then document conclusions, recommendations, actions taken, and results of actions.

5. Drug Usage Evaluation: Drug usage evaluation will be performed as a criteria-based, ongoing, planned and systematic process to assure that drugs are prescribed appropriately, safely and effectively. Functions of drug usage evaluation shall include:

(A) Continuously monitoring and evaluating the prophylactic, therapeutic and empirical use of drugs to help assure that they are provided appropriately, safely and effectively. This process includes:

i. the classes of drugs to be evaluated;

ii. the rationale for choice;

iii. the criteria to be used; and

iv. the methods of collecting and analyzing the data.

(B) A summary of the screening and peer review findings will be reviewed by the Executive Committee monthly. The Executive Committee or its designee will then document conclusions, recommendations, actions taken, and results of actions.

6. Pharmacy and Therapeutics Function: The Pharmacy and Therapeutics function shall be carried out by an appointed Member, the pharmacist, a representative of the nursing service, and administration. Representatives of other departments, services, and individuals as appropriate shall be invited to participate on an ad hoc basis. Predetermined valid criteria, which are approved by the Medical Staff, will be used for screening medical records for untoward drug reactions. Screening can be completed by non-Physician personnel. Cases not meeting these screens will be reviewed by the appointed Member.

(A) This function shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital, in order to seek optimum clinical results and a minimum potential for hazard. These functions include:

i. development and approval of policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing material;

ii. development and maintenance of a drug formulary, which is systematically reviewed and changed as required by new knowledge, availability of new drugs, and information on costs;

iii. formal approval and enforcement of protocol relating to the use of investigational or experimental drugs in the Hospital;

iv. defining and reviewing all "untoward drug reactions", and taking appropriate actions and follow-up;

v. serving as an advisory group to the Medical Staff and the pharmacist on matters pertaining to the choices of available drugs;

vi. making recommendations concerning drugs to be stocked on the nursing unit**,** emergency room, and by other services;

vii. preventing unnecessary duplication in stocking drugs, and drugs in combination, having identical amounts of the same therapeutic ingredients;

viii. evaluating clinical data concerning new drugs and preparations requested for use in the Hospital; and

ix. establishing standards concerning research in the use of recognized drugs.

(B) A summary of all functions, including the screening and peer review findings, will be reviewed quarterly by the Executive Committee. The Executive Committee or its designee will then document its conclusions, recommendations, actions taken, and results of actions.

7. Monitoring and Evaluation of Hospital Services:

(A) The Physician director, designated for each of the following services, is responsible for assuring that there is a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care, and for resolving identified problems in the following areas:

i. Diagnostic Radiology;

ii. Emergency Care;

iii. Ambulatory Care;

iv. Nuclear Medicine;

v. Pathology and Medical Laboratory;

vi. Physical Rehabilitation Services;

vii. Respiratory Care;

viii. Special Care Units; and

ix. Swing Bed Care.

(B) The functions of the Hospital Service Review shall be:

i. Assisting in the development and review of indicators and criteria used in monitoring the quality of care provided to patients by development staff, and the appropriateness of the services requested by the Medical Staff.

ii. Communicating findings from the monitoring and evaluation activities which involve Medical Staff practices to the Medical Staff.

(C) A summary of the monitoring and peer review findings for each service will be reviewed quarterly. The Medical Staff will then document its conclusions, recommendations, actions taken, and results of actions.

8. Other Review Functions: The Medical Staff shall participate in other review functions including Risk Management, Infection Control, internal and external Disaster Plan, Hospital Safety, and Utilization Review. The findings and recommendations from these review functions shall be reviewed quarterly by the Executive Committee**,** with documentation and conclusions and recommendations by the Executive Committee or its designee.

(A) Risk Management: The Medical Staff participates, as appropriate, in risk management activities related to the clinical aspects of patient care and safety. Functions shall include:

i. identifying general areas of potential risk in the clinical aspects of patient care and safety;

ii. assisting in development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety, and evaluation of these cases;

iii. participating in correction of problems in the clinical aspects of patient care and safety identified by risk management activities;

iv. assisting in designing programs to reduce risk in the clinical aspects of patient care and safety.

(B) Infection Control: the Medical Staff actively participates, as appropriate, in a program to prevent, to identify, and to control infections acquired in the Hospital or brought into the Hospital from the community. Functions shall include:

i. assisting in development and approval of the infection control program;

ii. instituting appropriate control measures when there is reasonably considered to be a danger to any patient or employee.

(C) Internal and External Disaster Plans: The Medical Staff actively participates, as appropriate, in an emergency preparedness program. Functions shall include assisting in development and approval of the emergency preparedness program.

