OGALLALA COMMUNITY HOSPITAL

Medical Staff Bylaws

MEDICAL STAFF BYLAWS

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THE BYLAWS OF
THE MEDICAL STAFF OF
OGALLALA COMMUNITY HOSPITAL

OGALLALA, NEBRASKA

PREAMBLE

WHEREAS, Ogallala Community Hospital is operated by Banner Health System, a nonprofit corporation organized under the laws of the State of Arizona;

WHEREAS, its purpose is to serve as a general acute care hospital 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 Chief Executive Officer and the Board of Directors are necessary to fulfill the Hospital's obligation to its patients.

NOW, THEREFORE, the physicians, dentists and podiatrists 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 Ogallala Community Hospital.

ARTICLE I
PURPOSES

The purposes of the Medical Staff are:

1.1 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.

1.2 To organize into committees in order to review the professional practices of Members and others granted privileges within the Hospital for the purposes of reducing morbidity and mortality. Such a review shall include assessment of, and formulation of recommendations concerning the nature, quality and necessity of, the care provided.

1.3 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.

1.4 To provide a means of communication among the Members, the Chief Executive Officer and Board of Directors.

ARTICLE II
DEFINITIONS

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

2.1 Hospital. The term "Hospital" shall mean Ogallala Community Hospital, a community hospital facility located in Ogallala, Nebraska.

2.2 Medical Staff. The term “Medical Staff” shall be interpreted to include all physicians, dentists and podiatrists who are formally appointed by the Board of Directors as Members. The term "Medical Staff" shall not include Allied Health Professionals or other health care providers who may be granted certain health care privileges within the Hospital and who are monitored by Members or committees of the Medical Staff, as hereinafter set forth.

2.3 Board of Directors. The term “Board of Directors” shall refer to the Board of Directors of Banner Health System, the governing board of such corporation, or any subcommittee thereof, as may be designated by the Board of Directors, unless otherwise specified.

2.4 Chief Executive Officer. The term “Chief Executive Officer” shall refer to the chief executive officer of the Hospital, or his or her designee.

2.5 Medical Executive Committee. The term “Medical 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.

2.6 Completed Application. The term "Completed Application” shall mean and refer 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, Sections 5.1-5.3.

2.7 Standards Required by these Bylaws. The phrase “standards required by these Bylaws” shall mean and refer to (1) standards set forth in these Bylaws, (2) standards adopted by the Medical Executive Committee and approved by the Board of Directors, such as those set forth in Article III, Section 3.2.3, and (3) standards required by any policy and procedure statement formally adopted by the Board of Directors.

2.8 Medical Staff Year. The term "Medical Staff Year" shall mean the period from January 1st to December 31st.

2.9 Corporate Bylaws. The term “Corporate Bylaws” shall refer to the corporate bylaws of Banner Health System.

2.10 Member. The term "Member" shall mean any Practitioner who has been appointed to membership on the Medical Staff by the Board of Directors.

2.11 Practitioner. The term "Practitioner" shall mean a doctor of medicine, a doctor of osteopathy, a doctor of dental medicine, a doctor of dental surgery, or a podiatrist.

2.12 Special Notice. The term "Special Notice" shall mean written notification delivered in person or sent by certified or registered mail, return receipt requested.

2.13 Applicant. The term "Applicant" shall mean 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.

2.14 Rules and Regulations. The term "Rules and Regulations" shall mean the written statements regulating the conduct of the Medical Staff within the broad guidelines provided by these Bylaws.

2.15 Allied Health Professional. The term "Allied Health Professional" shall mean an individual who, though not a Member, (1) is qualified by training, experience, and current competence in a discipline permitted to practice in the Hospital; and (2) functions in a medical support role to Members who have agreed to be responsible for such Allied Health Professional.

2.16 Fair Hearing Plan. The term "Fair Hearing Plan" shall mean the Fair Hearing Plan recommended by the Medical Executive Committee and approved by the Board of Directors, as the same may be supplemented and modified from time to time by policies adopted by the Board of Directors, including, without limitation, the appellate review policy.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership.

Membership on the Medical Staff is a privilege granted by the Board of Directors, which 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. Membership on the Medical Staff may be withdrawn at any time, in accordance with these Bylaws, if it is determined that a Member fails to meet the qualifications, standards and requirements of the Hospital and the Medical Staff. 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.

3.2 Qualifications for Membership.

3.2.1 Only Practitioners duly licensed to practice in the State of Nebraska who can continually document their education, background, experience, training, physical and mental health, and demonstrated competence; their adherence to the ethics of their professions; their good reputation; and their ability to work with others for the cooperative delivery of quality 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 the fact that he or she is licensed to practice his or her profession in this or in any other state, is a member of any professional organization, or has ever been granted such clinical privileges at another hospital.

3.2.2 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 or she meets the qualifications, standards and requirements set forth in these Bylaws, the Corporate Bylaws, and the bylaws, rules, regulations, policies and procedures of the Hospital, and that, if granted Medical Staff membership and clinical privileges, he or she would deliver quality care.

3.2.3 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: (i) he or she must possess such credentials for Medical Staff appointment and reappointment and for the specific clinical privileges requested, as the Medical Executive Committee shall, from time to time, establish, subject to final approval by the Board of Directors; (ii) at a minimum he or she must possess the following:

(a) Graduation from a medical school accredited at the date of graduation by the Liaison Committee on Medical Education or the Canadian Medical Association; graduation from a college of osteopathic medicine approved by the American Osteopathic Association; for graduates of foreign medical schools, a passing score on parts I and II of the National Board of Medical Examiners examination or a permanent certificate from the Educational Council for Foreign Medical Graduates; graduation from an accredited dental school; or graduation from an accredited school of podiatry;

(b) An unrestricted license to practice in the State of Nebraska issued by the Nebraska Board of Medical Examiners, the Nebraska Board of Osteopathic Examiners in Medicine and Surgery, the Nebraska Board of Dental Examiners, or the Nebraska Board of Podiatric Examiners; and

(c) Insurance coverage as required by these Bylaws; and

(d) He or she must possess the requisite physical and mental health status, skill, proficiency and competency required for the careful

practice of medicine, dentistry or podiatry within the clinical privileges requested.

3.2.4 Acceptance of an application for membership on the Medical Staff shall constitute an agreement that the Applicant shall strictly abide by these Bylaws, the Principles of Medical Ethics and rule 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 Code of Ethics of the American Podiatric Association, whichever is applicable, and the Standards for Hospitals as promulgated by the Joint Commission ("TJC").

3.3 Conditions and Duration of Appointment.

3.3.1 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 Executive Committee as provided in these Bylaws; provided, however, that in the event of unwarranted delay on the part of the Medical Executive Committee and after due notification of appropriate committees of the Medical Staff and the Chief of Staff, the Board of Directors may act without such recommendation on the basis of documented evidence of the Applicant's professional and ethical qualifications obtained from reliable sources. Prior to taking such action, however, the Board of Directors shall notify the Medical Executive Committee of its intent, and shall designate an action date prior to which the Medical Executive Committee may still fulfill its responsibility.

3.3.2 Initial appointments to the Medical Staff shall be governed by the provisions of Article V, Sections 5.1-5.2. Reappointments shall be for a period not exceeding twenty-four (24) months and shall be determined in accordance with Article V, Section 5.3.

3.3.3 Appointment 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.

3.3.4 As a condition to membership on the Medical Staff, each Member shall acknowledge his or her obligation to provide continuous care and supervision of his or her patients; to abide by these Bylaws, the Rules and Regulations, Policies and Procedures of the Hospital; to accept consultation assignments; and to participate in rotating staffing of the emergency department in accordance with these Bylaws and any applicable policies of the Hospital and the Medical Staff.

3.3.5 It shall be a condition of membership in 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 that are acceptable in form and amount to the Board of Directors and that the

Member has on file with the office of the Chief Executive Officer 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 or lapse of any of said policies of insurance. Failure to maintain such coverage may result in an automatic termination of privileges as set forth in Article VII, Section 7.7.4.

3.4 Responsibilities of Each Member.

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

3.4.2 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.

3.4.3 Each Member shall participate in the on-call coverage of the emergency department or shall provide on-call coverage for patients needing urgent or emergent care, depending upon specialty and shall participate in such other coverage programs as determined by the Medical Executive Committee or, if necessary, the Chief Executive Officer.

3.4.4 Each Member shall abide by these Bylaws, the Rules and Regulations, and the applicable bylaws, rules, regulations, policies and procedures of the Hospital.

3.4.5 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).

3.4.6 Each Member shall use confidential information only as necessary to provide patient care, 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.

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

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

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

3.4.10 Each Member shall promptly notify the Chief Executive Officer of any change in the status of liability coverage, licensure, Drug Enforcement Agency ("DEA") registration, or any other information on the application form.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

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

4.1 Active Staff

The Active Staff shall consist of those Members who have demonstrated a special interest in the Hospital by regularly admitting, treating and/or performing consultations for patients cared for at the Hospital; by locating his or her office and residence in such proximity to the Hospital as to be readily available to Hospital patients for continuous and emergency care; 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 Staff shall have delineated clinical privileges, shall be eligible to vote, to hold office and to serve on Medical Staff committees; provided, however, that dentists and podiatrists who are members of the Active Staff may not vote on specified matters or hold specified offices for which medical education, training and experience, beyond which dentists and podiatrists can demonstrate, are deemed prerequisites for making an informed judgment thereon or for carrying out the duties thereof. Members of the Active Staff also must participate in the on-call coverage of the emergency department.

