Medical Staff Bylaws

MEDICAL STAFF BYLAWS
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Banner Health
Platte County
Memorial Hospital

MEDICAL STAFF BYLAWS

PREAMBLE

Recognizing that Platte County Memorial Hospital is operated by Banner Health, a nonprofit corporation organized under the laws of the State of Wyoming; and

WHEREAS, its purpose is to serve as a provider of general hospital acute care and skilled care to patients; and

WHEREAS, it is recognized that the Medical Staff has the initial responsibility for the quality of medical care and must accept and discharge this responsibility, subject to the ultimate authority of the Governing Board, and the cooperative efforts of the Medical Staff, and the Chief Executive Officer are necessary to fulfill obligations to its patients;

THEREFORE, the physicians, podiatrists and dentists practicing in this organization shall carry out the functions delegated to the Medical Staff by the Governing Board in conformity with these bylaws.

ARTICLE ONE: NAME

The organizational component of Platte County Memorial Hospital to which these Bylaws are addressed is called the "Medical Staff of Platte County Memorial Hospital."

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 PURPOSES

The purposes of this Medical Staff are:

2.1-1 To continually seek to provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Platte County Memorial Hospital.

2.1-2 To provide a mechanism for accountability to the Board, through defined organizational structures, for the review of the appropriateness of care services, professional, and ethical conduct, so that care provided at this facility is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

2.1-3 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges and through which they fulfill the obligations of staff appointment.

2.1-4 To provide an orderly and systematic means by which staff members can give input to the Board and Administrator on medico-administrative issues and on organizational policy-making and planning processes.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2-1 To participate in the performance improvement and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided, including:

(a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically sound criteria;

(b) Engaging in the ongoing monitoring of patient care practices, including assessing processes, conducting Sentinel Clinical Event and intensive root cause analyses to improve care practices, and monitoring the effectiveness of improvements.

(c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and

(d) Promoting the appropriate use of organization resources.

2.2-2 To make recommendations to the Board concerning appointments and reappointments to the staff, including category, committee assignments, clinical privileges, and corrective action.

2.2-3 To develop, uphold and maintain Bylaws, Rules and Regulations, and policies that are consistent with sound professional practices, and to enforce compliance with them.

2.2-4 To participate in long-range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2-5 To exercise through its officers, committees, and other defined components, the authority granted by these Bylaws, to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.

ARTICLE THREE: MEMBERSHIP

3.1 MEMBER QUALIFICATIONS

Every practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws. Applicants have the burden of producing adequate information to establish their qualifications and competence and such applications shall be reviewed for completeness and verified for accuracy as set forth below in Sections --- and in the Medical Staff Credentialing Policy. The process for appointment and reappointment to the Medical Staff is set forth in further detail in the Medical Staff Credentialing Policy.

3.1-1 LICENSURE

Evidence of a currently valid license issued by the State of Wyoming to practice medicine, podiatry or dentistry.

3.1-2 PROFESSIONAL EDUCATION AND TRAINING

(a) Graduation from an approved medical, osteopathic, dental, or podiatric school.

For purposes of this section, an "approved" or "accredited" school or university is one fully accredited during the time of the practitioner's attendance by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the American Podiatric Medical Association , or by a successor agency to any of the foregoing or by an accrediting agency on file with the U.S. Secretary of Education.

(b) Satisfactory completion of an approved postgraduate training program. An "approved" postgraduate training program is one fully accredited throughout the time of the practitioner's training by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing, or a program equivalent to one accredited by the ACGME.

3.1-3 CLINICAL PERFORMANCE

Current experience, clinical results, and utilization patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

3.1-4 COOPERATIVENESS

Demonstrated ability to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care. It is the policy of the organization and this Medical Staff, that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, all Medical Staff members, and other practitioners must conduct themselves in a professional and cooperative manner. Failure to do so may constitute disruptive behavior. Disruptive behavior by any practitioner against any individual shall not be tolerated. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken in accordance with the Disruptive Medical Staff Member Policy or other applicable policies.

3.1-5 SATISFACTION OF CRITERIA FOR PRIVILEGES

Evidence of satisfaction of the criteria for the granting of clinical privileges in at least one section.

3.1-6 **PROFESSIONAL ETHICS AND CONDUCT**

Demonstrated high moral character and adherence to generally recognized standards of medical and professional ethics which include: seeking appropriate consultation when medically indicated; providing or arranging for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; obtaining appropriate informed patient consent to treatments; and placing the patient's welfare above one's own financial interests; and refraining from: paying or accepting commissions or referral fees for professional services; and delegating the responsibility for diagnosis or care to a practitioner or allied health professional not qualified to undertake that responsibility.

3.1-7 **DISABILITY**

Freedom from or adequate control of any significant physical or mental health impairment and freedom from abuse of any type of substance or chemical that may affect cognitive, motor, or communication ability in a manner that interferes with the ability to provide quality patient care or the other qualifications for membership. Issues that may arise in this area may be addressed in accordance with the Physician Health Policy.

3.1-8 **VERBAL AND WRITTEN COMMUNICATION SKILLS**

Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-9 **PROFESSIONAL LIABILITY INSURANCE**

Evidence of professional liability insurance of a kind and in an amount satisfactory to the Board.

3.1-10 **EFFECTS OF OTHER AFFILIATIONS**

No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:

(a) Licensure to practice;

(b) Completion of a postgraduate training program at a Banner Health hospital;

(c) Certification by any clinical board;

(d) Membership on a medical school faculty;

(e) Staff appointment or privileges at another health care facility or in another practice setting; or

(f) Prior staff appointment or any particular privileges at this Hospital or any other Banner hospital.

3.1-11 **NONDISCRIMINATION**

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, national origin, a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the delivery of quality and efficient patient care in the facility, to professional qualifications, to the facility's purposes, needs and capabilities, or to community need.

3.1-12 **EXEMPTIONS FROM QUALIFICATIONS**

Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the honorary staff.

3.2 PRE-APPLICATION PROCESS

3.2-1 An application for appointment to the Medical Staff shall only be sent upon request to those individuals who, according to the Medical Staff Bylaws and this policy, are eligible for appointment and clinical privileges because they meet the objective threshold criteria for appointment and clinical privileges consideration; who desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel; and who indicate an intention to utilize the Hospital as required by the staff category to which they desire appointment.

3.2-2 A "Request for Medical Staff Application" form which requests proof that the objective threshold criteria for appointment and clinical privileges consideration can be met by the individual. A completed "Request for Medical Staff Application" form must be returned to the Chief Executive Officer or designee within thirty (30) days after receipt of same if the individual desires further consideration.

3.2-3 Those individuals who meet the objective threshold criteria for consideration for appointment to the Medical Staff and clinical privileges shall be given an application. Individuals who fail to meet these criteria shall not be given an application and shall be so notified.

3.3 SUBMISSION OF APPLICATION

3.3-1 The application for Medical Staff appointment shall be submitted by the applicant to the Chief Executive Officer or a designee. It must be accompanied by payment of such processing fees as may be recommended by the Medical Executive Committee and approved by the Board. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Chief Executive Officer or designee shall transmit the complete application and all supporting materials to the Medical Executive Committee.