(D) Hospital Safety: The Medical Staff actively participates, as appropriate, in a comprehensive Hospital safety program involving the physical safety of patients, employees and visitors. Functions shall include assisting in the development of the Hospital safety program.

(E) Utilization Review: The Medical Staff actively participates, as appropriate, in a program to address over utilization, under utilization, and ineffective scheduling of resources. This function includes participating in utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services, and all related factors which may contribute to the effective

utilization of the Hospital and Member services. Functions shall include:

i. developing and approving a written utilization review plan for the Hospital, for approval by the Executive Committee, the Local Board and the Board of Directors;

ii. developing and approving of criteria used for identifying specific cases with potential utilization problems;

iii. reviewing cases identified by the criteria, with recommendations documented;

iv. correcting problems identified in clinical areas of utilization; and

v. monitoring of the process for improvement in performance.

ARTICLE X:
MEETINGS

Section 1. **General Medical Staff Meetings**

a. Frequency of Meetings. General Medical Staff meetings shall be held at least quarterly, at a time to be specified by the Chief of Staff.

b. Quorum. Fifty percent (50%) of the members of the Active Medical Staff shall constitute a quorum for the purpose of transacting such business as is permitted by these Bylaws.

c. Attendance. Members of the Active Medical Staff shall be required to attend fifty percent (50%) of the quarterly general Medical Staff meetings.

Section 2. **Special Meetings**

a. Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Board of Directors, the Executive Committee, or by twenty-five percent (25%) of the members of the Active Medical Staff, provided written notice and an agenda are mailed or delivered to each member of the Active Medical Staff, Executive Committee or Service Committee at least three (3) days in advance of the special meeting date.

b. Quorum. Fifty percent (50%) of the members of the Active Medical Staff, or of the Executive Committee or Service Committee, shall constitute a quorum for the purpose of transacting such business at a special meeting, as is permitted by these Bylaws.

c. Special Meeting and Conference Attendance.

1. A Practitioner whose patient(s)' clinical course of treatment is scheduled for discussion at an Active Medical Staff, Executive Committee or Service Committee special meeting shall be notified and invited to present the case.

2. Whenever a Medical Staff or Service Committee educational program is prompted by findings of quality assurance program activities, the Practitioner 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 its special applicability to the Practitioner's practice. Except in unusual circumstances, the Practitioner will be required to be present.

3. Whenever a pattern of suspected deviation from standard clinical practice is identified, the Chief of Staff or the applicable Service Committee chairman may require the Practitioner to confer with him 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 the conference, including the date, time and place, and a statement of the issue involved, and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference, unless excused by the Executive Committee upon showing good cause, will result in an automatic suspension of all or such portion of the Practitioner's clinical privileges as the Executive Committee may direct. A suspension under this Section will remain in effect until the matter is resolved by subsequent action of the Executive Committee or through corrective action, if necessary. Such resolution shall be made in a timely manner not to exceed ten (10) days.

ARTICLE XI:
ELECTIONS

1. The Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.

2. Except as otherwise provided in these Bylaws for the filling of vacancies, terms of office shall begin on January 1.

3. Nominations for Medical Staff officers shall be made from the floor, among members present at the December meeting. Voting shall be by secret ballot. In the event of a tie, if the nominees are unable to decide between themselves who will serve, the matter shall be decided by a coin toss.

ARTICLE XII:
ALLIED HEALTH PERSONNEL

Allied Health Personnel (AHP) are considered paramedical professionals who have been granted clinical privileges in the Hospital in accordance with the terms of the Allied Health Personnel Policy. AHP shall not be considered members of the Medical Staff, but are subject to the authority of the Medical Staff and the Hospital, as set forth in the Allied Health Personnel Policy, and to these Bylaws and the rules, regulations, policies, procedures, guidelines and requirements of the Medical Staff and the Hospital, to the extent the Board of Directors deem any of the foregoing are applicable to AHP. AHP are not afforded the same rights or privileges available to members of the Medical Staff and shall have only those rights or privileges that are set forth in the Allied Health Personnel Policy however, AHP may be invited to or required to attend Medical Staff meetings, at the discretion of the Medical Staff, but will have no voting authority. Without limiting the foregoing, AHP includes counseling or clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives, physicians' assistants and optometrists, as more particularly defined in the Allied Health Personnel Policy

ARTICLE XIII:
CONFIDENTIALITY, IMMUNITY AND RELEASES

Section 1. **Special Definitions**

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

a. "Information" means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Article XIII, Section 4.

b. "Malice" means the dissemination of a knowing falsehood or of information with a reckless disregard for whether or not it is true or false.

c. "Representative" means a board and any directors or committee thereof; a chief executive officer or his/her designee, a medical staff organization and any member, officer, service or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

d. "Third Parties" means both individuals or organizations providing information to any representative.

