Banner Health

Sterling Regional® MedCenter

Bylaws of the Medical,

Dental and Podiatric Staff

BYLAWS OF THE MEDICAL, DENTAL AND PODIATRIC STAFF

Sterling Regional MedCenter, Sterling, Colorado

Banner Health
Sterling Regional® MedCenter

BYLAWS OF
THE MEDICAL, DENTAL AND PODIATRIC STAFF

PREAMBLE

WHEREAS, the purpose of Sterling Regional MedCenter is to serve as a general acute care hospital providing patient care; and

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

THEREFORE, the physicians, dentists and podiatrists practicing in the Hospital are hereby organized into a Medical Staff in conformity with these Bylaws.

NAME

The name of this organization shall be the Medical Staff of Sterling Regional MedCenter.

ARTICLE 1: PURPOSES

The purposes of this organization are:

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

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

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

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

D. To initiate and maintain rules and regulations for governing the Medical Staff, which shall be binding on all Members and all applicants for membership in the Medical Staff, in accordance with these Bylaws, the Rules and Regulations, applicable Medical Staff policies and the bylaws, rules, regulations, and policies, of the Hospital and the Board of Directors.

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

ARTICLE 2: DEFINITIONS

The following words, terms or phrases contained in these Bylaws, the Professional Review/Corrective Action Plan, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, or the Rules and Regulations, shall be defined as follows:

ACTIVE STAFF: The term "Active Staff" shall refer to all members of the Active Medical Staff, the Active Dental Staff and the Active Podiatric Staff.

ADMISSION: The terms “admit”, “admitting” and/or “admission” shall refer to those instances in which a Member causes a patient to be assigned to a Hospital room and designated bed number, generally for inpatient care, but not necessarily excluding outpatient care. The requesting of ancillary outpatient services provided by the Hospital specifically does not constitute an admission. In addition, if the patient has not been assigned to a Hospital room and designated a bed number, this does not constitute an admission for the purposes of these Bylaws.

APPLICATION FOR APPOINTMENT OR REAPPOINTMENT TO THE MEDICAL STAFF: The term “application for appointment or reappointment to the Medical Staff” shall refer to application for appointment or reappointment to the Active Staff, Community Based Staff or the Associate Staff, and as a matter of definition, shall not be construed as to having any reference to the Honorary Staff.

ASSOCIATE STAFF: The term "Associate Staff" means all members of the Associate Medical Staff.

BOARD OF DIRECTORS: The term "Board of Directors" shall refer to the Board of Directors of Banner Health, an Arizona non-profit corporation, the governing board of such corporation.

BYLAWS: The term "Bylaws" shall refer to the Bylaws of the Medical, Dental and Podiatric Staff of the Hospital.

CHIEF EXECUTIVE OFFICER: The term "Chief Executive Officer" means the Chief Executive Officer of the Hospital.

COMMUNITY BASED STAFF: The term "Community Based Staff" means all members of the Community Based Medical Staff.

CORPORATE BYLAWS: The term "corporate bylaws" shall refer to the corporate bylaws of Banner Health, an Arizona non-profit corporation, formerly known as "Lutheran Health Systems".

CREDENTIALS COMMITTE: The term "Credentials Committee" shall refer to the Credentials/Allied Health Committee of the Medical Staff, as defined in these Bylaws.

DEMONSTRATED COMPETENCE: The term "demonstrated competence" shall mean documented evidence of a Practitioner's professional abilities and clinical judgment in the diagnosis and treatment of patients; his/her professional ethics; his/her compliance with these Bylaws, the Rules and Regulations and the policies and procedures of the Hospital and the Medical Staff; his/her ability to work with other Practitioners, health care providers, Hospital employees and patients; and other matters bearing on the Practitioner's ability and willingness to contribute to quality patient care in the Hospital. Documented evidence may include written or witness statements.

GEOGRAPHIC SERVICE AREA OF THE HOSPITAL: As used herein, the term "Geographic Service Area of the Hospital" shall be defined as the area that is within a driving time (at legal speed) of forty-five (45) minutes from the Hospital.

HONORARY STAFF: The term "Honorary Staff" means all members of the Honorary Medical Staff.

HOSPITAL: The term "Hospital" means Sterling Regional MedCenter of Sterling, Colorado.

HOSPITAL-BASED PRACTITIONER: The term "Hospital-Based Practitioner" means a Practitioner practicing in the specialty of anesthesia, pathology or radiology or a Practitioner providing only emergency medicine services or only hospitalist services.

MEDICAL DIRECTOR: The term "Medical Director" shall refer to a Member engaged by the Hospital or the Medical Staff, either full or part-time, in an administrative capacity, whose activities may include clinical responsibilities such as direct patient care, research or supervision of the patient care activities of other Members under the Medical Director's direction.

MEDICAL EXECUTIVE COMMITTEE: The term "Medical Executive Committee" shall refer to the executive committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Board of Directors.

MEDICAL STAFF: The term "Medical Staff" shall be interpreted to include all Practitioners who are formally appointed by the Board of Directors to membership on the Medical Staff. It does not include Allied Health Professionals or other health care providers who may be granted certain health care privileges within the Hospital, and who are monitored by Members or committees of the Medical Staff, as hereinafter set forth.