3.3-2 An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified. An application shall become incomplete if the need arises for new, additional, or clarifying information anytime during the evaluation. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn and no further action will be taken with respect to such application. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

3.3-3 The Chief Executive Officer or a designee shall post or circulate the name of the applicant so that each Medical Staff appointee may have an opportunity to submit to the Medical Executive Committee, in writing, information bearing on the applicant's qualifications for staff appointment or clinical privileges. In addition, any current Medical Staff appointee shall have the right to appear in person before the Medical Executive Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

3.4 MEDICAL EXECUTIVE COMMITTEE REVIEW OF APPLICATION

3.4-1 The Medical Executive Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the Medical Executive Committee, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

(a) As part of the process of making its recommendation, to the extent permitted by law, the Medical Executive Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Medical Executive Committee. The results of any such examination shall be made available to the Medical Executive Committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so, shall constitute a voluntary withdrawal of the application for appointment and clinical privileges. All processing of the application shall cease.

(b) As part of the process of making its recommendation, the Medical Executive Committee may request a meeting with the applicant to discuss the applicant's application, qualifications, and clinical privileges requested.

(c) The Medical Executive Committee may use the expertise of any member of the Medical Staff, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(d) If the Medical Executive Committee's recommendation for appointment is favorable, the Medical Executive Committee shall recommend appointment. All recommendations to appointment must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the Medical Executive Committee.

(e) If the recommendation of the Medical Executive Committee is delayed longer than ninety-(90) days, the Chairperson of the Medical Executive Committee shall send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3.4-2 **Favorable Medical Executive Committee Recommendation:**

(a) If the Medical Executive Committee's recommendation is to appoint the applicant and to grant the requested clinical privileges, it shall send its recommendation and written findings in support thereof to the Governing Board, through the Chief Executive Officer.

(b) Upon receipt of a favorable recommendation from the Medical Executive Committee that the applicant be granted appointment and the requested clinical privileges, the Governing Board (or its designated committee) may:

(1) appoint the applicant and grant clinical privileges as recommended; or
(2) refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or
(3) reject the recommendation in which event, the determination and the reasons in support thereof, shall be sent to the Chief Executive Officer, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Governing Board shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in this policy.

Whenever the Governing Board determines that it will decide a matter contrary to the Medical Executive Committee's recommendations, the matter will be submitted to a Joint Conference Committee in accordance with the Banner Health Corporate Bylaws for review and recommendation before the Governing Board makes a final decision.

3.4-3 **Unfavorable Medical Executive Committee Recommendation:**

If the Medical Executive Committee's recommendation is unfavorable and would entitle the applicant to request a hearing pursuant to the Fair Hearing Plan, it shall be forwarded to the Chief Executive Officer who shall promptly notify the applicant in writing, certified mail, return receipt requested. The recommendation shall not be forwarded to the Governing Board until the applicant has exercised or waived the right to a hearing as provided in the Fair Hearing Plan.

3.5 PROCEDURE FOR REAPPOINTMENT

All terms, conditions, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

3.5-1 **Application:**

(a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form.

(b) The reappointment application shall be furnished to the appointee by the Chief Executive Officer or a designee at least six (6) months prior to the expiration of the appointee's current appointment period. The completed reappointment application shall be submitted to the Chief Executive Officer or a designee at least three (3) months prior to the expiration of the appointee's current appointment period. Failure to submit an application by that time may result in automatic expiration of the Member's appointment and clinical privileges at the end of the then current appointment period.

(c) Reappointment, if granted by the Governing Board, shall be for a period of not more than two (2) years, with birth dates being used as the reappointment date.

An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the need

arises for new, additional, or clarifying information anytime during the evaluation. Any application that continues to be incomplete ninety (90) calendar days after the Applicant has been notified of the additional information required shall be deemed to be withdrawn and no further action shall be taken with respect to such application. It is the responsibility of the Applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

3.5-2 **Factors to be considered.** Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee's:

(a) ethical behavior, clinical competence, and clinical judgment in the treatment of patients;

(b) attendance at Medical Staff and committee meetings, and participation in staff duties;

(c) compliance with the Bylaws, Policies, and Rules and Regulations of the Medical Staff and the Hospital;

(d) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of this Hospital, or general attitude toward patients, the Hospital and its personnel;

(e) use of the Hospital's facilities for patients, taking into consideration the individual's comparative utilization patterns;

(f) the applicant's ability to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of Medical Staff appointment, with or without an accommodation;

(g) capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications;

(h) satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital, or applicable accreditation agencies;

(i) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

(j) current licensures, including currently pending challenges to any license or registration;

(k) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital;

(l) relevant findings from the Hospital's quality improvement activities; and

(m) other reasonable indicators of continuing qualifications.

To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the Medical Executive Committee to assess the applicant's current clinical competence for the privileges requested.

3.5-3 **Medical Executive Committee Procedure:**

(a) The Medical Executive Committee shall review all pertinent information available, including all information provided by the Medical Staff, Risk and Quality and from Hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(b) As part of the process of making its recommendation, the Medical Executive Committee may require that an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Medical Executive Committee either as part of the reapplication process or at any time during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Medical Executive Committee's consideration. Alternatively, the Medical Executive Committee may refer the matter in accordance with the Physician Health Policy. Failure of an individual seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Medical Executive Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Medical Executive Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(c) The Medical Executive Committee shall have the right to require the appointee to meet with the Medical Executive Committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

(d) The Medical Executive Committee may use the expertise of any member of the Medical Staff or an outside consultant if additional information is required regarding the appointee's qualifications for reappointment.

(e) Upon completion of its review, the Medical Executive Committee shall make a recommendation regarding the appointee’s application for reappointment.

(f) If the Medical Executive Committee's recommendation is to reappoint the Applicant and to grant the requested clinical privileges, it shall send its recommendation and written findings in support thereof to the Governing Board’s Chief Executive Officer. All recommendations to reappoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(g) Upon receipt of a favorable recommendation from the Medical Executive Committee that the individual be granted reappointment and the requested clinical privileges, the Governing Board (or its designated committee) may:

(1) reappoint the individual and grant clinical privileges as recommended; or

(2) refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

(3) reject the recommendation, in which event, the determination remains unfavorable to the applicant, that determination and the reasons in support thereof, shall be sent to the Chief Executive Officer, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Governing Board shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in the Fair Hearing Plan.

(4) Whenever the Governing Board determines that it will decide a matter contrary to the Medical Executive Committee's recommendations, the matter will be submitted to a Joint Conference Committee in accordance with the Banner Health Corporate Bylaws for review and recommendation before the Governing Board makes its final decision.

(5) If for any reasons the application for reappointment has not been finally acted on by the Governing Board prior to the end of the appointment year, the then current appointment and clinical privileges shall continue until final action is taken by the Governing Board.