4.1.1 For the purpose of this Article IV, Section 4.1, the phrase “regularly admitting, treating and/or performing consultations” means those Members who have either admitted or performed formal consultations for not less than five (5) inpatients, or who have otherwise treated or cared for not less than ten (10) outpatients at the Hospital in any twelve (12) month period.

4.1.2 Physicians who are members of the Active Staff may admit patients to the Hospital as provided in these Bylaws. A dentist or a podiatrist who is a member of the Active Staff may admit patients to the Hospital provided it is demonstrated, at the time of admission, that a physician who is a member of the Active 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.

4.1.3 Members of the Active Staff who are at least 60 years of age, have provided medical services in the Ogallala community for 30 years and have maintained clinical privileges at the Hospital for 30

years may request removal from participation in the on-call coverage of the emergency department. Said request shall be unconditionally granted by the Medical Executive Committee, unless to do so would create an extreme hardship for the others who serve on the call roster for that specialty. Notwithstanding the above, in the event of a disaster, as determined by the Chief Executive Officer, the requesting Member may be required to participate in on-call coverage for the duration of the disaster.

4.2 Courtesy Staff

The Courtesy Staff shall consist of those Members who only occasionally admit patients to the Hospital and/or who act only as consultants. Members of the Courtesy Staff shall have full privileges of admitting patients and may serve as members of special, ad hoc or standing Medical Staff committees. Members of the Courtesy Staff shall not be eligible to hold office or vote. Members of the Courtesy Staff shall have specifically delineated clinical privileges. Members of the Courtesy Staff who admit or treat more than ten (10) patients at the Hospital in a twelve (12) month period and whose office and/or residence is at a location in relation to the Hospital such that the Member may be readily available to Hospital patients for continuous and emergency care must apply for membership on the Active Staff at the end of such twelve (12) month period. Members of the Courtesy Staff also must participate in the on-call coverage of the emergency department, if assigned to do so by the Medical Executive Committee or, if necessary, the Chief Executive Officer.

4.3 Honorary Staff

The Honorary Staff shall consist of Members not active in Hospital practice, but whom, because of outstanding reputation, service, or recognition, may be appointed to the Honorary Staff. They shall not be eligible to vote, hold office or serve on standing committees, they may not admit patients, and they shall have no delineated clinical privileges.

ARTICLE V
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Responsibilities of Applicant.

5.1.1 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 Chief Executive

Officers, 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 he or she meets the standards required by these Bylaws, the Rules and Regulations, the bylaws, rules, regulations, policies and procedures of the Hospital and any applicable policies of the Board of Directors. In the event that the information supplied by the Applicant to the appropriate committees of the Medical Staff and the Board of Directors is not sufficient to permit an informed decision on the matter, then the application for appointment to the Medical Staff and for clinical privileges shall be deemed not to be a Completed Application and shall not be processed. If any requested information is not obtained from the Applicant within sixty (60) days after Special 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.

5.1.2 All Applicants shall complete, sign and file with the Chief Executive Officer 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 Article V, Section 5.1.1 above, including, without limitation, the following matters:

(a) All 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.

(b) All medical or healthcare related training programs of every type or description in which the Applicant participated, including, with respect to those programs completed by the Applicant, the date of completion of such programs.

(c) All factors bearing upon the Applicant's professional qualifications, including a listing of at least three (3) Practitioners who are personally acquainted with the Applicant. At least two (2) of the Practitioners named must have extensive experience in observing and working with the Applicant, and be in a position to provide adequate references pertaining to the Applicant’s professional competence, ethical character and compliance with the standards required for the appointment as set forth in Article V, Section 5.1.1, above. The Applicant shall identify all specialty boards to which he or she has applied for certification and dates of certification, if any. As to those Applicants who are not board certified in any specialized field of medical practice, but who consider themselves to be “board eligible”, the Applicant shall provide information concerning the date upon which he or she first became board eligible and the basis upon which board eligibility is claimed.

(d) All medical, surgical or health related organizations to which the Applicant has ever belonged or applied for membership and the current status of the Applicant's membership, including specialty organizations as well as professional societies and other professional organizations of every type.

(e) 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.

(f) Any pending or completed action or recommendation to deny, revoke, suspend, reduce, limit, impose supervision or consultation requirements; any refusal to process or withdrawal of an application; any voluntary or involuntary relinquishment (by resignation, expiration or otherwise); and/or any imposition of probation, letter of censure, letter or concern or other warning of or by or relating to medical staff membership status, prerogatives, or clinical privileges at any hospital or health care institution; specialty or subspecialty board certification or eligibility; and/or any professional society and other professional organization.

(g) 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 Applicant shall disclose 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.

(h) The Applicant's experience with regard to any licensing agency of federal, state or local government, including all licenses granted, denied, suspended or revoked relating to the privilege of practicing any healthcare profession, including, but not limited to, the practice of medicine, osteopathy, dentistry or podiatry.

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

(j) Any pending or current action against the Applicant that may exclude him or her from participation in Medicare and/or any other federally-supported healthcare program.

(k) The Applicant's physical and mental health status and any health impairments (including alcohol and/or drug dependencies) that may affect the Applicant's ability to perform professional and Medical Staff duties fully.

5.1.3 By making application for appointment or reappointment to the Medical Staff, the Applicant acknowledges his or her 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.

5.1.4 By making application for appointment or reappointment to the Medical Staff, the Applicant authorizes the release of all information required for the making of an informed judgment concerning the Applicant's compliance with the standards required by these Bylaws. Without limiting the foregoing, the Applicant authorizes the release of:

(a) medical records and information relating to the Applicant's physical and mental health; and

(b) peer review information by all other hospitals or other health care organizations at which the Applicant has ever applied for or received medical staff membership or clinical privileges, even though said peer review records might be deemed “confidential” or “privileged”.

5.1.5 By making application for appointment or reappointment, the Applicant agrees to submit to such physical or mental examinations as the Medical Executive Committee or Board of Directors may require. In addition, by making application for appointment to the Medical Staff, the Applicant releases from civil liability the agents, attorneys, employees and representatives of the Hospital and Banner Health System, the agents and representatives of the Medical Staff, as well as the agents, attorneys, employees and representatives of the hospitals and other health care organizations to which inquiries are directed under these Bylaws, for all acts taken by said individuals in supplying information concerning the Applicant.

5.1.6 By making application for appointment or reappointment, the Applicant acknowledges that the Applicant has received and read these Bylaws and the Rules and Regulations, and agrees to be bound by the terms thereof without regard to whether or not he or she is granted membership on the Medical Staff and clinical privileges at the Hospital.

5.2 Appointment Process.

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

5.2.1 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 Chief Executive Officer all of the following documentation: (i) a completed application form, (ii) copies of degrees and certificates of completion, (iii) copies of insurance policies and certificates of insurance, (iv) responses to letters of inquiry from the Chief Executive Officer and (v) 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 5.1. Upon receipt by the Chief Executive Officer of all of the foregoing documentation, review and evaluation of the Completed Application shall be commenced.

5.2.2 The Completed Application shall be reviewed and evaluated by the Medical Staff in accordance with this Article V, Section 5.2.2, and the Medical Executive Committee shall formulate recommendations to the Board of Directors concerning the Applicant's compliance with the standards required by these Bylaws.

The Completed Application shall be processed by the Medical Staff as follows:

(a) The Medical Executive Committee shall review the Applicant's qualifications and measure them against the standards required by these Bylaws, and may conduct an interview. In special situations where there are no Members on the Medical Executive Committee with the appropriate qualifications to review the Applicant's qualifications and requested privileges.

(b) The Medical Executive Committee shall make a determination concerning appointment of the Applicant to the Medical Staff and the granting of delineated clinical privileges. Upon such approval of the Applicant by the Medical Executive Committee and the Chief of Staff, the Applicant may request temporary privileges as provided in Article VI, Section 6.2 below.

(c) The Medical Executive Committee shall take action on the matter. The forms of action available to the Medical Executive Committee shall include, without limitation: (i) deferral of the application for further consideration or for further determination of specified issues, clarification of recommendations or the gathering of additional information; (ii) the formulation of a recommendation to the Board of Directors concerning the granting of Medical Staff membership and delineated clinical privileges, or (iii) recommendation against appointment to the Medical Staff and/or recommendation against granting of any or all of the clinical privileges requested by the Applicant.

5.2.3 The effect of the Medical Executive Committee's actions shall be as follows:

(a) Favorable Recommendation

A recommendation of the Medical Executive Committee that is favorable to the Applicant in all respects shall be promptly forwarded to the Board of Directors.

(b) Adverse Recommendation

An adverse recommendation of the Medical Executive Committee shall entitle the Applicant to the procedural rights provided in these Bylaws and the Fair Hearing Plan.