MEDICAL STAFF YEAR: The term "Medical Staff Year" means the period from January 1 to and including December 31.

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

PATIENT MANAGEMENT CONTACTS: As used herein, the term "patient management contacts" shall refer to admissions, consultations, performed procedures, or orders for diagnostic testing such as laboratory and medical imaging.

PRACTITIONER: The term "Practitioner" means a doctor of medicine, a doctor of osteopathy, a doctor of dental medicine, a doctor of dental surgery, or a podiatrist.

SPECIAL NOTICE: The term "Special Notice" means written notification delivered in person or sent by certified or registered mail, return receipt requested. Receipt of the Special Notice shall be effective upon personal delivery, and in the event a Special Notice is sent by mail, such receipt shall be presumed when the Special Notice is delivered and accepted.

STANDARDS REQUIRED BY THESE BYLAWS: The phrase "standards required by these Bylaws" means and refers to standards set forth in (1) these Bylaws, (2) standards adopted by the Medical Executive Committee and approved by the Board of Directors, such as those set forth in Article 3, Section 2, Paragraph C, and (3) standards required by any policy and/or procedure statement formally adopted by the Medical Staff and/or the Board of Directors.

SUPPORT STAFF: The term “Support Staff” means certain members of the administrative staff of the Hospital and of Banner Health who may or may not be Members of the Medical Staff including, but not limited to, the Hospital’s Chief Executive Officer, Facility Medical Director, Chief Nursing Officer and/or designees, and Quality Management, members of the Medical Staff Services Department, members of the Banner Health Board and Banner Health leadership, members of the Banner Health Legal Department and members of the Banner Health Risk Management Department, including Loss Control and Claims and Litigation Management staff.

THE COMPLETED APPLICATION: The term "the completed application" means and refers to an application for appointment or reappointment to the Medical Staff in such form as the Board of Directors may require, plus all documentation required by these Bylaws for consideration of an application for appointment or reappointment to the Medical Staff, including, but not limited to, the documentation set forth in Article 5, Section 2, Paragraph A, and Article 5, Section 3, Paragraph A.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

SECTION 1
NATURE OF MEDICAL STAFF MEMBERSHIP

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

SECTION 2
QUALIFICATIONS FOR MEMBERSHIP

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

B. An applicant for appointment or reappointment to the Medical Staff shall have the burden of establishing, to the satisfaction of the appropriate committees of the Medical Staff and to the Board of Directors, that he or she meets the qualifications, standards and requirements set forth in these Bylaws, and that, if granted Medical Staff membership and clinical privileges, he or she would provide quality medical care.

C. In order to qualify for appointment and reappointment to the Medical Staff and to be granted clinical privileges to practice at the Hospital, each Practitioner must continually meet all of the following standards: (1) he or she must possess such credentials for Medical Staff appointment and reappointment and for the specific clinical privileges requested, as the Medical Executive Committee shall, from time to time establish, subject to final approval by the Board of Directors, and (2) he or she must possess the following:

    1. Graduation from a medical school accredited at the date of graduation by the American Medical Association Liaison Committee on Medical Education or the Canadian Medical Association, or from a college of osteopathic medicine approved by the American Osteopathic Association; or graduation from a foreign medical school, together with a permanent certificate of the Education Council for Foreign

Medical Graduates or completion of a 5th pathway; or graduation from an accredited dental school; or graduation from an accredited school of podiatry.

2. A current unrestricted license to practice in the State of Colorado issued by any of the Colorado Board of Medical Examiners, the Colorado Board of Dental Examiners, or the Colorado Board of Podiatric Examiners. A license under probationary status shall be considered restricted unless at least 1 year of probation has been completed satisfactorily as confirmed by the Colorado Board of Medical Examiners, the Colorado Board of Dental Examiners, or the Colorado Board of Podiatric Examiners, as the case may be, and as approved by the Medical Executive Committee.

3. Board Certification by the appropriate specialty board that is recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Association of Oral and Maxillofacial Surgeons (AAOMS), American Board of Podiatric Surgery (ABPS), American Board of Orthopedic Podiatrics (ABOP) or Primary Podiatric Medicine (PPM) OR active candidate for board certification OR demonstrate to the satisfaction of the Credentials Committee and the Medical Executive Committee, competency and training equal or equivalent to that required for Board Certification.

   Members who are not board certified at the time of initial appointment must achieve board certification within five (5) years of graduation from an approved residency or fellowship. Members who do not become board certified during the five (5) year period may be granted an extension upon the recommendation of the Credentials Committee and approved by the Medical Executive Committee. The board certification requirement is not applicable for dental specialties except as specified above.

   Continued Board Certification during the course of Medical Staff membership is expected. Exceptions or extensions may be granted upon the recommendation of the Credentials Committee and approved by the Medical Executive Committee
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4. Insurance coverage as required by these Bylaws.

5. The requisite physical and mental health status, skill, proficiency and competency required for the careful practice of medicine, dentistry or podiatry within the clinical privileges requested. The committees of the Medical Staff and the Board of Directors shall consider such factors as age and health in determining a Practitioner's ability to perform certain procedures and to practice within certain privileges.