3.5-4 **Unfavorable Medical Executive Committee Recommendations:**

If the Medical Executive Committee recommendation is unfavorable and would entitle the applicant to request a hearing pursuant to the Fair Hearing Plan, it shall be forwarded to the Chief Executive Officer who shall promptly notify the applicant in writing, certified mail, return receipt requested. The recommendation shall not be forwarded to the Governing Board, until the applicant has exercised or waived the right to a hearing as provided in the Fair Hearing Plan.

3.5-5 **Meeting with Affected Individual:**

If, during the processing of an individual's reappointment, it becomes apparent to the Medical Executive Committee that the Medical Executive Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chief of Staff shall notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the Medical Executive Committee prior to any final recommendation by the Medical Executive Committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated, and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in the Fair Hearing Plan with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the Medical Executive Committee shall indicate as part of its report to the Governing Board whether such a meeting occurred, and shall include a summary of the meeting.

3.6 **TERM OF APPOINTMENT**

Appointments to the Medical Staff and granted clinical privileges are for a period of two years, except that:

(a) New members of the staff may be subject to such period of monitoring as shall be determined by the Medical Executive Committee and as more particularly set forth in the Banner Health Medical Staff Focused Professional Practice Evaluation (FPPE) Policy. FPPE is a time-limited process whereby the Medical Executive Committee evaluates the privilege-specific competency of the member or the member's ability to provide safe high quality patient care. These requirements may be waived or reduced by the Medical Executive Committee, as long as approved by the Governing Board. The FPPE shall be performed by at least one (1) physician with appropriate experience who is appointed by the Chief of Staff. In the event that there are no physicians on the Medical Staff with appropriate qualifications, or when otherwise deemed advisable, the Chief of Staff may appoint a qualified physician from outside the Medical Staff to perform the FPPE. While preferable that the outside physician directly observe the new member, the outside monitoring physician may perform the FPPE by review of a required number of medical records.

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

(b) Completed applications are submitted to the Chief Executive Officer or his/her designee, who will then transmit the complete application to the Medical Executive Committee, subject to final approval by the Governing Board.

(c) The Governing Board, after considering the recommendations of the Medical Executive Committee, may set a more frequent reappraisal period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability or has been the subject of disciplinary action.

3.7 **EXPIRATION**

The appointment of each staff member shall expire every two years during the birth month of the practitioner.

3.8 **BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP**

Each staff member, regardless of assigned staff category, and each practitioner exercising temporary privileges under these Bylaws, shall:

(a) Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate;

(b) Abide by the Banner Health Corporate Bylaws, these Bylaws, Rules and Regulations and all other standards and policies of the Medical Staff at Platte County Memorial Hospital;

(c) Discharge such staff, committee, department, section, and Hospital functions for which he or she is responsible;

(d) Prepare and complete in timely fashion, according to these Bylaws and to Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, services, or departments;

(e) Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and to obtain consultation when necessary for the safety of those patients;

(f) Participate in continuing education programs;

(g) Participate in emergency service coverage and supervisory or consultation functions as may be determined by the Medical Executive Committee

(h) 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 facility business information designated as confidential by the facility or its representatives prior to disclosure;

(i) Refrain from disclosing confidential information to anyone unless authorized to do so; and

(j) Protect access codes and computer passwords to ensure confidential information is not disclosed.

(k) Complete a history and physical examination ("H&P") in all cases within 24 hours after admission. The Member or Allied Health Professional must be approved by the Medical Staff to perform admission H&Ps. The completed H&P must be on the medical record prior to surgery or invasive procedure or any procedure in which conscious sedation will be administered or the case will be cancelled unless the responsible practitioner documents in writing that such delay would constitute a hazard to the patient. A legible H&P performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition within 24 hours of admission. The contents of a complete H&P shall include, but are not limited to, documentation of date of admission, identification data, chief complaint, allergies, history of present illness, pertinent past/social/family history, pertinent psychosocial needs, and a review of body systems. A physical exam must reflect a comprehensive physical assessment and be authenticated by the Member or Allied Health Professional. A statement of the conclusion or impression (provisional diagnoses) drawn from the admission H&P

and a course of action planned for the patient must be documented. Further details regarding the H&P are delineated in the General Rules and Regulations.

(m) agrees that when corrective action is initiated or taken or when a recommendation is made by any committee or any person acting on its behalf, the effect of which is to deny, revoke, or otherwise limit the privileges or membership of the Member, such Member shall exhaust the administrative remedies afforded in these Bylaws (and Fair Hearing Plan) prior to initiating litigation.

3.9 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.9-1 QUALIFICATIONS AND SELECTION

A practitioner, who is or who will be providing specified professional services pursuant to a contract or employment with the organization, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as any other staff member.

(a) Practitioners rendering professional services pursuant to employment or contracts with the organization shall be required to maintain Medical Staff membership and privileges.

(b) Unless otherwise provided in the contract for professional services, termination of such employment or contracts shall not result in automatic termination of Medical Staff membership and privileges.

3.9-2 SUPERVISION

The practitioner must complete the supervision requirements as set forth in the rules and regulations unless a waiver of supervision has specifically been recommended by the Medical Executive Committee and approved by the Governing Board.

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.1 CATEGORIES

There will be four (4) categories of appointment to the staff: active, courtesy, telemedicine, and honorary.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS FOR ACTIVE STAFF

The active staff shall consist of physicians who:

(a) Demonstrate a genuine concern, interest, and activity in the organization through substantial involvement in the affairs of the Medical Staff or Hospital and regularly

admit patients to, or are regularly involved in the care of patients in the facilities. Twenty-five patient contacts per year are necessary to maintain active staff as noted in a following section. Patient contacts are determined utilizing the following reports for patient activity statistics: histories and physicals, discharge summaries, consultation reports, and/or operative or procedure reports; and

(b) Satisfy the meeting attendance requirements established by the Medical Executive Committee.

4.2-2 **PREROGATIVES OF ACTIVE STATUS**

An active staff member may:

(a) Admit patients;

(b) Exercise such clinical privileges as are granted by the Governing Board;

(c) Vote on all matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a member; and

(d) Hold office at any level in the staff organization and be chair or a member of a committee provided the specific qualifications for the position involved are met and except as otherwise provided in these Bylaws or by resolution of the Medical Executive Committee; and

(e) Active staff members who are at least 60 years of age, have provided medical services in the Wheatland 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 as set forth in Section 4.2.3 (b) below. 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 active staff member may be requested to participate in on-call coverage for the duration of the disaster.

4.2-3 **OBLIGATIONS OF ACTIVE STATUS**

An active staff member must, in addition to meeting the basic obligations set forth in Section 3.2:

(a) Contribute to the organizational, administrative and medico-administrative, quality review, and utilization management activities of the Medical Staff; be willing to serve in Medical Staff, department, and section offices and on Hospital and Medical Staff committees, and faithfully perform the duties of any office or position to which elected or appointed;

(b) Participate equitably and appropriately in the discharge of staff functions such as training, and continuing education programs; serve when necessary on the on-call roster except as set forth in Section 4.2.2 (e) above; review and supervise the

performance of other practitioners and fulfill such other staff functions as may be reasonably required; and

(c) Satisfy the meeting attendance and special appearance requirements of the Medical Staff and the assigned department and section.