(c) Deferral

An action by the Medical Executive Committee to defer the application for further consideration or for further determination shall be followed up at its next regular meeting or upon receipt of adequate information with its recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, Medical Staff category, prerogatives, department and section affiliation, and scope of clinical privileges.

5.2.4 At its next regularly scheduled meeting, the Board of Directors may adopt or reject, in whole or in part, a recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral. Favorable action by the Board of Directors is effective as its final decision. If the Board of Director's action is adverse to the Applicant in any respect, the Chief Executive Officer shall, by Special Notice, promptly so inform the Applicant who is then entitled to the procedural rights provided in these Bylaws and the Fair Hearing Plan. Board action after completion of the procedural rights provided in these Bylaws and Fair Hearing Plan or after waiver of these rights is effective as the final decision of the Board of Directors.

5.3 Reappointment Process.

5.3.1 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 all of the current information required for initial appointment to the Medical Staff under the provisions of Article V, Section 5.1. 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 Medical Staff membership and clinical privileges, the Applicant must complete, sign and file with the Chief Executive Officer 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 Medical Staff and/or Board of Directors, within fifteen (15) days of the request thereof, 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 sixty (60) days after Special 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.

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

(a) The Chief Executive Officer shall cause to be mailed to the Applicant at the most recent business address found in the Hospital's records, or shall hand deliver, a reappointment form.

(b) The Applicant shall cause the completed form to be signed and filed with the Chief Executive Officer.

(c) 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 Medical Executive Committee. The Medical Executive Committee shall take action thereon concerning renewal of the Applicant's Medical Staff membership and renewal, extension, or curtailment of the Applicant's clinical privileges.

(d) Failure, without good cause, to submit a complete reappointment application or to provide all requested information within forty-five (45) days prior to the expiration of the Member's current Medical Staff appointment shall be deemed a voluntary resignation from the Medical Staff at the end of such Member's current appointment period, and the procedures set forth in the Fair Hearing Plan shall not apply. In such event, the subject Member shall be required to reapply for Medical Staff membership and Clinical Privileges.

5.3.3 At the next regularly scheduled meeting of the Medical Executive Committee, the Medical Executive Committee shall take action on the request for reappointment and delineated clinical privileges.

5.3.4 The Medical Executive Committee shall review the Applicant's file, and any other relevant information available to it and either make a recommendation for reappointment or non-reappointment and for Medical Staff category, department and section assignment, and clinical privileges, or defer action for further consideration.

5.3.5 Final processing of reappointments shall follow the procedure set forth in Article V, Sections 5.2.3 -5.2.4 above.

5.4 Leaves of Absence.

5.4.1 Request for Leave of Absence

(a) A Member may, for good cause, be granted a voluntary leave of absence by the Chief of Staff and the Chief Executive Officer, subject to the approval of the Board of Directors, for a definitely stated period of time, not to exceed two (2) years, except for military service. Absence for longer than the period of time granted shall constitute voluntary resignation of Medical Staff membership and clinical privileges unless an exception is made by the Board of Directors upon recommendation by the Medical Executive Committee. A Member may be granted a leave of absence for an additional period of time so long as the total duration of the leave of absence does not exceed two (2) years. Such extensions shall be considered only in extraordinary cases where the additional period of time for the leave of absence would be in the best interest of the Hospital.

(b) Requests for leaves of absence shall be sent, in writing, to the Chief Executive Officer. The request shall include the reasons for the leave of absence, the proposed commencement date of the leave of absence and the proposed duration of the leave of absence. The Chief of Staff and the Chief Executive Office shall forward the request, together with their recommendations, to the Medical Executive Committee for transmittal to the Board of Directors. The Medical Executive Committee also shall notify the Medical Executive Committee of all such requests.

(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.

5.4.2 Reinstatement

(a) A Member who has been granted a leave of absence may request reinstatement of Medical Staff status and clinical privileges at the conclusion of the leave of absence or at any time prior to the defined ending date of the leave of absence. Such request for reinstatement shall be submitted, in writing, to the Chief Executive Officer and shall include a summary of all professional activities undertaken during the leave of absence as well as evidence of current licensure, DEA registration, if applicable, and liability insurance coverage. If the leave of absence extended beyond the Member's current appointment term, then, the Member also shall

be required to complete an application for reappointment to the Medical Staff.

(b) The Chief of Staff and the Chief Executive Office shall forward the request for reinstatement, together with their recommendations, to the Medical Executive Committee for further consideration. The Member who is requesting reinstatement also shall provide such other information as may be requested by the Medical Executive Committee at such time.

(c) If the leave of absence was for medical reasons, the Member who is requesting reinstatement shall submit a report from his or her Practitioner indicating that the Member is physically and mentally capable of exercising the clinical privileges requested. The Member also shall provide such other information as may be requested by the Medical Executive Committee at such time.

(d) After considering all relevant information, the Medical Executive Committee shall make its recommendation on the request for reinstatement to the Medical Executive Committee and the Board of Directors. The Medical Executive Committee may approve reinstatement either to the same or a different Medical Staff category and may limit or modify the clinical privileges to be extended to the Member upon reinstatement. If the recommendation of the Medical Executive Committee is adverse to the Member seeking reinstatement, such recommendation shall be processed in accordance with the Fair Hearing Plan.

5.5 Requests for Modification of Appointment.

A Member may, either in connection with reappointment or at any other time, request modification of his or her Medical Staff category or clinical privileges by submitting a written application to the Chief Executive Officer. Such application shall be processed in substantially the same manner as provided in Article V, Section 5.3 for reappointment.

5.6 Contracted or Employed Practitioners.

Applicants employed or retained by the Hospital shall be subject to the same requirements and procedures for appointment and reappointment as all other Applicants. Any Member employed by, or providing services through a contract with, the Hospital shall not have his or her Medical Staff membership or clinical privileges modified in any manner without the same due process provided to any other Member, unless such Member's employment agreement or contract with the Hospital specifically provides otherwise.

ARTICLE VI
CLINICAL PRIVILEGES

6.1 Clinical Privileges Restricted.

6.1.1 Every Member shall be entitled to exercise only those clinical privileges specifically granted to him or her by the Board of Directors, except as provided in Article VI, Sections 6.2 and 6.3 below.

6.1.2 The following must be successfully completed, as applicable, prior to exercising clinical privileges at the Hospital:

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

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

(c) Exceptions may be made for Practitioners granted temporary or disaster privileges.

6.1.3 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. Specific requests also must be submitted for temporary clinical privileges and for modification of clinical privileges in the interim between reappointment.

6.1.4 Requests for clinical privileges shall be considered only when accompanied by evidence of education, training, equivalent experience, and demonstrated current competence, as specified by the Hospital. 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 Medical Executive Committee and the Medical 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.

6.1.5 Requests for clinical privileges shall be evaluated on the basis of prior and continuing education, training, equivalent experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment unless it is determined that such procedure shall not be performed at the Hospital. The Applicant shall have the burden of establishing his or her qualifications and competency in the clinical privileges he or she requests.

6.1.6 Privileges granted to dentists shall be based on their training, equivalent experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients

shall receive the same basic medical appraisal as patients admitted to other surgical services. 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.

6.1.7 Privileges granted to podiatrists shall be based on their training, equivalent experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Surgery. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. 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.

6.1.8 As used herein, "equivalent experience" shall consist of a body of procedures or clinical privileges exercised in a prior setting in which such activity was subject to a documented quality assurance process.

6.2 Temporary Privileges.

6.2.1 Upon receipt of a Completed Application from an appropriately licensed Applicant, and with the approval of the Medical Executive Committee and the Chief of Staff, the Chief Executive Officer may grant temporary admitting and clinical privileges to the Applicant for up to ninety (90) days; provided, however, that in exercising such privileges, the Applicant shall act under the supervision of the Members who the Chief of Staff assigns to monitor his or her practice.

6.2.2 Temporary clinical privileges for the care of a specific patient may also be granted by the Chief Executive Officer to Practitioners who do not intend to become Members under the following terms and conditions:

(a) the Applicant shall advise the Chief of Staff, or his or her designee, of his or her qualifications and the extent to which he or she complies with the standards required by these Bylaws; and

(b) the Applicant shall furnish proof of licensure and of adequate professional liability insurance coverage.

Under such circumstances, and upon the recommendation of the Chief of Staff, or his or her designee, the Chief of Staff may grant temporary clinical privileges. Such temporary clinical privileges shall be restricted to the treatment of not more than two (2) patients in any twelve (12) month period.

6.2.3 A Practitioner may be permitted to serve as locum tenens Practitioner for a Member under the following conditions:

(a) The Member desiring to utilize a locum tenens Practitioner shall advise the Chief of Staff of the name and address of the proposed locum tenens Practitioner, and the period of time during which the Member shall be absent from the community. 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.

(b) The locum tenens Practitioner shall complete and sign an application for appointment to the Medical Staff. The application shall not be processed for review, but shall be used as a source of information concerning the qualifications of the locum tenens Practitioner, and by signing the application, the locum tenens Practitioner agrees to be bound by these Bylaws, the Rules and Regulations and the bylaws, rules, regulations, policies and procedures of the Hospital.

(c) Service as a locum tenens Practitioner shall not exceed ninety (90) consecutive days without reapplication for temporary privileges.