D. A Practitioner with proper credentials who, under pressure, stress, substance abuse or other personal circumstances, engages in erratic behavior which is dangerous or contrary to good patient care, shall not be qualified for Medical Staff membership or clinical privileges.

E. Acceptance of an application for membership on the Medical Staff shall constitute an agreement that the applicant will strictly abide by these Bylaws and with the Principles of Medical Ethics and Rules of the Judicial Council of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Code of Ethics of the American Dental Association, or the Code of Ethics of the American Podiatric Association, whichever is applicable, and the Standards for Hospitals as promulgated by The Joint Commission ("TJC").

SECTION 3
CONDITIONS AND DURATION OF APPOINTMENT

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

B. All initial appointments (excluding the Honorary Staff category)are provisional in nature and shall be placed into an Initial Focused Professional Practice Evaluation (FPPE) review period as per the System Focused Professional Practice Evaluation (FPPE) policy and procedure and these Members are subject to the following conditions:

1. The initial FPPE period shall be for six (6) months following the date on which clinical privileges were granted by the Governing Board.

2. During the initial FPPE period, the Member shall be entitled to admit patients to the Hospital and exercise the clinical privileges granted by the Governing Board.

3. During the initial FPPE period, the Member may be proctored by the chair of the appropriate clinical committee or a Member appointed by the Chief of Staff or designee for the initial performance of admissions and/or procedures as deemed necessary by the Medical Executive Committee and/or Credentials Committee.

4. Upon successful completion of the initial FPPE period, the Medical Executive Committee shall review a summary of the Member’s patient care activity at the Hospital and the written reports of the monitor/proctor(s. Following review of the Member’s patient care activity and monitored/proctored cases, the Medical Executive Committee shall make recommendations to the Governing Board regarding advancement from the provisional status. Upon approval by the Governing Board, the new Member shall function as a non-provisional Member of the Medical Staff category to which he/she has been assigned and shall be

reappointed in accordance with the provisions of these Bylaws. In the event of concerns regarding the Member's patient care activity or the monitored/proctored cases, the Medical Executive Committee shall determine whether any action under these Bylaws, such as correction action or further monitoring/proctoring, is warranted.

5. The initial FPPE period may be extended for additional periods of six (6) months each for as many times as deemed necessary, but advancement must occur prior to completion of twenty-four (24) months of membership. Failure to complete the initial FPPE period and advance from provisional status at the end of twenty (24) months shall result in automatic termination of the Member's initial appointment and Medical Staff membership.

C. As a condition to membership on the Medical Staff, each Practitioner shall: (1) acknowledge his or her obligation to provide continuous care and supervision of his or her patients, consistent with the then-current policies and guidelines of the Colorado Board of Medical Examiners; (2) abide by these Bylaws, the Rules and Regulations and applicable policies and procedures of the Medical Staff and the Hospital; (3) accept medically appropriate consultation assignments that are not in conflict with the personal beliefs of the consultant; (4) acknowledge his or her obligation to participate in the Emergency Department call schedule in accordance with established policies; (5) acknowledge his or her obligation to participate in the peer review process; and (6) submit continuing medical education activities at the time of appointment and reappointment.

D. It shall be a condition of membership on the Active Staff , Community Based Staff or the Associate Staff, and a condition to the exercise of any delineated clinical privilege, that the Practitioner shall have in full force and effect a policy or policies of professional liability insurance which are acceptable in form and amount to the Board of Directors (as specified in the most current policy directive from the Board of Directors dealing with this issue), and that the Practitioner has on file with the Chief Executive Officer a certificate of insurance issued by an acceptable insurance carrier(s) specifying the terms of coverage, the policy period in effect, and the limits of coverage available. Timely notice shall be given to the Hospital of any modification, termination, cancellation, revocation or lapse of any of said policies of insurance.

E. It shall be a condition of membership on the Active Staff , Community Based Staff or the Associate Staff, and a condition to the exercise of any delineated clinical privilege, that the Practitioner shall notify the Chief Executive Officer immediately of any the following: (1) if any pending claims or suits are made against his/her malpractice liability coverage; (2) if his/her professional license in any state is under investigation or is suspended or revoked; (3) if any licensure board issues to him/her a letter of reprimand, letter of admonishment, letter of censure or other similar letter; (4) if his/her membership or privileges at or with any other hospital or other healthcare provider are suspended, revoked or otherwise adversely affected; (5) if his/her Drug Enforcement Agency registration is suspended or revoked; (6) if he/she is under investigation by, threatened with exclusion from, or excluded from, any healthcare program funded in whole or part by the federal government, including Medicare

or Medicaid; (7) if he/she receives notice of any proposed or actual sanctions against Medicare or Medicaid participation; (8) if he/she has been convicted, plead guilty to, or pled nolo contendere to any felony (9) if there is any change in any of the information on his/her application form; or (10) if he/she ceases to meet any of the standards or requirements set forth herein for continued Medical Staff membership or clinical privileges.