4.2-4 FAILURE TO SATISFY QUALIFICATIONS

Failure of an active staff member to satisfy the qualifications or obligations of the active staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been moved from the active staff category may request reconsideration of the change by the Medical Executive Committee. Failure to utilize the Hospital during an entire reappointment period shall result in a practitioner being ineligible to apply for reappointment to the Medical Staff.

4.3 COURTESY STAFF

4.3-1 QUALIFICATIONS

The courtesy staff shall consist of physicians who admit patients to the Hospital only on an occasional basis.

4.3-2 PREROGATIVES

A courtesy staff member may:

(a) Admit patients to the hospital;

(b) Exercise such clinical privileges as have been granted by the Governing Board;

(c) Vote on matters presented at committees to which he or she has been appointed and at Department and section meetings unless otherwise limited by these Bylaws or Rules and Regulations.

4.3-3 OBLIGATIONS

A courtesy staff member must, in addition to meeting the basic obligations set forth in Section 3.2:

(a) Satisfy the special appearance requirements of the Medical Staff

4.3-4 CHANGE IN STAFF CATEGORY

Courtesy staff who meet the qualifications set forth in Section 4.2-1 may request elevation to the active staff during the appointment period. Failure to utilize the Hospital during an entire reappointment period shall result in a practitioner being placed in the courtesy staff category.

4.3-5 FAILURE TO SATISFY QUALIFICATIONS OR OBLIGATIONS

Failure of a courtesy staff member to satisfy the qualifications or obligations of the courtesy staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been moved from the courtesy staff category may request reconsideration of the change by the Medical Executive Committee. Failure to utilize the Hospital during an entire reappointment period shall result in a practitioner being ineligible to apply for reappointment to the Medical Staff.

4.4. **TELEMEDICINE STAFF**

4.4-1 QUALIFICATIONS

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

4.4-2 PREROGATIVES

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

4.4-3 OBLIGATIONS

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

4.5 **HONORARY STAFF**

4.5-1 **QUALIFICATIONS**

Membership on the honorary staff is by invitation and is restricted to Medical Staff Members for whom, upon retirement from practice, the Medical Executive Committee recommends and the Governing Board approves this status in recognition of long-standing service to the Hospital or other noteworthy contributions to its activities.

4.5-2 **PREROGATIVES**

Honorary staff shall not be eligible to vote on matters presented to the Medical Staff nor to hold elected office; are not required to have malpractice insurance or a license to practice and are not required to pay dues or assessments. Honorary staff may serve on committees and may vote on matters presented at committees of which they are members. Honorary staff are not allowed to admit or treat patients.

4.6 **LIMITATION OF PREROGATIVES**

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff appointment, by other sections of these Bylaws, by department rules and regulations, and by other policies of the Medical Staff or Hospital.

Allied Health Professionals (AHPs) are not members of the Medical Staff but are subject to the authority of the Hospital and its Medical Staff as set forth in the AHP rules. AHPs and, if applicable, their sponsoring practitioner(s) are subject to the AHP rule and all other Bylaws, policies, rules, regulations, procedures, guidelines, and requirements of the hospital and its Medical Staff as the Governing Board deems applicable to AHPs. Completed applications for AHPs' Staff membership and privileges will be submitted to the Medical Executive Committee for review and action prior to submission to the Governing Board. The process for appointment and reappointment to the AHP Staff is set forth in further detail in the Allied Health Professionals Policy.

Every practitioner practicing at this Hospital by virtue of Medical Staff appointment shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board as set forth in the Credentials Policy and Procedure Manual.

ARTICLE FIVE: DELINEATION OF PRACTICE PRIVILEGES

5.1 **EXERCISE OF PRIVILEGES**

5.1-1 **IN GENERAL**

(a) The following must be successfully completed prior to exercising privileges at Platte County Memorial Hospital:
- Banner Health's electronic medical record/computerized physician order entry (CPOE) training; and
- Banner Health's electronic New Provider Orientation.
- Exceptions may be made for practitioners granted temporary or disaster privileges.

(b) Except in an emergency or as otherwise provided in these Bylaws or in the Credentialing Policy, a practitioner providing clinical services at this facility may exercise only those clinical privileges specifically granted to him/her by the Governing Board as set forth in the Credentialing Policy.

5.2 **BASIS FOR PRIVILEGES DETERMINATIONS**

Clinical privileges shall be granted in accordance with education and training, experience, current health status, and demonstrated competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Additional factors that may be used in determining privileges include those qualifications set forth in Article Three. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determination(s). In reappointment determinations, results of performance data and utilization review, supervised cases, and where appropriate, practice at other hospitals will also be considered. In review of requests for changes in privileges, evidence of appropriate training and experience and current clinical competence must be documented. The applicant shall have the burden of establishing his or her qualifications for and current competence to exercise the clinical privileges requested.

Except in an emergency or as otherwise provided in these Bylaws or in the Credentialing Policy, a practitioner providing clinical services at this facility may exercise only those clinical privileges specifically granted to him/her by the Governing Board as set forth in the Credentialing Policy.

5.3 SPECIAL CONDITIONS

5.3-1 ORAL SURGEONS AND DENTISTS

Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Medical Director of Surgery. The final decision whether to proceed with any proposed surgical or special procedure must be agreed upon by the oral surgeon or dentist and the physician consultant. The Medical Director of Surgery will decide the issue in case of dispute.

5.3-2 PODIATRISTS

Surgical procedures performed by a podiatrist are under the overall supervision of the Medical Director of Surgery. Patients must be admitted by a physician member of the Medical Staff who must perform a basic medical appraisal for each patient immediately after admission, be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization, and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. A podiatrist may write orders.

5.4 EXCLUSIVE CONTRACTS

If the Hospital has an exclusive contract with a group or individual to provide services, clinical privileges for that service will not be granted to practitioners or other providers not included in the exclusive contract, and the inability of a practitioner to apply for initial appointment or reappointment to the Medical Staff and for clinical privileges as a result of the Hospital's decision to enter into an exclusive arrangement shall not constitute a reviewable action.

The inability of a member of the Medical Staff to exercise clinical privileges and/or the rights and prerogatives of Medical Staff membership as a result of (a) 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 (b) the termination or modification of the Medical Staff 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 of the Medical Staff would be afforded any of the rights set forth in the Fair Hearing Plan.