(d) The Chief Executive Officer may permit a locum tenens Practitioner to care for patients in the Hospital only with the approval of the Chief of Staff.

6.2.4 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.

6.2.5 Upon the recommendation of the Chief of Staff or another member of the Medical Executive Committee, the Chief Executive Officer, 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 Chief Executive Officer, 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 6.2. 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.

6.2.6 Special requirements or conditions may be imposed by the Chief of Staff or the Chief Executive Officer on any Practitioner granted temporary privileges. The Chief Executive Officer may, at any time, without notice, revoke temporary privileges, and the Chief Executive Officer 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.

6.3 Emergency Medical Situations.

In the event of a medical emergency, any Member, to the degree permitted by his or 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, the Member must request the clinical privileges necessary to continue to treat the patient. In the event that the request for such clinical privileges is denied or the Member does not desire to request such clinical privileges, the patient shall be assigned to an appropriate Member by the Chief of Staff. For the purpose of this Article VI, Section 6.3, 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.

6.4. Telemedicine Privileges.

6.4.1 "Telemedicine Privileges" means the authorization granted to a Practitioner by the Board of Directors to render a diagnosis of a patient at the Hospital through the use of electronic communication or other communications technologies. The Practitioner will not be a Member and may not provide direct patient care.

6.4.2 Any Practitioner who wishes to be considered for Telemedicine Privileges will provide the following documentation to the Chief Executive Officer, or his/her designee:

(a) Signed consent and release/authorization form;

(b) Current Nebraska license to practice medicine;

(c) Curriculum Vitae;

(d) Current copy of DEA and state controlled substance certificate, if applicable;

(e) Current copy of professional liability insurance coverage certificate in such minimum amount as may be required by the Hospital;

(f) Evidence of no exclusion from any federal health care program;

(g) Evidence of medical staff appointment and clinical privileges in good standing at another JCAHO accredited or equivalent hospital/organization; and

(h) Such additional information as may be requested by the Hospital.

6.4.3 The following verifications will be completed by the Chief Executive Officer, or his/her designee:

(a) Query to the National Practitioner Data Bank;

(b) Query to determine that the Practitioner has not been excluded from any federal health care program;

(c) Verification of the Practitioner's medical staff status at the Practitioner's primary JCAHO accredited or equivalent hospital/organization;

(d) Verification of the Practitioner's medical license(s) in the Practitioner's primary state and the state in which telemedicine services will be provided (when applicable); and

(e) Verification of the Practitioner's current DEA status, when applicable, and verification of the Practitioner's current board status (when applicable).

6.4.4 The Medical Executive Committee will confer with the Chair(s) of the applicable Medical Staff committee(s) regarding the clinical services that may be offered through telemedicine.

The Chief Executive Officer, with input from the Medical Executive Committee, will determine the specific services to be provided at the Hospital via telemedicine.

The Medical Executive Committee will make a recommendation to the Board of Directors regarding whether the Practitioner's request for Telemedicine Privileges should be granted. The decision of the Board of Directors will be final.

6.4.5 Practitioners may be granted Telemedicine Privileges for a period not to exceed two (2) years and will be required to submit an application for reappointment prior to the expiration of his or her Telemedicine Privileges.

6.4.6 A Practitioner who has been granted Telemedicine Privileges will immediately report to the Chief Executive the loss or suspension of any license, certificate or authorization described in Article 6, Section 6.4.2, above. Such loss or suspension will result in the immediate and automatic relinquishment of any and all Telemedicine Privileges with no right to a hearing or an appeal as outlined in these Bylaws.

If telemedicine services are being provided at the Hospital through a contracted group, it will be the responsibility of the contracted group to notify the Chief Executive Officer or his/her designee of any Practitioner who requires Telemedicine Privileges and of any Practitioner who no longer needs to maintain Telemedicine Privileges.

6.4.7 If any Practitioner who has been granted Telemedicine Privileges intends to direct patient care or to provide "hands-on" patient care, such Practitioner will be required to apply for Medical Staff membership and clinical privileges at the Hospital prior to the provision of any such direct patient care.

ARTICLE VII
PROFESSIONAL REVIEW PROCEDURES AND CORRECTIVE ACTION

7.1 Nature of Professional Review Procedures.

7.1.1 Resolution of any controversy or request for an inquiry regarding 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.

7.1.2 Initiation of Professional Review Procedures

(a) Whenever a matter that alleges grounds for a review comes to the attention of any Member, the Chief Executive Officer or the Board of Directors, a request shall be made, in writing, to the Chief of Staff, or in his or her absence or inability to act, the Vice Chief of Staff. The allegations shall be supported by reference to specific activities or conduct that would be grounds for such review. No anonymous or oral requests shall be considered.

(b) The Chief of Staff (or the Vice Chief of Staff) shall arrange for a confidential review of the matters alleged in the request by an ad hoc committee of not less than two (2) Members. The Chief of Staff also shall notify the Chief Executive Officer of the review. If possible, the members of the ad hoc committee shall not be in direct economic competition with the Member in question.

(c) If preliminary review by the ad hoc committee indicates that the matter does not warrant further attention, the ad hoc committee shall prepare a report to the Chief of Staff, and the review shall be closed without further action. A copy of this report shall be retained in the quality/peer review file of the Member in question.

(d) If additional information is needed to complete the preliminary review, the Chief of Staff shall promptly notify the Member and shall give the Member an opportunity to meet informally with the ad hoc committee before it makes a final recommendation. The Member shall be provided, in advance of this informal meeting, the general nature of the review, and of the evidence supporting the review. The Member shall be invited to discuss, explain or refute the evidence. 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 informal meeting shall not constitute a hearing, and none of the procedural rules set forth in these Bylaws and the Fair Hearing Plan shall apply. If the matter can be resolved to the satisfaction of the ad hoc committee, it shall report such recommendation to the Chief of Staff and the matter shall be dismissed with documentation being retained in the quality/peer review file of the Member in question.

(e) If the ad hoc committee 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 Medical Executive Committee, along with supporting documentation.

(f) An informal review process, as set forth above 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 an investigation, one may be requested pursuant to this Article VII.

7.2 Procedural Rights.

If, after an initial review is completed and the Medical Executive Committee has recommended corrective action, or at any other time a corrective action is initiated, the Member shall be entitled to the procedural rights as provided for in these Bylaws and the Fair Hearing Plan, and the matter shall be processed in accordance with these Bylaws and the Fair Hearing Plan.

7.3 Corrective Action.

7.3.1 If it appears that a Member does not meet the standards required by these Bylaws for Medical Staff membership or for specific clinical privileges that have been granted, or otherwise appears to have engaged in a course of conduct or practice that is, or is reasonably likely to be, detrimental to the quality of patient care or safety, is 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 Chief Executive Officer or the Board of Directors.

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

(a) A written request for corrective action must be submitted to the Chief of Staff or in his or her absence or inability to act, the Vice Chief of Staff. A copy of the request shall be provided to the Chief Executive Officer. If the corrective action is initiated by the Medical Executive Committee, this requirement need not be met. The request shall then be presented to the Medical Executive Committee.

(b) The written request for corrective action must specify the type of action requested and shall give a general description of the basis upon which corrective action has been requested;

7.3.3 Decision and course of action by the Medical Executive Committee

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

(b) The Medical Executive Committee may:

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

(ii) Determine that more information is needed and request an investigation pursuant to Article VII, Section 7.1 above.

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

7.3.4 Notice to the Member

(a) If a recommendation for corrective action is made by the Medical Executive Committee, the Chief of Staff shall, by Special Notice, 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.

(b) If the recommendation for corrective action is non-reviewable, the Medical Executive Committee shall consider its implementation and so advise the Member in the Special Notice.

(c) If the recommendation for corrective action is reviewable, the Member shall be informed in the Special Notice of his or her rights to a Fair Hearing and shall be provided a copy of these Bylaws and the Fair Hearing Plan.

7.4. Non-reviewable Forms of Corrective Action.

7.4.1 Not every form of requested corrective action entitles a Member to a formal hearing and/or appeal pursuant to the Fair Hearing Plan before it is implemented. Specifically, 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 Medical Executive Committee without affording the Member the procedural steps provided for in the Fair Hearing Plan:

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

(b) The requirement of additional training or education that does not require the Member to terminate or take a leave of absence from his or her practice;

(c) The issuance of a letter of concern or warning;

(d) The issuance of a letter of admonition or reprimand; or

(e) The requirement for consultation for a time not to exceed one (1) year.

(f) Conditional Medical Staff appointment or appointment for a limited duration.

7.4.2 The inability of a Member to exercise clinical privileges and/or the rights and prerogatives of Active Staff membership as a result of (i) the Hospital's decision to enter into, to terminate, or to modify an exclusive arrangement with a single Practitioner or provider group to provide certain clinical services or (ii) the termination or modification of the Member's relationship with the exclusive provider shall not constitute a reduction, suspension or revocation of such clinical privileges and/or Medical Staff membership such that the affected Member would be afforded any of the rights set forth in the Fair Hearing Plan.