SECTION 4
RESPONSIBILITIES OF EACH MEMBER

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

B. Each Member shall prepare and complete, in a timely fashion, according to these Bylaws and Hospital policies, the medical and other required records for all patients to whom the Member provides care in the Hospital, or within its facilities, services or departments.

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

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

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

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

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

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

I. Each Member and Allied Health Professional shall complete a history and physical examination ("H&P") in all cases within 24 hours after patient 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 thirty (30) days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The content of complete H&P is delineated in the Rules and Regulations of the Medical, Dental and Podiatric Staff.

The failure of a Member to meet any of the above obligations may result in non-reappointment or in the imposition of corrective action as provided in the Professional Review/Corrective Action.

SECTION 5
RIGHTS OF MEMBERS

A. Each Member has the right to an audience with the Medical Executive Committee.

B. Each Member has the right to initiate a recall election of a Medical Staff officer. A petition for such recall must be presented to the Medical Executive Committee and be signed by at least ten percent (10%) of the Active Medical Staff. Upon presentation of a valid petition, the Medical Executive Committee shall schedule a special meeting of the Medical Staff for the purpose of discussing the issue and, if appropriate, shall entertain a no confidence vote, followed by the removal of such Medical Staff officer from office, if appropriate.

C. Each Member has the right to initiate a call for a meeting of the Medical Staff. Upon presentation of a petition signed by ten percent (10%) of the Active Medical Staff, the Medical Executive Committee shall schedule a meeting of the Medical Staff for the specific purpose(s) addressed by the petitioners. No business other than that in the petition may be transacted.

D. Each Member has the right to initiate a challenge to any Medical Staff rule or policy established by the Medical Executive Committee. In the event any Medical Staff rule or policy is felt to be inappropriate, any Member may submit a petition signed by ten percent (10%) of the Active Staff.

1. The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to Medical Staff members. The petitioner must acknowledge that he/she has read the petition and all attachments, if any, in order for his/her signature to be considered valid.

2. The Medical Executive Committee will consider the challenge at its next meeting and will determine what changes will be made to the Medical Staff rule or policy or

will appoint a subcommittee to review and challenge and recommend potential changes to address the concerns. The Medical Executive Committee will review subcommittee recommendations and take final action on the rule or policy. The Medical Executive Committee will communicate all changes to the Medical Staff.

3. Should the parties fail to reach resolution, or if the voting members do not approve any proposed solution agreed to by the petitioners and the Medical Executive Committee, the petition and all accompanying materials will be forwarded to the Board for its review and consideration. The decision of the Board shall be final.

4. If, on the other hand, the voting members accept the conflict resolution as proposed by the petitioners and the Medical Executive Committee, the resolution, the initial petition and all accompanying materials shall be forwarded to the Board for its review and consideration. The decision of the Board shall be final.

5. Nothing under this section precludes direct communication between an individual member from communicating with the Board regarding any rule, regulation or policy already adopted by the Medical Staff or the Medical Executive Committee.

6. Such communication shall be forwarded to the Medical Executive Committee of the Board through the Chief Executive Officer of the Hospital and to the Medical Executive Committee through the Chief of Staff. The Chair of the Board shall determine the manner and method of responding to any physician(s) communicating to the Board of Directors under this Article.

E. Sections D (1) through D (6) above do not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging. Such issues are governed by Sections F-G below and the Professional Review/Corrective Action Plan.

F. Any Member has a right to a hearing/appeal as outlined in Section G below pursuant to the Professional Review/Corrective Action Plan in the event any of the following actions are taken or recommended:

1. denial of initial Medical Staff appointment;

2. denial of reappointment;

3. revocation of Medical Staff appointment;

4. denial or restriction of requested clinical privileges;

5. reduction in clinical privileges;

6. revocation of clinical privileges;

7. individual application of, or individual changes in, mandatory concurring consultation requirement; or

8. suspension of Medical Staff appointment or clinical privileges if such suspension is for more than fourteen (14) days.

G. **Hearing and Appeal Rights**

1. Fair Hearing. When hearing rights are triggered, the practitioner is notified of the grounds for the adverse action or recommendation and his/her right to request a hearing by submitting a written request to the Chief Executive Officer within 30 days.

2. Hearing Committee. When a hearing is requested, the hearing will be conducted by a committee composed of at least three members. No person in direct economic competition with the practitioner or who has participated in the adverse recommendation shall participate. Members of the hearing committee shall be physicians and may, but need not, be members of the medical staff.

3. Scheduling the Hearing. Except when the practitioner has the right to request an expedited hearing and has requested such a hearing, the Chief Executive Officer shall send the practitioner notice of the date, time, and place of the hearing at least 30 calendar days prior to the hearing. Efforts will be made to schedule the meeting to commence not less than 30 calendar days nor more than 45 calendar days after the Chief Executive Officer sends special notice to the practitioner. Upon receipt of a written request by a practitioner for an expedited hearing, the hearing must be held as soon as the arrangements may reasonably be made. The above stated time periods may be modified upon the mutual agreement of the practitioner and the Chief Executive Officer.