5.5 DISASTER MANAGEMENT

Upon the recommendation of the Chief of the Medical Staff or another member of the MEC, the CEO, or his or 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: (a) a current picture hospital identification card that clearly identifies the volunteer practitioner's professional designation; (b) a current license to practice medicine in the United States; (c) 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 (d) 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 by the Chief of the Medical Staff, or his/her designee, to a member of the Medical Staff for oversight of the care provided, which oversight may be done by direct observation and/or clinical record review. Such temporary privileges shall last for the duration of the disaster or for ninety (90) days, whichever occurs first. Verification of the credentials of any practitioner granted disaster privileges will begin as soon as the immediate situation is under control and will be completed within seventy-two (72) hours from the time the volunteer practitioner presents to the Hospital, if possible. If extraordinary circumstances, such as no means of communication or lack of resources, prevent the primary source verification from being completed within seventy-two (72) hours, the CEO, or his or her designee, shall document (1) the reason for the delay, (2) evidence of a demonstrated ability on the part of the volunteer practitioner to provide adequate care, treatment and services, and (3) 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 II, Part G. Furthermore, notwithstanding any existing delineation of privileges or scope of authority, members of the Medical Staff, 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.

5.6 PROCESS FOR "DISTANT SITE" CREDENTIALING OF TELEMEDICINE PROVIDERS

Where the Medical Center ("Originating Site") has a contract with a Joint Commission accredited facility ("Distant Site") approved by the Medical Executive Committee, the Medical Center will accept the credentialing and privileging decision of the Distant Site for applicants who provide telemedicine services and are credentialed at the Distant Site. Privileges at the Originating Site shall be identical to those granted at the Distant Site, except for the services which the Medical Center does not perform. Privileges shall be granted and renewed for the same period as have been granted by the Distant Site. Board approval of privileges at the Distant Site qualifies as Board approval at the Medical Center.

ARTICLE SIX: CORRECTIVE ACTION

6.1 CRITERIA FOR INITIATING AN INVESTIGATION AND CORRECTIVE ACTION

An investigation and corrective action may be initiated against a practitioner if it appears that the practitioner does not meet the standards required by these Bylaws or any applicable Medical Staff policies, or if the practitioner is or may be engaged in a course of conduct, either within or outside Platte County Memorial Hospital, that is detrimental to patient care or lower than the standards or aims of the Medical Staff.

6.2 PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

6.2-1 INITIATION OF PROFESSIONAL REVIEW

(a) A request for an investigation and/or corrective action may be submitted to the Chief of the Staff by any member of the Medical Staff, the Administrator, or the Governing Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request.

(b) The Medical Executive Committee will consider the request If the Medical Executive Committee or an ad hoc committee thereof considers the request, it shall determine whether an investigation is warranted. If the Medical Executive Committee determines that the request is warranted, it shall begin the investigation. An investigation shall begin only after a formal vote/resolution of the Medical Executive Committee to that effect.

6.3 PROCEDURE FOR PROFESSIONAL REVIEW

(a) The Medical Executive Committee of the Medical Staff shall conclude an investigation and document its findings within 60 days of the receipt of a request for investigation and/or corrective action, or (b) the determination that an investigation is warranted. Prior to making any recommendations the affected practitioner shall have an opportunity for an interview with the Medical Executive Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto. A record of such interview shall be made by the Medical Executive Committee and included with its report. In certain instances, an investigation may not be concluded within 60 days. In such instances, the investigation shall be concluded as soon as reasonably practicable. The affected practitioner shall have no procedural rights arising out of such delay.

6.4 MEDICAL EXECUTIVE COMMITTEE REPORT AND RECOMMENDATIONS

Following its investigation, the Medical Executive Committee shall prepare a written report that shall contain the findings, conclusions and recommendations of the Medical Executive Committee. Such recommendations may include, without limitation, the following:

(a) that no corrective action is justified;

(b) that a letter of concern, warning, admonition, or reprimand be issued;

(c) that conditions for continued appointment may be imposed;

(d) that the Member obtains additional training or education;

(e) that the Member be counseled by the Chief of Staff, or his or her designee;

(f) that the Member be required to obtain a consultation from another Member with respect to any or all of his/her clinical privileges prior to, or concurrent with, treating patients at the Hospital;

(g) that the Member's clinical privileges be reduced, modified, or revoked;

(h) that the Member's Medical Staff category be changed to another category; or

(i) that the Member's Medical Staff membership be revoked.

The Medical Executive Committee may defer taking action on the request for corrective action if additional time is needed to complete the investigation.

If the recommended action is non-reviewable pursuant to Section 6.9 below, the Medical Executive Committee shall consider the manner in which the action shall be implemented. The Medical Executive Committee also shall forward any adverse recommendation to the Governing Board.

6.5 NOTICE TO THE MEMBER:

(a) If a recommendation for corrective action is made by the Medical Executive Committee, the Chief of Staff shall send to the Member, by Special Notice, a summary of the request for corrective action, the recommendation of the Medical Executive Committee, and a course of action to be followed.

(b) If the recommendation for corrective action is adverse and 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 this Corrective Action/Fair Hearing Plan.

6.6 SUMMARY SUPERVISION

6.6-1 INITIATION

Whenever criteria may exist for initiating an investigation and/or corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities and until such time as a final determination is made regarding his or her privileges. Supervision may include but is not limited to concurrent or retrospective chart review, in-person oversight, and/or consultation by a second physician. Any **two** of the following individuals in concert shall have the right to impose supervision:

(a) Chief of the Medical Staff or designee, acting as a member of and on behalf of the Medical Executive Committee;

(b) Administrator or designee, acting on behalf of the Governing Board; and

(c) Medical Executive Committee member, acting as a member of and on behalf of the Medical Executive Committee.

6.7 SUMMARY SUSPENSION

6.7-1 INITIATION

Whenever immediate action must be taken in the best interest of care in Platte County Memorial Hospital or to prevent imminent danger to the health of any individual, any **two** of the following shall have the right to summarily suspend membership and all or any portion of the clinical privileges of a practitioner:

(a) Chief of the Medical Staff, acting as a member of and on behalf of the Executive Committee;

(b) Administrator or designee, acting on behalf of the Governing Board; and

(c) Medical Executive Committee member, acting as a member of and on behalf of the Medical Executive Committee.

A summary suspension is effective immediately upon imposition and shall be followed promptly by special notice to the affected practitioner.

6.7-2 REVIEW BY THE MEDICAL EXECUTIVE COMMITTEE

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Medical Executive Committee The review must be requested within 15 days of the practitioner's receipt of notice of the suspension. Such review shall take place within fifteen (15) days of the request for review. Upon deliberation, the Medical Executive Committee may direct that summary suspension be terminated or continued.

6.7-3 EXPEDITED HEARING RIGHTS

In the event summary suspension is continued, special notice of the decision shall be sent to the affected practitioner who may request an expedited hearing pursuant to the Fair Hearing Plan.

6.7-4 ALTERNATIVE COVERAGE

Immediately upon imposition of summary suspension, the Chief of the Medical Staff shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the facility. Patient's wishes shall be considered in the selection of an alternative practitioner.

6.8 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 these Bylaws whenever any of the following actions occur:

6.8-1 **LICENSE**

(a) Revocation: Whenever a practitioner's license to practice in this State is revoked, Medical Staff appointment and clinical privileges are immediately and automatically revoked.

(b) Restriction: Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that are within the scope of the limitation or restriction are similarly immediately and automatically restricted.

(c) Suspension: Whenever a practitioner's license is suspended, Medical Staff appointment and clinical privileges are automatically suspended for the term of the licensure suspension.