7.5 Recommended Adverse Action.

If the corrective action recommended by the Medical Executive Committee constitutes a reviewable adverse action against the Member's clinical privileges or Medical Staff membership, then the Member is afforded all the rights set forth in the Fair Hearing Plan. All parties shall abide by the procedure set forth in the Fair Hearing Plan, if such a recommendation is made by the Medical Executive Committee.

7.6. Precautionary Suspension.

7.6.1 Whenever a Member willfully disregards or grossly violates these Bylaws, the Rules and Regulations or any applicable policies of the Hospital or the Medical Staff, or whenever the Member's 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 materially disrupts the operations of any part of the Hospital, the Chief of Staff, the Chief Executive Officer, the Medical Executive Committee, or the Board of Directors shall have the authority to immediately suspend the Member's Medical Staff appointment or any or all portions of the Member's clinical privileges. Whoever imposes the precautionary suspension shall immediately notify the Chief Executive Officer of such action. Precautionary suspension shall become effective immediately upon imposition, and the Chief of Staff or the Chief Executive Officer shall notify the Member promptly of the imposition of the precautionary suspension. The Medical Executive Committee also shall be notified promptly of such action.

7.6.2 Medical Executive Committee Action

Upon the written request of the suspended Member, a meeting of the Medical Executive Committee shall be convened as soon as reasonably

possible after the imposition of the precautionary suspension to review and consider the action taken. Otherwise, the review and consideration shall take place at the next regularly scheduled meeting of the Medical Executive Committee. The Medical Executive Committee shall recommend to the Board of Directors modification, continuation or termination of the terms of the precautionary suspension and the action, if any, to be taken by the affected Member to have the suspension lifted.

7.6.3 Procedural Rights

(a) Unless the Medical Executive Committee recommends termination of the suspension and cessation of all other corrective action, the Member shall be entitled to the procedural rights as provided for in these Bylaws and the Fair Hearing Plan. If the Medical Executive Committee recommends termination of the suspension, the suspension shall be lifted until the Board of Directors has reviewed the recommendation and taken action.

(b) If the Board of Directors decides to continue the suspension, the suspension shall remain in effect or be reinstated and the Member shall be entitled to the procedural rights as provided for in these Bylaws and the Fair Hearing Plan.

(c) If the Medical 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 modify or terminate the suspension. If the suspension is continued, either as originally imposed or as modified, the Member shall be entitled to the procedural rights as provided for in these Bylaws and the Fair Hearing Plan.

7. 7. Automatic Suspension.

7.7.1 Medical Records

A temporary suspension of a Member's admitting privileges and surgical/procedure scheduling privileges effective until medical records are completed, shall be imposed automatically within twenty-two (22) days after the allocation date as provided in the Hospital's Policy for Documentation Requirements for the Medical Record. Prior to the temporary suspension, a written warning to the Member of the delinquency for failure to complete medical records will be provided to the Member within the time period specified in the Medical Staff General Rules and Regulations and the Hospital's Policy for Documentation Requirements for the Medical Record.

7.7.2 Licensure

(a) If a Member's license to practice his or her profession in Nebraska 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 his or her privileges at the Hospital.

(b) If a Member's license to practice his or her profession in Nebraska has been made subject to terms and conditions of probation or other restrictions, the Medical Executive Committee shall treat the matter as a request for corrective action and the procedures for such shall be followed. The suspension, after review by the Medical Executive Committee and the Board of Directors, may be lifted or modified, in whole or in part during the pendency of the corrective action process.

(c) When the decision by the licensing agency has been to revoke or suspend, any request for the opportunity to practice at the Hospital after the license has been reinstated by the licensing agency, shall be treated as if it is an initial application for Medical Staff membership and clinical privileges.

7.7.3 DEA Registration

A Member whose DEA registration is revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of his or her right to prescribe medications covered by such registration. The Medical Executive Committee shall treat the matter as a request for corrective action and the procedures for such shall be followed.

7.7.4 Malpractice Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of the Member's clinical privileges, and if, within sixty (60) calendar days after written warning of the delinquency, the Member does not provide evidence of the required professional liability insurance coverage, the Member shall be deemed to have resigned voluntarily from the Medical Staff and must reapply for Medical Staff membership and clinical privileges.

7.7.5 Failure to Actively Practice

(a) When a Member has not admitted a patient to the Hospital, or has not provided professional services to any patient in the Hospital for two (2) years, he or she may be given Special Notice that in sixty (60) days, the Member's clinical privileges shall be automatically revoked unless an admission to the Hospital or professional services to a patient in the Hospital occurs within such sixty (60) day period.

(b) The Medical Executive Committee, however, shall have the authority to retain on the Medical Staff an inactive Member if there

is determined to be a sufficient benefit to the community as a result of such Medical Staff membership.

7.7.6 False or Misleading Statements on Applications

By making application for appointment or reappointment to the Medical Staff, the Applicant acknowledges his or her responsibility to give full, complete and accurate information. Any failure to provide true, complete and accurate information, including the making of misleading statements, shall be sufficient grounds for automatic suspension of the Member's clinical privileges or other corrective action as provided for in these Bylaws.

7.7.7 Conviction of a Felony

Conviction of a felony may be cause for automatic suspension of a Member's clinical privileges or other corrective action as provided for in these Bylaws.

7.7.8 Excluded Member

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.

7.7.9 Procedural Rights

(a) With respect to an automatic suspension or revocation, the Member shall be entitled to a Fair Hearing only with respect to whether the suspension or revocation was imposed in error.

(b) The imposition of a corrective action, other than an automatic suspension for matters described under this Article VII, Section 7.7, shall be conducted pursuant to the corrective action process in these Bylaws.

7. 8 Enforcement and Continuity of Patient Care During a Suspension.

7.8.1 The Chief of Staff shall provide for alternative coverage for the Hospital patients of a Member suspended pursuant to a precautionary or an automatic suspension. The wishes of the patients shall be considered, where feasible, in choosing a substitute Member. The suspended Member shall confer with the substitute Member to the extent necessary to provide safe, competent care for the patient(s).

7.8.2 The Chief of Staff shall cooperate with the Chief Executive Officer to enforce all suspensions.

7.9. Confidentiality.

7.9.1 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 and the Fair Hearing Plan shall not be disclosed except in accordance with reporting requirements imposed by applicable federal and state laws, rules and regulations.

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

7.10. Reporting.

7.10.1 Precautionary and automatic suspensions that exceed thirty (30) days shall be reported as required by law to the National Practitioner Data Bank and, if required, to the Member's licensing board.

7.10.2 Any final action imposed by the Board of Directors, after the exhaustion of all appeal rights, shall also be reported as required by law to the National Practitioner Data Bank and, if required, to the Member's licensing board.

ARTICLE VIII
OFFICERS

8.1 Officers of the Medical Staff.

The officers of the Medical Staff shall be:

(a) The Chief of Staff;

(b) The Vice Chief of Staff; and

(c) The Secretary-Treasurer.

8.2 Qualifications of Officers.

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

8.3 Election of Officers.

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

8.4 Term of Office.

The term of office for each officer of the Medical Staff shall be a period of one (1) year, commencing as of the first (1st) day of the Medical Staff Year following such officer's election and continuing until the end of the first (1st) Medical Staff Year following such election, or until a successor is elected and qualified.

8.5 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 on the Medical Staff, (b) becomes disabled to the extent that he or she cannot fulfill the duties of his or her office, or (c) dies. Except for the office of the Chief of Staff, vacancies in office shall be filled by the Medical Executive Committee. In the event the office of the Chief of Staff becomes vacant, the Vice-Chief of Staff shall serve out the remaining term.

8.6 Duties of Officers.

8.6.1 The Chief of Staff

The Chief of Staff shall serve as the highest elected official of the Medical Staff to do the following:

(a) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern with respect to the Hospital;

(b) Call, preside at, and be responsible for the agenda of all regular and special meetings of the Medical Staff;

(c) Call, serve as a member of, preside at, and be responsible for the agenda of all meetings of the Medical Executive Committee;

(d) Serve as ex-officio member of all other Medical Staff committees without vote;

(e) Be responsible for the enforcement of these Bylaws and the Rules and Regulations, 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;

(f) Appoint members to all standing, special, and multi-disciplinary Medical Staff committees except the Medical Executive Committee; provided, however, that appointments to standing committees shall be subject to approval of the Medical Executive Committee;

(g) Represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer and the Board of Directors;

(h) 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;

(i) Be responsible for the educational activities of the Medical Staff; and

(j) Be the spokesman for the Medical Staff in its external professional and public relations.

8.6.2 The Vice Chief of Staff

In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties, and have all the authority of, the Chief of Staff. He or she shall be a member of the Medical Executive Committee. He or she shall automatically succeed the Chief of Staff if the office of the Chief of Staff should become vacant for any reason.

8.6.3 The Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The Secretary-Treasurer shall keep accurate and complete minutes of all Medical Staff 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 or her office.

8.7 Removal and Vacancies of Medical Staff Officers.

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

8.7.1 Special Meeting

A special meeting of the Medical Staff shall be called as provided in Article X, Section 10.3 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.

8.7.2 Quorum

Fifty percent (50%) of the members of the Active Staff shall constitute a quorum for the purpose of conducting a special meeting held pursuant to the provisions of this Article VIII, Section 8.7.