Section 2. **Authorizations and Conditions**

By applying for, or exercising, clinical privileges of providing specified care services within the Hospital, an Applicant:

a. Authorizes Representatives of the Hospital and the Medical Staff to solicit, provide and act upon information, including otherwise privileged or confidential information, provided by Third Parties bearing on her/his credentials professional ability and qualifications.

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

c. Acknowledges that the provisions of this Article XIII are express conditions to application for, or acceptance of, Medical Staff membership and the continuation of such membership or to exercise clinical privileges or to provide specified patient services at the Hospital.

Section 3. **Confidentiality of Information**

Information with respect to any Applicant submitted, collected, or prepared by any Representative of the Hospital or the Medical Staff or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contribution to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a bona fide Representative of the Medical Staff, the Hospital, or the Board of Directors, nor be used in any way except as provided herein 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 file or of any general Hospital records.

Section 4. **Immunity from Liability**

a. No Representative of the Hospital or Medical Staff shall be liable to an Applicant for damages or other relief for any action taken or 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 a reasonable effort under the circumstances to ascertain the truthfulness of the facts, and in the reasonable belief that the action, statement or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be absolute defense in all circumstances.

b. No Representative of the Hospital or Medical Staff and no Third Party shall be liable to an Applicant for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a Representative of the Hospital or the Medical Staff, or to any other health care facility or organization of health professionals concerning an Applicant who is or has been an Applicant to, or member of, the Medical Staff, or who did or does exercise clinical privileges or provide specified services at the Hospital, provided that such Representative or Third Party acts in good faith and without Malice.

Section 5. **Activities and Information Covered**

a. Activities: The confidentiality and immunity provided by this Article XIII shall apply to all acts, communications, reports, recommendations or disclosures performed

or made in connection with the Hospital or the Medical Staff or any other health care facility's or organization's activities concerning, but not limited to:

1. Applications for appointment, clinical privileges or specified services;

2. Periodic reappraisals for reappointment, clinical privileges or specified services;

3. Evaluating requests for changes in Medical Staff category or clinical privileges;

4. Corrective action;

5. Hearings and appellate reviews;

6. Patient care audits;

7. Medical care evaluations;

8. Utilization reviews;

9. Quality Assurance activities;

10. Other Hospital, service, committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

11. Matters or inquiries concerning the credentials of any Applicant;

12. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital;

13. Reports to the National Practitioner Data Bank or to any other state or federal agency pursuant to applicable law, rule or regulation; and

14. PRO, Medicare, Medicaid reviews and sanctions.

b. Information: The acts, communications, reports, recommendations, disclosures and other information referred to in this Article XIII may relate to an Applicant's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

Section 6. **Releases**

Each Applicant shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article XIII, 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 the State of Colorado. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XIII.

Section 7. **Cumulative Effect**

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality or information and immunities from liability shall be in addition to other protection provided by law and not in limitation thereof; and in the event of conflict, the applicable law shall be controlling.

ARTICLE XIV:
RULES AND REGULATIONS

The Medical Staff shall adopt rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations have the same force and effect as these Bylaws, and they may be amended at any regular meeting or special meeting of the Medical Staff, without previous notice, by two-thirds (2/3rds) vote of the total voting members of the Active Medical Staff present. The rules and regulations and all amendments there to become effective only upon approval by the Board of Directors.

ARTICLE XV:
AMENDMENTS

Comprehensive review of these Bylaws will be done at least once every two (2) years and more frequently as needed. Amendments to these Bylaws may be adopted upon approval of the Executive Committee and approval by the majority vote of the members of the Active Medical Staff. Each member of the Active Medical Staff will receive a copy of the proposed amendments or a summary thereof, which summary has been approved by the Medical Staff Executive Committee, prior to any such vote of the Active Medical Staff. New bylaws, or any amendments to these Bylaws, shall become effective only upon approval by the Board of Directors.

ARTICLE XVI:
ADOPTION

These Bylaws and Fair Hearing Plan, together with the appended rules and regulations of the Medical Staff, have been adopted by the Active Medical Staff following recommendation of the Executive Committee.

Adopted by the Active Medical Staff of East Morgan County Hospital by a vote completed on _____, 2015.

_____
Chief of Staff

_____
Vice Chief of Staff

Approved by the Governing Board on October 8, 2015.