(d) Probation: Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.

6.8-2 **CONTROLLED SUBSTANCES REGISTRATION**

Whenever a practitioner's DEA or other controlled substances registration is revoked, restricted, or suspended, the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

6.8-3 **EXCLUSION FROM FEDERAL PROGRAMS**

Whenever a practitioner is excluded from Medicare or other federally funded healthcare programs, the practitioner’s membership and privileges will be summarily terminated. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of ability to participate in federal healthcare programs. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.8-4 **MEDICAL RECORDS**

A temporary suspension of privileges to admit new patients or to schedule new procedures, may be imposed for failure to complete medical records within the time periods established by the Executive Committee. Such suspension shall not apply to patients admitted or already scheduled at the time of the suspension or to emergency patients. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension may become automatic permanent suspension for failure to complete delinquent records.

6.8-5 **PROFESSIONAL LIABILITY INSURANCE**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under these Bylaws. Affected practitioners may request reinstatement during a

period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.8-6 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, in accordance with Section 9.3-2, shall automatically be suspended from exercising all clinical privileges. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership and privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.8-7 FAILURE TO EXECUTE RELEASES OR PROVIDE REQUESTED INFORMATION

A practitioner who fails to execute a release, as set forth in Section 10.1, or who fails to provide documentation or other information during a term of appointment when requested by the Chief of the Medical Staff shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.9 NONREVIEWABLE ACTION

Not every action entitles the practitioner to rights pursuant to the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension as set forth in Section 6.8 are not reviewable under the Fair Hearing Plan. In addition, the following occurrences are also non-reviewable under the Fair Hearing Plan:

(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 evaluation tools or monitoring of professional practices, other than direct supervision, for a period of 6 months or less;

(d) Termination or limitation of temporary privileges;

(e) Supervision and other requirements imposed under the FPPE process;

(f) Termination of any contract with or employment by the Platte County Memorial Hospital.

(g) Any recommendation voluntarily imposed or accepted by a practitioner;

(h) Denial of membership and privileges for failure to complete an application for membership or privileges;

(i) Removal of membership and privileges for failure to complete supervision within the time period granted by these Bylaws;

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

(k) Reduction or change in staff category;

(l) Refusal of the Medical Executive Committee to consider a request for appointment, reappointment, staff category, department or section assignment, or privileges within one year of a final adverse decision regarding such request;

(m) Removal or limitation of call obligations;

(n) Any requirement to complete an educational assessment or training program; and any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.

(o) Granting of conditional appointment or appointment of a limited duration to the Medical Staff.

Where an action that is not reviewable under the Fair Hearing Plan has been taken against a practitioner, the affected practitioner may request that the Medical Executive Committee review the action, and the practitioner 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, and the affected practitioner shall have no appeal or other rights in connection with the Medical Executive Committee's decision.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 GENERAL OFFICERS OF THE STAFF

7.1-1 IDENTIFICATION

The general officers of the staff are:

(a) Chief of the Medical Staff

(b) Vice Chief of the Medical Staff

(c) Secretary

7.1-2 QUALIFICATIONS

Each general officer must:

(a) Be a member of the active staff at the time of nomination and election and remain a member in good standing during his or her term of office;

(b) Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence;

(c) Have demonstrated a high degree of interest in and support of the Medical Staff and organization; and

(d) Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general officers of the Medical Staff, the Chief Executive Officer, and the Board.

A practitioner may not hold simultaneously two or more general staff offices.

7.2 TERM OF OFFICE

The term of office of general staff officers is one year. All Officers shall assume office on the first day of January following their election by the active staff members of the Medical Staff, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office.

7.3 ELIGIBILITY FOR RE-ELECTION

A general staff officer is eligible for nomination and re-election in succeeding terms.

7.4 NOMINATIONS

Nominations will be solicited prior to the expiration of officers' current term. Medical Executive Committee will forward a slate of candidates to the active staff members of the medical staff prior to the election.

7.5 ELECTIONS, VACANCIES, AND REMOVALS

7.5-1 ELECTION PROCESS

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

(a) A majority of the votes cast for any office shall be necessary to elect any officer. If more than two nominees appear on the ballot and no nominee receives a majority of the votes cast, a second vote shall be conducted between the two candidates receiving the highest number of votes.

(b) In the case of a tie, when only two nominees appear on the ballot, a majority vote of the Medical Executive Committee shall decide the election.

7.5-2 VACANCIES IN ELECTED OFFICES

In the event of a vacancy for Chief of the Medical Staff, the Vice President of the Medical Staff shall assume the duties of the Chief of the Medical Staff for the remainder of the unexpired term. A vacancy in any other general staff office shall be filled by appointment by the Chief of the Medical Staff with the approval of the Executive Committee.

7.5-3 RESIGNATIONS AND REMOVAL FROM OFFICE

(a) Resignations: any officer may resign at any time by giving written notice to the Executive Committee. Such resignation takes effect on the date of receipt of the resignation or at any time specified in the notice.

(b) Removals: removal from office may be initiated only by the Medical Executive Committee or by petition signed by at least one-third of the active staff members. Such removal shall be considered at a special meeting of the Medical Staff as provided in Section 9.1-2, for the purpose of considering and acting upon the request for removal. Removal shall require a two-thirds vote of the voting members present at the special meeting and shall be effective immediately upon tabulation of the vote by the Administrator or his designee.

(c) Criteria for consideration for removal from office shall include failure to continue to meet the qualifications for the office, failure to perform the duties required of the position in a timely and appropriate manner, misfeasance in office (i.e., illegal activities), or substantiated allegations as an impaired practitioner.

7.6 DUTIES OF OFFICERS

7.6-1 CHIEF OF THE MEDICAL STAFF

The Chief of the Medical Staff shall serve as the highest elected officer of the Medical Staff to:

(a) enforce the Bylaws and implement sanctions where indicated;

(b) call, preside at, and be responsible for the agenda of all general staff meetings and meetings of the Medical Executive Committee;

(c) serve as an ex officio member of all other staff committees without vote. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;

(d) appoint, with the consultation of the Medical Executive Committee, members for all standing and special Medical Staff or multi-disciplinary committees, and designate the chair of these committees;

(e) as appropriate, participate in Sentinel Clinical Event assessments and delegate responsibility to appropriate other Medical Staff members to lead the process review and/or root cause analyses;

(f) interact with the Chief Executive Officer and the Board in all matters of mutual concern within the facility;

(g) represent the views and policies of the Medical Staff to the Board and to the Chief Executive Officer;

(h) be a spokesman for the Medical Staff in external professional affairs;

(i) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Medical Executive Committee; and

(j) serve as an ex officio member of the Local Board for the length of the term of office.

7.6-2 VICE CHIEF OF THE MEDICAL STAFF

The Vice Chief of the Medical Staff shall assume all duties and authority of the Chief of the Medical Staff in his or her absence. The Vice Chief of the Medical Staff shall be a member of the Medical Executive Committee and shall perform such other duties as the Chief of the Medical Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

7.6-3 SECRETARY

The secretary shall determine that accurate and complete minutes of all Medical Staff meetings are maintained. The secretary shall perform all such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of the Medical Staff or the Medical Executive Committee.