8.7.3 Required Vote

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

8.7.4 Effective Date

Removal of a Medical Staff officer shall be effective upon the vote of the Active Staff pursuant to Article VIII, Section 8.7.3 above.

8.7.5 Vacancy

In the event the office of the Chief of Staff becomes vacant, the Vice Chief of Staff shall immediately succeed to the position of the Chief of Staff, and he or she shall continue to serve in such position until the end of the then current Medical Staff Year. In the event any other office of the Medical Staff shall become vacant, it may be filled by the Medical Executive Committee, with the person so appointed to hold office until the end of the then current Medical Staff Year. If an office is filled by the Medical Executive Committee, it shall, prior to the end of the then current 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 (1st) day of the Medical Staff Year following his or her election and expire on the same date as provided for the other Medical Staff officers.

8.7.6 Notwithstanding the provisions contained in Article VIII, Section 8.7.5 above, in the event a vacancy is created by removal of a Medical Staff officer, the Medical Executive Committee, may, in 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.

ARTICLE IX
COMMITTEES AND FUNCTIONS OF THE MEDICAL STAFF

All of the various committees and functions may be combined so that the responsibilities of two or more are performed by the Medical Staff acting as a “committee of the whole.” In addition, special committees may be appointed for specific purposes by the Chief of the Medical Staff, and their appointments will cease upon the accomplishment of their purposes. They shall report to the Executive Committee.

9.1 Committees.

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

Committee. The Chief of Staff or his designee shall be a member ex-officio of all committees.

The committees of the medical staff shall be:

1. Medical Executive Committee
2. Nominating Committee (optional)
3. Bylaws

9.1.1 MEDICAL EXECUTIVE COMMITTEE

a. Composition: The Medical Executive Committee shall be composed of not less than the Chief of the Medical Staff, Vice-Chief, the Secretary-Treasurer and the Hospital administrator or his/her designee.

b. Duties: The duties of the Medical Executive Committee shall be:

i. 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.
ii. review and evaluation of all applicants for Medical Staff membership.
iii. to coordinate the activities and general policies of the Medical Staff;
iv. 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;
v. to make and implement policies of the Medical Staff;
vi. to provide liaison between Medical Staff, the administrator and Board of Directors;
vii. to recommend action to the administrator on matters of a medical-administrative nature, and to advise concerning implementation of new departments, services, and other medical-administrative matters;
viii. to make recommendations on hospital management matters (for example, long range planning) to the Board of Directors through the Administrator;
ix. to fulfill the medical staff's accountability to the Board of Directors for the medical care rendered to all patients in the Hospital;
x. to provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
xi. to review the credentials of all applicants and to make recommendations for Medical Staff membership and delineation of clinical privileges;
xii. to review periodically all information available regarding the performance and clinical competence of Medical Staff 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;

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

xiv. to report at each Medical Staff meeting;

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

xvi. to monitor and regulate the activities of Allied Health Personnel and to be responsible for formulating protocols, which shall be subject to final approval by the Board of Directors, concerning the use of Allied Health Personnel. The protocols shall consider the functioning and activities of Allied Health Personnel on a categorical basis.

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

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

-- objective assessment of the cause and scope of problems or concerns, including 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;

-- 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;

-- monitoring activities designed to assure that the desired results have been achieved and sustained;

-- documentation that reasonably substantiates the effectiveness of the overall program to enhance patient care to assure sound clinical performance.

It shall be the responsibility of the Committee to propose policies and procedures for adoption by the Board of Directors which are intended to achieve the foregoing goals.

It is the intent of these Bylaws that all information given to the Committee, the Local Board, the Board of Directors and others as necessary, as well as the record of actions and proceedings of the Committee shall be confidential and shall be protected from disclosure as is stated in Article XV.

c. Meetings: Meetings shall be held regularly at a date and place, which shall be determined by the Chairperson of the committee upon notice to all members.

9.1.2. NOMINATING COMMITTEES

(a) Composition: The Nominating Committee shall consist of three (3) members of the Medical Executive Committee, whose chairman shall be the chairman of the Nominating Committee.

(b) Duties: At the regular October meeting of the medical staff, the Nominating Committee shall submit nominations for officers of the medical staff for which the elective terms will expire by the end of the calendar year. After nominations of qualified candidates have been closed, elections shall proceed as hereinafter provided in Article XI.

(c) Meetings: The Nominating Committee shall meet at least yearly prior to the regular October meeting of the medical staff and shall transmit a written report of the activities to the Medical Executive Committee.

9.1.3 BYLAWS COMMITTEE

a. The Bylaws Committee shall consist of the current and past Chiefs of Staff and one (1) member of the active medical staff, appointed annually.

b. Duties: Its purpose shall be to review the Bylaws and general rules and regulations for consideration of revisions and amendments and act upon any proposals for same that may originate from the Medical Executive Committee or an active medical staff member.

c. Meetings: Meetings shall be held as needed, but at least annually, at a date and place, which shall be determined by the chairman of the committee upon written notice to all members. It shall submit a written report to the medical staff annually in October.

9.2. Functions.

Unless otherwise designated by these Bylaws, the following functions shall be performed by members of the medical staff who shall be appointed by the Chief of the Medical Staff subject to approval by the Medical Executive Committee. The Chief of Staff or his designee shall be a participant ex-officio in all functions.

9.2.1 Peer Review Functions

(a) Clinical Services review

(b) Surgical Care review

(c) Medical Record review

(d) Blood Usage review

(e) Drug Usage Evaluation

(f) Pharmacy and Therapeutic function

9.2.2 Hospital Services – Monitoring and Evaluation

(a) Diagnostic Radiology

(b) Emergency Care

(c) Ambulatory Care

(d) Nuclear Medicine

(e) Pathology and Medical Laboratory

(f) Physical Rehabilitation Services

(g) Respiratory Care

(h) Special Care Unit

(i) Swing Bed Care (if appropriate)

9.2.3 Other Review Functions

(a) Risk Management

(b) Infection Control

(c) Internal and External Disaster Plans

(d) Hospital Safety

(e) Utilization Review

9.2.4 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 individuals 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 this Section 9.2.

(a) CLINICAL SERVICES REVIEW

Responsibility:

The 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:

The monitoring and evaluation of the quality and appropriateness of patient care provided by all individuals with clinical privileges will encompass all major clinical services.

Medical Staff monitoring and evaluation includes the following:

- Objective written clinical criteria, and thresholds approved by the medical staff, reflective of current knowledge and clinical experience.
- Routine collection of information about important aspects of patient care provided by the medical staff and clinical performance of its members.
- Periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care.
- When important 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

Communication:

A summary of the variations will be reviewed monthly. Medical staff will then document conclusions, recommendations, actions taken, and results of actions.

(b) SURGICAL CASE REVIEW

Responsibility:

This function shall include review of all surgical and invasive and 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 pre-operative, post-operative and pathological diagnosis. This function may include consults with individual medical staff members and requests for written justification for 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 Medical Executive Committee.

Surgical case review shall be performed monthly to help assure that surgery performed in the hospital is justified and of appropriate quality.

Predetermined clinically valid criteria which are approved by the medical staff will be used for screening medical records for surgical case review. Screening can be completed by non-physician personnel. Cases not meeting the criteria will be reviewed by the appointed medical staff member(s).

Functions:

Review is conducted for each case, whether or not a tissue or non-tissue specimen was reviewed.

This review includes:

- Operations performed in operating room, ambulatory surgery and emergency service.
- Tissue cases
- Non-tissue cases
- Tissues exempt from pathology review
- Major invasive diagnostic procedures

- All cases in which a major discrepancy exists between preoperative and postoperative (including pathologic) diagnoses are evaluated.

- 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.

Communication:

A summary of the screening and peer review findings will be reviewed monthly. Medical staff will then document conclusions, recommendations, actions taken, and results of actions.

(c) MEDICAL RECORD REVIEW

Responsibility:

The medical record review functions shall be carried out by an appointed medical staff member, the medical record director, representative(s) of nursing, administration and other departments as appropriate.

Predetermined clinically valid criteria, which are 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 the criteria will be reviewed by the appointed medical staff member.

Review Functions:

- Clinical Pertinence

  This review function assures that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic test, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge.

- 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.

- 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 Medical Executive Committee any members of the medical staff who are persistently delinquent in completion of their records.

Other Functions:

This Medical Record Review function also includes recommending the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems for medical record purposes.

Communication:

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. Medical staff will then document conclusions, recommendations, actions taken, and results of action.

(d) BLOOD USAGE REVIEW

Responsibility:

Blood usage review shall be performed quarterly 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 medical staff member.

Functions:

- The evaluation of the appropriateness of all cases in which patients were administered transfusions, including the use of whole blood and blood components.
- The evaluation of all confirmed transfusion reactions.
- The development or approval of policies and procedures relating to the distribution, handling, use and administration of blood and blood components.
- The review of the adequacy of transfusion services to meet the needs of patients.

- The review of ordering practices for blood and blood products.

Communications:

A summary of the screening and peer review findings will be reviewed by the medical staff monthly. Medical staff will then document conclusions, recommendations, actions taken, and results of action.