4. Hearing Process. The Medical Executive Committee has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the practitioner has the right to submit evidence and testimony to challenge the adverse recommendation or action provided that the procedures set forth in the Professional Review/Corrective Action Plan have been followed.

5. Appellate Review. The appeal will be conducted in accordance with the Board of Directors' Appellate Review Policy to be provided to the practitioner upon request.

6. Scheduling the Appeal. Upon receipt of a timely and proper request for appellate review, the General Counsel of Banner shall schedule the appellate review as soon as practicable. The General Counsel will attempt to schedule the review at a date and time acceptable to the practitioner, representatives of the Medical Staff and members of the Appeals Subcommittee.

7. Appeal Process. The practitioner has the burden of demonstrating, by preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, or applicable law, and created demonstrable prejudice; or the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record. Thereafter, the Medical Executive Committee may present evidence in support of the reconsidered recommendation or action.

H. **Non-Reviewable Actions**. Not every recommended action entitles a Member to a formal hearing and/or appeal pursuant to the above sections before it is implemented. Specifically, the following actions are non-reviewable which are set forth in more detail the Medical Staff's Professional Review/Corrective Action Plan:

1. Imposition of an automatic suspension or limitation pursuant to Section J. below;

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

3. The requirement of additional training or education that does not require the practitioner to terminate or take a leave of absence from his/her practice.

4. The issuance of a letter of concern or warning.

5. The issuance of a letter of admonishment or reprimand.

6. The requirement for consultation for a time not to exceed one year.

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

8. The inability of a practitioner to exercise clinical privileges as a result of the Hospital's decision to enter into an exclusive arrangement with a single practitioner or provider group to provide certain clinical services shall not constitute a reduction, suspension or revocation of such clinical privileges.

Where an action that is not reviewable has been taken against an Applicant or Member, the affected Applicant or Member may request that the Medical Executive Committee review the action, and such Applicant or Member 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 Applicant or Member shall have no appeal or other rights in connection.

I. **Precautionary Suspension**. Whenever a Medical Staff member willfully disregards or grossly violates the Medical Staff Bylaws, the Rules and Regulations or any applicable policies, or whenever the practitioner's conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of serious injury or damage to the health or safety of any patient, employee, or other person present in the Hospital, or when the conduct materially disrupts the operations of any part of the Hospital, the Chief of Staff, the Chief Executive Officer, or the Medical Executive Committee shall have the authority to immediately suspend the Medical Staff appointment or any or all portions of the clinical privileges of the Medical Staff member. Whoever imposes the precautionary suspension shall immediately notify the Chief Executive Officer. Such precautionary suspension shall become effective immediately upon imposition and the Chief of Staff or the Chief Executive Officer shall notify the practitioner promptly. The Medical Executive Committee shall also be notified promptly of the action.

J. **Process for Automatic Suspension**. When grounds exist for automatic suspension, the privileges of the practitioner will be automatically suspended. The Chief of Staff will notify the practitioner of the suspension and may assign care of the patients to other practitioners. The following acts may result in automatic suspension of the Practitioner's membership and/or clinical privileges and are covered in more detail in the Professional Review/Corrective Action Plan.

1. A Practitioner's License to Practice Medicine or Controlled Substance Registration is:
   a. Revoked
   b. Restricted
   c. Suspended
   d. Placed on Probation

2. Revocation or suspension of a Medical Staff member's Drug Enforcement Administration (DEA) Number;

3. Failure to timely complete medical records;

4. Failure to "Actively Practice" as defined in the Professional Review/Corrective Action Plan;

5. Failure to maintain the required level of Professional Liability Insurance;

6. Providing False or Misleading Statements on Applications;

7. Conviction of a Felony may be cause for automatic suspension of a Medical Staff member's privileges, or other correction action.

SECTION 6
MEDICAL DIRECTOR ROLE

When provided for by contract, a Medical Director's responsibilities shall include assisting the Medical Staff and/or the Care Management Council of Banner Health to carry out its peer review and quality improvement activities.

ARTICLE 4: CATEGORIES OF THE MEDICAL STAFF

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

A. **Active Staff**:

1. Active Medical Staff: The Active Medical Staff shall consist of those physicians (a) who practice primarily in Sterling, Colorado, (b) who regularly attend patients in the Hospital, (c) whose residences are located within the Geographic Service Area of the Hospital, and (d) who can assume all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, consultation assignments. The Active Medical Staff also shall consist of Hospital-Based Practitioners who practice primarily at the Hospital, regardless of where their residences are located. Members of the Active Medical Staff will participate in the call schedule for unassigned patients unless otherwise determined by the Medical Executive Committee.

   Members of the Active Medical Staff shall be eligible to vote, to hold office and to serve on Medical Staff committees.

   Members of the Active Medical Staff must have at least ten (10) patient management contacts within the last two (2) years in order to be eligible for reappointment to the Active Medical Staff.

2. Active Dental Staff: The Active Dental Staff shall consist of those dentists who practice primarily in Sterling, Colorado. Members of the Active Dental Staff shall take an active role in Medical Staff affairs and shall be eligible to vote and hold office; provided, however, that members of the Active Dental Staff may not vote on specified matters for which medical education, training and experience beyond their area of specialty are deemed prerequisites for making an informed judgment thereon and may not hold the offices of Chief of Staff or Vice Chief of Staff. Members of the Active Dental Staff must have at least ten (10) patient management contacts within the last two (2) years in order to be eligible for reappointment to the Active Dental Staff.