ARTICLE EIGHT: COMMITTEES

8.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, the descriptions of which will be contained in the Medical Staff Rules and Regulations. In addition, special or ad hoc committees may be appointed for specific purposes by the Chief of Staff; such appointment will cease upon the accomplishment of the purpose of the committee. Such special or ad hoc committees shall report to the Executive Committee.

8.2 GENERAL PROVISIONS

8.2-1 EX OFFICIO MEMBERS

The Chief of Staff and the Chief Executive Officer or their respective designees are ex officio members of all standing and special committees of the Medical Staff.

8.2-2 SUBCOMMITTEES

Any standing committee may elect to perform any of its specifically designated functions by appointing a subcommittee that reports its recommendations to the parent committee. Any such subcommittee may include individuals appointed by the committee chair who are not members of the standing committee.

8.2-3 APPOINTMENT OF MEMBERS AND CHAIRS

Except as otherwise provided, the Chief of Staff shall appoint, in consultation with the Executive Committee, the members and chair of any Medical Staff committee formed to accomplish Medical Staff functions. The chair of all standing committees shall be members

of the active staff. Chairs of special or ad hoc committees may be appointed from the active, courtesy, or honorary staff.

8.2-4 TERM, REMOVAL, RESIGNATIONS, AND VACANCIES

(a) Except as otherwise provided, committee members and chairs shall be appointed by the Chief of the Medical Staff for a term of one (1) year which shall coincide with the term of the Chief of the Medical Staff or until the member's successor is appointed, unless such member or chair sooner resigns or is removed from the committee.

(b) Resignations: Any committee chair or member may resign at any time by giving written notice to the Chief of the Medical Staff. Such resignation takes effect on the day of the receipt of the resignation or at any time specified in the notice.

(c) A Medical Staff member serving on a committee, except one serving ex officio, may be removed by the Chief of Staff or by action of the Executive Committee. A committee chair or member, removed by Executive Committee or the Chief of the Medical Staff, shall have the right to an appearance before the Executive Committee to request reconsideration of the removal.

(d) Criteria for consideration for removal of a committee chair or member shall include failure to continue to meet the qualifications for the office, failure to perform the duties required of the position, (i.e., illegal activities), or substantiated allegations as an impaired practitioner Removal of a committee chair or member shall be effective upon approval by the Board.

(e) A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment was made.

8.2-5 VOTING RIGHTS

Each Medical Staff committee member shall be entitled to one vote on committee matters.

8.3 MEDICAL EXECUTIVE COMMITTEE

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. The Medical Executive Committee shall include physicians and may include other practitioners and any other individuals as determined by the Medical Staff. The Medical Executive Committee will communicate proposed amendments to the Medical Staff prior to adoption, except when urgent action is required. The Medical Executive Committee may act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its authority as set forth in the Bylaws and may perform the more specific duties set forth in Section 8.3-3 below.

8.3-1 COMPOSITION

The Medical Executive Committee shall consist of:

(a) Chief of Staff, as chair

(b) Vice Chief of Staff

(c) Chief Executive Officer (ex officio without vote)

8.3-2 **ELECTIONS, TERMS, VACANCIES, AND REMOVALS**

(a) Elections

The Medical Staff officers shall be elected as outlined

(b) Terms of office

All members of the Executive Committee shall serve a one-year term.

(c) Removals and Vacancies

Removals and vacancies of general staff officers and department chairs will be determined as outlined in the Medical Staff Bylaws. Vacancies will be filled in the manner prescribed for general staff officers.

8.3-3 **DUTIES**

The duties and authority of the Medical Executive Committee are to:

(a) Act on all matters of Medical Staff business, except for the election or removal of general staff officers;

(b) Receive and act upon reports and recommendations from Medical Staff committees;

(c) Coordinate and implement the professional and organizational activities and policies of the Medical Staff;

(d) Make recommendations to the Chief Executive Officer and to the Board on Platte County Memorial Hospital medico-administrative matters;

(e) Review the qualifications, credentials, performance, and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding such matters;

(f) Establish processes to promptly address bioethical issues and professional health issues;

(g) Account to the Board for the quality and efficiency of medical care provided in the facility, including a summary of specific findings, actions, and results and including an assessment of the quality of services rendered pursuant to contract;

(h) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members;

(i) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees; and

(j) Assist in obtaining and maintaining accreditation of Platte County Memorial Hospital.

(k) Organize the Medical Staff organization's quality assurance and performance-improvement activities and establish a mechanism designed to conduct, evaluate and revise such activities.

8.3-4 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least six times a year.

8.3-5 ATTENDANCE REQUIREMENTS

All members of the Medical Executive Committee are required to attend a minimum of 50% of the Medical Executive Committee meetings. If attendance does not meet the minimum, the Chief of Staff may appoint a replacement with the approval of the Medical Executive Committee.

ARTICLE NINE: MEETINGS

9.1 MEDICAL STAFF MEETINGS

9.1-1 REGULAR MEETINGS

General staff meetings will be scheduled to occur once a month and with a minimum of six per calendar year to be held.

9.1-2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, or the Board.

9.2 COMMITTEE MEETINGS

Committees will meet as necessary to fulfill the obligations/business of the committee.

9.3 ATTENDANCE REQUIREMENTS

9.3-1 GENERALLY

In addition to satisfying the special appearance requirements, each member of the active staff is expected to attend the annual and general staff meetings, and meetings of committees on which he or she serves, unless excused. Other staff members who serve on committees have these same attendance requirements for the committees to which they have been appointed. To maintain active status, staff members should attend the annual general staff meeting and are expected to attend at least 50% of general medical staff

meetings. Failure to comply with this requirement may result in a reduction in staff category. Committee meeting attendance will also be a factor considered in maintaining active staff category and in committee appointments.

9.3-2 SPECIAL APPEARANCE OR CONFERENCES

(a) A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed.

(b) Whenever a department or section perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified of the time, date, place of the program, the subject matter to be covered, and its special applicability to their practice. Attendance is mandatory. Failure to attend may result in summary suspension or other initiation of corrective action proceedings.

(c) Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance, the Chief of Staff, may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefore. Failure of a practitioner to appear at any such meeting may result in summary suspension or the initiation of corrective action proceedings.

9.4 QUORUM

9.4-1 GENERAL STAFF MEETINGS

The presence of 3 qualified voting members of the staff at any regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws.

9.4-2 COMMITTEE MEETINGS

The presence of 50% of the voting members of the Executive Committee or of any other medical staff committee shall constitute a quorum.

9.5 ALTERNATIVE MECHANISMS TO CONDUCT MEDICAL STAFF BUSINESS

General Staff and Committee meetings may be held in alternative forums, including telephonically. Medical Staff members may be advised of Medical Staff business, asked to vote or requested to provide input through mail, facsimile, email, or other electronic communication.