(e) DRUG USAGE EVALUATION

Responsibility:

Drug usage evaluation will be performed as a criteria-based, ongoing, planned and systematic process to assure that drugs known to have significant risk are prescribed appropriately, safely and effectively.

Functions:

Continuously monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to help assure that they are provided appropriately, safely and effectively. The drug usage evaluation process includes :

- The classes of drugs to be evaluated
- The rationales for choice
- The criteria to be used
- The methods of collecting and analyzing the data

Communication:

A summary of the screening and peer review findings will be reviewed by the medical staff monthly. Medical staff will then document conclusions, recommendations, actions taken, and results of actions.

(f) PHARMACY AND THERAPEUTICS FUNCTION

Responsibility:

The pharmacy and therapeutics function shall be carried out by an appointed medical staff member, the pharmacist, a representative of nursing service, administration, and other departments, services, and individuals as appropriate. Predetermined clinically

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 medical staff member.

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.

Functions:

- Development and approval of policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing material.

- Development and maintenance of a drug formulary which is systematically reviewed and changed as necessitated by new knowledge, availability of new drugs and information on costs.

- Formal approval and enforcement of protocols relating to the use of investigational or experimental drugs in the hospital.

- Define and review all "untoward drug reactions", take appropriate actions and follow-up.

- Serve as an advisory group to the hospital medical staff and the pharmacist on matters pertaining to the choice of available drugs.

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

- Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

- Evaluate clinical data concerning new drugs or preparations requested for use in the hospital; and

- Establish standards concerning research in the use of recognized drugs.

Communications:

A summary of all functions including the screening and peer review findings will be reviewed quarterly. Medical staff will then document conclusions, recommendations, actions taken, and results of actions.

9.2.5 HOSPITAL SERVICE FUNCTION – MONITORING AND EVALUATION

Responsibility:

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/resident care and for resolving identified problems.

(a) Diagnostic Radiology

(b) Emergency Care

(c) Ambulatory Care

(d) Nuclear Medicine

(e) Pathology and Medical Laboratory

(f) Physical Rehab Services

(g) Respiratory Care

(h) Special Care Unit

(i) Swing Bed Care (if applicable)

Functions:

- Assist in developing and reviewing indicators/criteria used in monitoring and quality of care provided to patients by department staff and the appropriateness of the services requested by the medical staff.

- Communicate findings from the monitoring and evaluation activities that involve medical staff practices to the medical staff.

Communications:

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

9.2.6 OTHER REVIEW FUNCTIONS

The medical staff shall participate in other review functions, including risk management, infection control, internal and external disaster plans, hospital safety and utilization review.

Communications:

The findings of, and recommendations from these review functions are reviewed quarterly by the medical staff, with documentation of conclusions and recommendations.

(a) Risk Management

Responsibility:

The medical staff actively participates, as appropriate, in risk management activities related to the clinical aspects of patient care and safety.

Functions:

- Identification of general areas of potential risk in the clinical aspects of patient care and safety.
- Development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety, and evaluation of these cases.
- Correction of problems in the clinical aspects of patient care and safety identified by risk management activities.
- Design programs to reduce risk in the clinical aspects of patient care and safety.

(b) Infection Control

Responsibility:

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:

- Development and approval of the infection control program.

- To institute any appropriate control measures or studies when there is reasonably considered to be a danger to any patient or personnel.

(c) Internal and External Disaster Plans

Responsibility:

The medical staff actively participates, as appropriate, in an emergency preparedness program.

Functions:

- Development and approval of the emergency preparedness program.

(d) Hospital Safety

Responsibility:

The medical staff actively participates, as appropriate, in a comprehensive hospital safety program involving the physical safety of patients, employees and visitors.

Functions:

- Assist in development of the hospital safety program.

(e) UTILIZATION REVIEW

Responsibility:

The medical staff actively participates, as appropriate, in a program to address over-utilization, under-utilization, and ineffective scheduling of resources. This function includes conducting 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 physician services. It shall also formulate a written utilization review plan for the hospital for approval by the Medical Executive Committee, the Local Board and the Board of Directors.

Functions:

- Development and approval of a written UR Plan for the hospital for approval by the Medical Executive Committee, the Local Board and the Board of Directors. (The hospital

will provide such secretarial and statistical assistance as may be required).

- Development and approval of criteria used for identifying specific cases with potential utilization problems.
- Review cases identified by the criteria, with recommendations documented.
- Correction of problems identified in clinical areas of utilization.

ARTICLE X
MEETINGS

10.1. Annual Meeting.

10.1.1. The annual meeting of the active medical staff shall be held in December, at which time the retiring officers shall make such reports as may be indicated.

10.1.2 Election of officers and members to fill vacancies on the Executive Committee will be announced as provided in Article XI.

10. 2 General Medical Staff Meetings.

General medical staff meetings shall be held quarterly, unless otherwise requested by the Medical Executive Committee.

10.3 Special Meetings.

Special meetings of the medical staff may be called at any time by the Chief, the Board of Directors, the Medical Executive Committee, or by any five (5) members of the active medical staff, provided written notice and an agenda is mailed or delivered to each active medical staff member at least seven (7) days in advance of the special meeting date.

10.4 Attendance and Quorum.

Each member of the active medical staff shall attend the annual meeting and at least two (2) of the general meetings of the medical staff, unless excused by the Medical Executive Committee for just cause. The failure to meet the foregoing attendance requirements shall be grounds for corrective action and may lead to revocation of medical staff membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application; and all such applications shall be processed in the same manner as applications for original appointment.

Fifty percent (50%) of the members of the active medical staff shall constitute a quorum for the purpose of transacting such business of the medical staff as is permitted by these Bylaws.

10.5 Executive Session.

Executive session is a meeting of a Medical Staff committee that only voting members of the Medical Staff committee and the Chief Executive Officer, or his/her designee, may attend, unless others are expressly requested by such Medical Staff committee to attend. The committee chair may excuse the Chief Executive Officer when Hospital administration is under discussion, but an alternative representative of the Hospital shall be allowed to attend. Executive session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other issues requiring confidentiality.

ARTICLE XI
ELECTIONS

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

11.2. The Nominating Committee, as provided in Article IX, Section 9.1.2, shall submit a slate of nominees at the last regular meeting preceding the annual meeting of the medical staff, at which time additional nominations may be made. The name of at least two qualified members shall be submitted for each elected office.

11.3. Election of officers so nominated will be completed by secret ballot seven (7) days prior to the annual meeting of the medical staff.

11.4. There shall be no ballot other than the official ballot provided by the Secretary-Treasurer. Ballots for the election of officers shall be distributed to all members of the active medical staff only.

11.5. If more than two (2) nominees appear on the ballot, and no nominee receives a majority of the votes cast on the first ballot, all of the nominees except the two highest shall be dropped, and a second vote shall be

taken within seven (7) days thereafter to determine by majority vote the winning candidate for said office.

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

ARTICLE XII
ALLIED HEALTH PERSONNEL

12.1. Definition.

The term "Allied Health Personnel" means those persons engaged in direct patient care under the general supervision of a member of the medical staff, but who are not physicians, or dentists. The Medical Executive Committee shall, from time to time, recommend to the Board of Directors for their approval, the categories of health care specialists which are deemed to be "Allied Health Personnel" and subject to the provisions of this Article. Without limiting the foregoing, the term "Allied Health Personnel" includes:

Nurse Practitioners
Nurse Anesthetists
Physician Assistants

12. 2. Protocol/Rules and Regulations.

A protocol shall be developed in accordance with this section, which shall take the form of rules and regulations of the medical staff, for the purpose of defining the criteria for selection of Allied Health Personnel (AHP), the definition of their duties and responsibilities, and the regulation of their patient care work in the hospital.

12.2.1 The procedures to be followed in developing a protocol for the use of Allied Health Personnel shall be:

(a) initial development of the protocol by the Allied Health Personnel Committee;

(b) review and recommend approval of the protocol by the Medical Executive Committee

(c) review and approval of the protocol by the Board of Directors.

The Medical Executive Committee may review and propose amendments to the protocol at any time. No category of, or protocol for, the use of AHP shall become effective until approved by the Board of Directors. (Individuals who occupied the status of "Affiliate Staff" under Medical Staff Bylaws in existence prior to the adoption of these Bylaws, shall continue to have the same clinical privileges after the adoption of these Bylaws but only until the affiliate staff appointment which is in effect at the time of

adoption of these Bylaws expires, or the person's privileges and/or status is altered, reduced or revoked by action of the medical staff committees as set forth in Section 12.3.)

12.2.2 Every protocol developed for the use of AHP shall include the following elements:

(a) a statement of the function, duties and authority of AHP and a delineation of the tasks that AHP are permitted to and prohibited from performing;

(b) a description of the education, training and experience requirements which must be satisfied by AHP before being granted authority to work in the hospital;

(c) a description of the process to be utilized for accepting, reviewing and obtaining Medical Executive Committee and Board of Directors' approval of individual applicants;

(d) a description of the procedure to be utilized by the department for monitoring the quality of care practiced or provided by AHP;

(e) a description of the plan to be followed by the department in the periodic reappraisal and reappointment of AHP;

(f) each protocol must meet the criteria set forth in Article IX.