3. Active Podiatric Staff: The Active Podiatric Staff shall consist of those podiatrists who practice primarily in Sterling, Colorado. Members of the Active Podiatric Staff shall take an active role in Medical Staff affairs and shall be eligible to vote and hold office; provided, however, that members of the Active Podiatric Staff may not vote on specified matters for which medical education, training and experience beyond their area of specialty are deemed prerequisites for making an informed judgment thereon and may not hold the offices of Chief of Staff or Vice Chief of Staff. Members of the Active Podiatric Staff must have at least ten (10) patient management contacts within the last two (2) years in order to be eligible for reappointment to the Active Podiatric Staff.

B. **Associate Staff:** The Associate Staff designation is granted to Practitioners who meet the requirements of one of the following categories: (1) they are Practitioners who do not practice primarily in Sterling, Colorado or whose residences are not located within the Geographic Service Area of the Hospital; (2) they are Hospital-Based Practitioners who do not practice primarily at the Hospital; or (3) they are locum tenens Practitioners who provide services at the Hospital for an extended period of time.

A member of the Associate Staff who is not a Hospital-Based Practitioner or a locum tenens Practitioner shall provide consultation in the diagnosis and treatment of Hospital patients, but shall not serve as an attending physician or an admitting physician. A member of the Associate Staff who is not a Hospital-Based Practitioner or a locum tenens Practitioner shall not serve as a surgeon of record for any inpatient procedure unless all of the following conditions are met: (1) the Board of Directors, upon recommendation of the Medical Executive Committee, has determined that the inpatient procedures for which such member of the Associate Staff is requesting to serve as surgeon of record may be performed by Associate Staff members in such member's specialty, (2) such member of the Associate Staff will be located within the Geographic Service Area for the duration of the patient's inpatient stay or such member of the Associate Staff has a cross coverage arrangement acceptable to the Medical Executive Committee with a Member with appropriate privileges on the Active Staff, and (3) such member of the Associate Staff has been granted appropriate

clinical privileges to perform the specific inpatient procedures for which he or she is requesting to serve as surgeon of record.

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

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

Members of the Associate Staff must have at least two (2) patient management contacts within the last two (2) years in order to be eligible for reappointment to the Associate Staff.

Practitioners who qualify for membership on the Active Staff are not eligible to apply for membership on the Associate Staff.

C. **Community Based Staff**: The Community Based Staff category shall consist of Practitioners who do not practice in the Hospital but request services for their patients and desire to maintain Medical Staff membership. The Community Based Staff category is a membership-only category of the Medical Staff with no clinical privileges. As members of the Medical Staff, Community Based Staff shall be credentialed and shall be granted membership with approval by the Board of Directors. Since no clinical privileges are granted, Community Based Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

Members of the Community Based Staff may visit their hospitalized patients and review their patients' medical records (if CPOE training has been completed); order outpatient diagnostic services, and be appointed to Medical Staff committees and vote on matters presented at those Medical Staff committees unless otherwise provided by these Bylaws or another Medical Staff Document. Members of the Community Based Staff cannot exercise clinical privileges and may not write orders, progress notes, or any notations in the medical record. Members may attend continuing medical education programs or meetings of the Medical Staff without a vote. Community based members shall not be eligible to vote or serve as an officer of the Medical Staff.

Each member of the Community Based Staff shall discharge the basic obligations of staff members as required in these Bylaws including paying all Medical Staff dues and assessments in a timely manner as detailed in the Medical Staff dues requirements in Article 12 of these Bylaws. They shall not provide emergency on-call coverage or perform any

other duties for which clinical privileges are required. Each member of the Community Based Staff shall establish appropriate referral and coverage arrangements with an Active or Associate Staff member for the medical care of his/her patients that require Hospital services.

D. **Honorary Staff:** The Honorary Staff shall consist of those Practitioners who are not active in Hospital practice but who, because of outstanding service, reputation or recognition, deserve to become members of the Honorary Staff. Honorary Staff status shall be granted by the Medical Staff. Members of the Honorary Staff may not admit patients, shall have no delineated clinical privileges, and shall not be eligible to serve on Medical Staff committees, to vote or to hold office**.**

E. **Discretion of the Medical Executive Committee**: The Medical Executive Committee, in its sole discretion, may determine whether the Medical Staff category requested by a Practitioner is appropriate, and such determination shall not be subject to review by any committee of the Medical Staff or the Board of Directors and shall not be the subject of any proceedings under the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors.

ARTICLE 5: ALLIED HEALTH PROFESSIONALS

The term "Allied Health Professionals" means those persons who are permitted to practice or provide services in the Hospital, but who are not Practitioners. Only those classes of non-Practitioner providers that have been approved by the Board of Directors will be permitted to practice or provide services in the Hospital. The identification of the classes of Allied Health Professionals that will be allowed to practice in the Hospital as well as the criteria for selection of Allied Health Professionals, the definition of their duties and responsibilities, and the regulation of their patient care work in the Hospital shall be as established by the Hospital Policy for Allied Health Professionals, the Rules and Regulations, and by delineation of clinical privileges and criteria.