ARTICLE TEN: CONFIDENTIALITY, IMMUNITY AND RELEASES

10.1 AUTHORIZATIONS AND RELEASES

By submitting an application for staff appointment or reappointment or by applying for or exercising clinical privileges or providing specified patient care services at Platte County Memorial Hospital, a practitioner:

(a) authorizes facility representatives to solicit, provide, and act upon information bearing on or reasonably believed to bear upon the practitioner's professional ability, utilization practices, and qualifications;

(b) agrees to be bound by these Bylaws regardless of whether membership or clinical privileges are granted or are subsequently limited;

(c) acknowledges that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and the exercise of clinical privileges or provision of specified patient care services at this organization;

(d) agrees to release from legal liability and hold harmless the organization, Medical Staff, Medical Staff committees, and all persons engaged in peer review activities, which include but are not limited to those activities identified in Section 10.3 of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws or any applicable federal or state statute or regulation; agrees that his/her sole remedy for any corrective action taken or recommended by the Medical Staff, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review action shall be the right to seek injunctive relief pursuant to applicable state law.

(e) agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to this organization or its representatives; and

(f) authorizes the release of information about the practitioner to other Banner Health facilities where the practitioner has or requests membership or privileges.

10.2 CONFIDENTIALITY OF INFORMATION

Information obtained or prepared for the purpose of evaluating or improving the quality and efficiency of patient care, reducing morbidity and mortality, or contributing to teaching or clinical research, shall, to the fullest extent permitted by law, be confidential. Such information shall only be disseminated to the extent necessary for the purposes identified above or except as otherwise specifically authorized by law. Such confidentiality shall also extend to information provided by third parties.

10.3 ACTIVITIES COVERED

The confidentiality and immunity provided by this Section applies to all information obtained or disclosures made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) applications for appointments, clinical privileges, or specified services;

(b) periodic reappraisals for reappointment, clinical privileges, or specified services;

(c) corrective or disciplinary actions;

(d) hearings and appellate reviews;

(e) quality review program activities;

(f) utilization review and management activities;

(g) claims reviews;

(h) profiles and profile analysis;

(i) risk management activities, and

(j) other hospital, committee, or staff activities related to monitoring and maintaining quality and efficient care and appropriate professional conduct.

10.4 RELEASES

Each practitioner shall, upon request of Platte County Memorial Hospital, execute general and specific releases in accordance with the tenor and import of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases upon request during a term of appointment to the staff shall result in automatic suspension.

10.5 CUMULATIVE EFFECT

Provisions in these Bylaws and in application and reapplication forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protection provided by relevant Wyoming and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE ELEVEN: GENERAL PROVISIONS

11.1 MEDICAL STAFF SERVICES POLICIES AND PROCEDURES

The Medical Executive Committee shall adopt Medical Staff Policies, Procedures, Rules and Regulations as may be necessary to implement the general principles found in these Bylaws. The policies shall be consistent with the Medical Staff Bylaws and organization policies. The Executive Committee may act for the staff in adopting or amending them. A copy shall be sent to all members of the Medical and Allied Health Professional Staffs.

11.2 SPECIAL NOTICE

When special notice is required, the Chief Executive Officer or designee shall send such notice by hand-delivery or certified mail to the address provided by the practitioner. If the post office

indicates that the letter has been refused, such notice shall be deemed to be delivered on the date delivery was first attempted. If the post office indicates the letter is undeliverable or if the hand-delivery is refused, there shall be an attempt to contact the practitioner at the location last identified by him or her. If such attempt is unsuccessful, notice shall be deemed to be delivered on the date delivery was first attempted.

11.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

11.4 PARLIAMENTARY PROCEDURE

The rules contained in the current edition of Roberts Rules of Order shall govern the Medical Staff in all cases to which they are applicable, in all cases that they are not inconsistent with these Bylaws, and any special rules of order the Medical Staff may adopt.

ARTICLE TWELVE : ADOPTION AND AMENDMENT

12.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff shall be responsible for the development, adoption, and periodic review of these Bylaws which must be consistent with the policies and applicable laws. The Bylaws of the Medical Staff are adopted by the Medical Staff and approved by the Board prior to becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws, except the Board may unilaterally amend the Bylaws in accordance with the Corporate Bylaws by Banner Health.

12.2 MEDICAL STAFF ACTION

12.2-1 The Medical Executive Committee will distribute proposed changes to the Medical Staff Bylaws to the active staff and its recommendations regarding the changes. A favorable vote of a majority of those voting is required on each proposed amendment.

12.2-2 Subject to approval by the Governing Board, the Medical Executive Committee shall adopt such Medical Staff General Rules and Regulations as may be necessary to implement the general principles found in these Bylaws; such general rules and regulations shall be consistent with these Bylaws and the organization policies. The Medical Executive Committee may act for the staff in adopting or amending them. A copy shall be sent to all members of the Medical Staff.

12.3 BOARD ACTION

12.3-1 WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION

When approved by the Board, the Medical Staff recommendations regarding proposed Bylaws, or amendments thereto, shall be effective upon the affirmative vote of the Board.

12.3-2 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are technical or legal modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately upon Board approval.

ADOPTIONS AND REVISIONS TO BYLAWS

Adopted by the Medical Staff	May 22, 1989
Approved by the Lutheran Hospital & Homes Board	June 2, 1989
Revision by the Medical Staff	December 30, 1996
Approved by the Luther Health Systems Board	January 8, 1997
Revision by the Medical Staff	March 31, 1997
Approved by the Lutheran Health Systems Board	April 30, 1997
Revision by the Medical Staff	January 31, 2000
Approved by the Banner Health System Board	February 10, 2000
Revision by the Medical Staff	March 31, 2003
Approved by the Banner Health System Board	April 2003
Revision by the Medical Staff	January 28, 2008
Approved by the Banner Health Board	February 14, 2008
Revision by the Medical Staff	March 31, 2009
Approved by the Banner Health Board	April 9, 2009
Revision by the Medical Staff	October 27, 2009
Approved by the Banner Health Board	November 12, 2009
Revisions by the Medical Staff	February 23, 2011
Approved by the Banner Health Board	March 9, 2011
Revisions by the Medical Staff	August 30, 2011
Approved by the Banner Health Board	October 13, 2011
Revisions by the Medical Staff	May 29, 2012
Approved by the Banner Health Board	June 14, 2012
Revisions by the Medical Staff	_____, 2013
Approved by the Banner Health Board	April 11, 2013
Revisions by the Medical Staff	_____, 2013
Approved by the Banner Health Board	September 19, 2013
Revisions by the Medical Staff	_____ 2013
Approved by the Banner Health Board	December 12, 2013
Revisions by the Medical Staff	_____, 2015
Approved by the Banner Health Board	February 12, 2015
Revisions by the Medical Staff	_____, 2016
Approved by the Banner Health Board	March 10, 2016
Revisions by the Medical Staff	_____, 2016
Approved by the Banner Health Board	August 11, 2016
Revisions by the Medical Staff	_____, 2018
Approved by the Banner Health Board	June 14, 2018