12.3 Withdrawal of Privilege.

It is the express intent of these Bylaws that persons who have the privilege of engaging in patient care activities as AHP shall not be deemed members of the medical staff, and they are not covered by the provisions of Article VII of the Medical Staff Bylaws, nor are they covered by the provisions of the Fair Hearing Plan. It is the intent of these Bylaws to grant to the physician, who may specifically request the same, permission to use a designated AHP for certain designated and approved functions. The privilege of participating in patient care activities at the hospital of an AHP may be suspended, terminated or revoked at any time as provided in Sections 12.3.1-12.3.3 below.

12.3.1 Adverse Action Review and Appellate Process

(a) Initiation of Adverse Action Review and Appeal Process
AHP who are subject to Adverse Action (other than Non-reviewable Actions defined in Section 12.3.3 shall be afforded an Adverse Action Review and appeal process in accordance with this policy. Adverse Action includes: denial of a request to provide any patient care services within the applicable scope of practice or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable scope of practice.

(b) Notice of Adverse Recommendation or Action
Within fifteen (15) days after Adverse Action is taken against an AHP, the AHP shall be notified in writing of the specific reasons for the Adverse Action and the AHPs rights per this policy.

(c) Request for Review of Adverse Recommendation or Action
The AHP may request an Adverse Action Review following the procedure set forth in this policy. If the AHP does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) days following the AHP's notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

(d) Composition of the Review Committee
The Chief of Staff will appoint up to three (3) members of the Medical Staff and a Nursing Administration representative will consider the request and serve as the Review Committee.

(e) Notice of Time and Place for Review
The AHP shall be given ten (10) days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, which will be called to support the Adverse Action.

(f) Statements in Support
The Medical Staff Representative and the AHP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Chief Executive Officer at least five (5) days prior to the review.

(g) Rights of Parties
During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. None of the AHP, the hospital or the Medical Staff Representative shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

(h) Burden Of Proof
The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

(i) Action on Committee Review
Upon completion of the review, the Review Committee shall consider the information and evidence presented and make a recommendation, which shall include the basis therefore, and forward it to the Chief of Staff. The

AHP and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

(j) Duty To Notify Of Noncompliance

If the AHP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP must promptly notify the Chief of Staff of such deviation, including this policy or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

(k) Request for Appellate Review

If the AHP is dissatisfied with the Committee's recommendation, such party may submit a written request for an Appellate Review, provided that the Chief Executive Officer receives such request within ten (10) days following the AHP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with these Rules & Regulations or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable.

(l) Interview with Medical Executive Committee

Upon a proper and timely request for an Appellate Review, the AHP shall be given an interview with the Medical Executive Committee. The AHP shall be given at least five (5) days prior written notice of the time, place and date of the Appellate Review. At the appeal, the parties shall be allowed to present written and/or oral arguments as to why the Committee's recommendation should be reversed or modified.

(m) Final Determination by the Medical Executive Committee

The Medical Executive Committee shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the Medical Executive Committee shall not be subject to further appeal.

The final decision will be submitted to the Governing Board.

12.3.2. Automatic Suspension or Limitation

Automatic suspension shall be immediately imposed under the conditions contained in this section. In addition, further corrective action may be recommended in accordance with the provisions contained within this policy whenever any of the following actions occur:

(a) License
Whenever an AHP's license is revoked, restricted, or suspended, the AHP's scope of practice is similarly revoked, restricted, or suspended.

(b) Controlled Substances Registration
Whenever an AHP's DEA or other controlled substances registration is revoked, restricted, or suspended, the AHP's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

(c) Professional Liability Insurance
An AHP's appointment shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Governing Board. Affected AHPs may request reinstatement during a period of 60 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such AHPs shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership.

(d) Exclusion From Medicare/State Programs
The Chief Executive Officer with notice to the Chief of Staff will immediately and automatically suspend an Excluded Practitioner. An "Excluded Practitioner" is an AHP whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, Indian Health Service, or CHAMPUS program.

(e) Failure To Satisfy Special Appearance Requirement
An AHP, who fails without good cause to appear at a meeting where his or her special appearance is required, shall automatically be suspended. Failure to appear within 3 months of the request to appear shall result in revocation of appointment. Thereafter, the affected AHP must reapply for appointment.

(f) Failure To Execute Releases and/or Provide Documents
An AHP who fails to execute a general or specific release and/or provide documents during a term of appointment when requested by the Chief of Staff or designee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the AHP shall be reinstated. Thereafter, such AHP shall be deemed to have resigned voluntarily and must reapply for appointment.

12.3.3. Non-reviewable Actions

Not every action entitles the AHP to rights pursuant to this policy. Those types of corrective action giving rise to automatic suspension as set forth

in Section 12.3.2 are not reviewable under this policy. In addition, the following occurrences are also non-reviewable under this policy:

(a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.

(b) Issuance of a warning or a letter of admonition or reprimand.

(c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.

(d) Termination or limitation of temporary privileges.

(e) Any recommendation voluntarily imposed or accepted by the AHP.

(f) Denial of membership for failure to complete an application for membership or privileges.

(g) Removal of membership for failure to complete the minimum supervisory requirements.

(h) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.

(i) Any requirement to complete an educational assessment or training program.

(j) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.

(k) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.

(l) Retrospective chart review.

(m) Removal of privileges for lack of a sponsoring physician.

Where an action that is not reviewable (automatic or non-reviewable action) has been taken against an AHP, the affected AHP may request that the action be reviewed and may submit information demonstrating why the action is unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission and whether to take or recommend any action. The affected AHP shall have no appeal or other rights in connection with the Medical Executive Committee's decision.

ARTICLE XIII
RULES AND REGULATIONS

The Medical and Dental 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 vote of the total voting members of the active medical staff present. The rules and regulations and all amendments thereto become effective only upon approval by the Board of Directors.

ARTICLE XIV
DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, as committee chairs, or to the Medical Executive Committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

ARTICLE XV
CONFIDENTIALITY, IMMUNITY AND RELEASES

15.1 Authorizations and Conditions

By applying for, or exercising, Clinical Privileges within the Hospital, an Applicant or Member:

(a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's or Member's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning the Applicant or Member to the Medical Staff.

(c) agrees to be bound by the provisions of this Article XV and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 15.3; and

(d) acknowledges that the provisions of this Article XV are express conditions to an application for Medical Staff membership, the continuation of such Medical Staff membership, and the exercise of Clinical Privileges at the Hospital.

15.2 Confidentiality of Information

15.2.1 General

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in the Hospital, including, but not limited to, meetings of the Medical Staff, meeting as a committee of the whole, meetings of Medical Staff committees established under Article IX, and meetings of special or ad hoc committees created by the Medical Executive Committee, including information regarding any Applicant or Member, shall, to the fullest extent permitted by law, be confidential.

15.2.2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of Applicants and Members to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with other Hospital, professional society, or licensing authorities, is outside appropriate standards of conduct for the Medical Staff, violates these Bylaws, and shall be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

15.3 Immunity from Liability

15.3.1 For Action Taken

Each representative of the Medical Staff and the Hospital shall be immune, to the fullest extent provided by law, from liability to an Applicant or Member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or the Hospital.

15.3.2 For Providing Information

Each representative of the Medical Staff and the Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to a Practitioner for damages or other relief by reason of providing information to a representative of another medical staff or hospital concerning such Practitioner who is, or has been, an Applicant or Member or who did, or does, exercise Clinical Privileges or provide services at the Hospital.

15.4 Activities and Information Covered

The confidentiality and immunity provided by this Article XV shall apply to all acts, communications, reports, recommendations or disclosures performed or

made in connection with activities of the Hospital or any other health care facility concerning, but not limited to:

(a) application for appointment, reappointment, or Clinical Privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

15.5 Releases

Each Applicant or Member shall, upon request of the Medical Staff or the Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article XV. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XV.

ARTICLE XVI
AMENDMENTS

Amendments to these Bylaws may be adopted upon approval of the Bylaws Committee, the Medical Executive Committee, and approval by a majority vote of the members of the active medical staff. Ballots shall be sent to each member of the active medical staff, accompanied by a copy of the proposed amendments or a summary thereof, which summary has been approved by the Medical Executive Committee. The Bylaws shall be reviewed at least annually by the Bylaws Committee. New bylaws or any amendments to these Bylaws shall be submitted to the Medical Staff for approval and become effective only upon approval by the Board of Directors.

ARTICLE XVII
ADOPTION

These Bylaws and Fair Hearing Plan, together with the appended Rules and Regulations, have been adopted by the active medical staff following recommendation of the Medical Executive Committee and approved by the Board of Directors.

ARTICLE XVIII
MISCELLANEOUS

Unless expressly provided otherwise herein, the quorum required for the transaction of any business by a medical staff committee (but not meetings of the general staff) shall be fifty percent (50%) of the committee's membership. Action by such committee shall be valid if taken by a majority vote of the committee members present at any meeting, regular or special, called in the manner provided by these Bylaws.

Adopted by the Active Medical Staff of Ogallala Community Hospital at the regular Medical Staff Meeting on _____, 2013.

_____
Chief of Staff

_____
Secretary

Approved by the Board of Directors on February 14, 2013.

_____
Secretary
Board of Directors