Allied Health Professionals are provided oversight by members of the Active Staff and the Associate Staff as outlined in the Rules and Regulations, the Hospital Policy for Allied Health Professionals, and delineation of their individual privileges.

ARTICLE 6: RESIDENT PHYSICIANS

“Resident physicians” as used in these Bylaws, refer to persons who are currently enrolled in a graduate medical education program and under the supervision of qualified Members of the Medical Staff. Residents shall not be considered Practitioners, as defined in these Bylaws, shall not be eligible for clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. Resident physicians shall abide by the provisions outlined in the Resident Physician Scope of Activities Policy. Resident physicians enrolled with a graduate medical education program which is conducted by Banner Health will not require an affiliation agreement with the Hospital (Banner Residents). All other

resident physicians shall be credentialed by the sponsoring training program in accordance with provisions in a written affiliation agreement between the Hospital and the program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in the performance of their supervisory function.

The Graduate Medical Education Committee (GMEC) has been established to oversee graduate and post graduate medical education provided by Banner Residents within the Hospital.

ARTICLE 7: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1
RESPONSIBILITIES OF APPLICANT

A. It shall be the responsibility of each Practitioner making application for appointment or reappointment to the Medical Staff and requesting clinical privileges to supply all information reasonably required by the Medical Staff committees and the Board of Directors in order to make an informed judgment as to the applicant's qualifications and compliance with the standards required by these Bylaws. To that end, it shall be the responsibility of the applicant to supply all information requested by the appropriate committees of the Medical Staff, the officers of the Medical Staff, the Chief Executive Officer, and/or the Board of Directors, and the applicant's duty to supply such information is not necessarily fulfilled simply by completing the application form. The applicant shall have the burden of establishing to the satisfaction of the appropriate Medical Staff committees and to the Board of Directors that he or she meets the standards required by these Bylaws, the Rules and Regulations, any applicable Medical Staff policies, and any applicable policies, rules and regulations of the Hospital and the Board of Directors. In the event that the information supplied by the applicant to the committees of the Medical Staff and the Board of Directors is not sufficient to permit an informed decision on the matter, as determined by the committees of the Medical Staff or the Board of Directors, then the application for appointment to the Medical Staff and for clinical privileges shall not be deemed a completed application as defined in these Bylaws and shall not be processed.

B. Practitioners interested in Medical Staff membership shall request an application. If the Practitioner meets the criteria for Medical Staff membership, an application will be forwarded.

C. All applicants for appointment and reappointment to the Medical Staff and for clinical privileges shall complete, sign and file with the Chief Executive Officer such application or reappointment form as the Board of Directors may require. Such forms shall require full and complete disclosure by the applicant of all information required by Article 6, Section 1, Paragraph A above, including, but not limited to, the following matters:

1. Education: The form shall require a full disclosure of all the institutions of higher learning attended by the applicant (meaning all institutions attended after graduation

from high school), including dates of attendance, areas of study and degrees awarded.

2. Training: The form shall require a complete listing of all training programs of every type or description that are medically or health care related in which the applicant has participated, and, for those programs completed by the applicant, the date(s) of completion.

3. Professional Qualifications: The form shall require a full disclosure of all factors bearing upon the applicant's professional qualifications. This shall include a listing of at least three (3) professional references (physicians, dentists or podiatrists, as applicable) who are personally acquainted with the applicant. These professional references must have extensive current experience in observing and working with the applicant and must be in a position to provide adequate references pertaining to the applicant's professional competence, ethical character and compliance with the standards required for the appointment as set forth in Article 7, Section 1, Paragraph A above. The form shall require the applicant to identify all specialty boards to which he or she has applied for certification and dates of certification, if any.

4. Hospital Experience: The form shall require a complete listing of every hospital facility or other acute care facility, including governmentally owned or operated facilities, at which the applicant has applied for, and/or received Medical Staff appointment and/or other patient care privileges. This shall require full disclosure by the applicant of any action, on a voluntary or involuntary basis, by any such health care facility to deny, revoke, limit, suspend, place on probation, terminate, not renew, or take corrective action concerning, the applicant's privileges or Medical Staff appointment.

5. Peer Review Information: The form shall require a full disclosure of all peer review information from hospitals in which any form of disciplinary or corrective action was taken, recommended or requested.

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

7. Licensing Experience: The form shall require full disclosure of the applicant's experience with regard to any licensing agency of any federal, state or local government, including full disclosure with respect to all licenses granted, voluntarily

or involuntarily denied, suspended, reduced, limited, placed on probation, terminated, not renewed, relinquished, sanctioned, diminished, restricted, surrendered or revoked relating to the privilege of practicing any health care profession, including, but not limited to, the practice of medicine, osteopathy, dentistry or podiatry.

8. Health Status: The form shall require full disclosure of any physical, chemical or mental condition/behavior which could affect the Practitioner's ability to exercise the clinical privileges requested, or which would require an accommodation in order for the Practitioner to exercise the privileges requested, safely and competently.

D. By making application for appointment or reappointment to the Medical Staff, the applicant acknowledges his or her responsibility to give full, complete and accurate information concerning the matters required by these Bylaws. The applicant further acknowledges that the making of untrue statements in the application for appointment or reappointment, or the failure to make materially true statements in said application, shall be sufficient grounds for denial of the application for appointment or reappointment, and/or for automatic suspension of privileges already granted.

E. By making application for appointment or reappointment to the Medical Staff, the applicant authorizes the release of all information required for making an informed judgment concerning the applicant's compliance with the standards required by these Bylaws. Without limiting the foregoing, the applicant authorizes the release of peer review information by all other hospitals or other health care organizations at which the applicant has ever applied for or received Medical Staff privileges, even though said peer review records might be deemed "confidential" or "privileged". By making application for appointment or reappointment, the applicant agrees to submit to such physical or mental examination(s), solely at applicant's expense, as the Medical Executive Committee or the Board of Directors may require. In addition, by making application for appointment or reappointment to the Medical Staff, the applicant releases from civil liability the agents, attorneys, employees and representatives and Support Staff of the Hospital and Banner Health, the agents, attorneys and representatives of the Medical Staff, and the agents, attorneys, employees and representatives of the hospitals and other health care organizations to which inquiries are directed under these Bylaws, for all acts taken in good faith by said individuals in supplying information concerning the applicant.

F. The forms shall include a statement that the applicant has received and read these Bylaws and the Rules and Regulations, and that he or she agrees to be bound by the terms thereof without regard to whether or not he or she is granted membership and clinical privileges.

SECTION 2
APPOINTMENT PROCESS

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

A. Review and evaluation of an application for appointment to the Medical Staff shall not commence until the applicant has delivered, or caused to be delivered, to the Chief Executive Officer, or his/her designee, all of the following documentation: a completed application form, copies of degrees and certificates of completion, copies of certificates of insurance, responses to letters of inquiry from the Chief Executive Officer, or his/her designee, and all other information which has been requested by the Medical Staff or the Board of Directors within the scope of the provisions of Article 7, Section 1 above. Upon receipt by the Chief Executive Officer, or his/her designee, of all of the foregoing documentation, review and evaluation of the application shall commence. For purposes of these Bylaws, all of the documentation referred to in this Article 7, Section 2, Paragraph A and in Article 7, Section 1 above shall be referred to as "the completed application".

The applicant will be notified if his or her application is incomplete and shall have thirty (30) days to provide the missing information. If the information is not provided within thirty (30) days, the application will be deemed withdrawn and the review process will be terminated. If the applicant wishes to reapply after the review process has been terminated, he or she will need to complete a new application form and to pay the initial application fee.

The completed application shall be reviewed and evaluated by the Medical Staff in accordance with this Article 7, Section 2, Paragraph A, and the Medical Staff shall formulate recommendations to the Board of Directors concerning the applicant's compliance with the standards required by these Bylaws. The process used to review the completed application shall be as follows:

1. The completed application shall be referred to the Credentials Committee. The Credentials Committee shall review the applicant's qualifications and measure them against the standards required by these Bylaws. The Credentials Committee may conduct an interview with the applicant. In special situations where there are no Members on the Credentials Committee with the expertise and/or experience to review the applicant's qualifications and formulate recommendations regarding appointment and the requested privileges, the Chief of Staff may appoint one or more Members, if possible, or Practitioners from outside of the Medical Staff, if necessary, to advise the Credentials Committee, for the specific purpose of helping the Credentials Committee make a recommendation on the applicant.

2. The Credentials Committee shall make a recommendation to the Medical Executive Committee concerning appointment of the applicant to the Medical Staff and the granting of delineated clinical privileges.

3. The Medical Executive Committee shall consider and take action on the completed application. The recommendation of the Credentials Committee may be accepted in its entirety, partially accepted or rejected. The forms of action available to the Medical Executive Committee shall include, but shall not be limited to:

    a. referral of the matter back to the Credentials Committee;

b. formulation of a recommendation to the Board of Directors concerning the granting of Medical Staff membership and delineated clinical privileges; or

c. recommendation against appointment to the Medical Staff and/or recommendation against granting of any or all of the clinical privileges requested by the applicant.

Upon recommendation for approval of the applicant by each of the Medical Executive Committee, the Chief of Staff, and the Chief Executive Officer, the applicant may request temporary privileges as provided in Article 8, Section 3, Paragraph A below.

4. The committees of the Medical Staff should complete the review process of a completed application, as outlined above, within one hundred eighty (180) days. Such time period is a guideline and does not create any right to have an application processed within a specified period of time.

B. In the event the recommendation of the Medical Executive Committee is favorable to the applicant, the recommendation shall be forwarded to the Board of Directors for action in accordance with the Banner Health Medical Staff Expedited Review Policy.

C. In the event of a recommendation of the Medical Executive Committee that the applicant be denied appointment to the Medical Staff or that the applicant be appointed to the Medical Staff but with fewer privileges than had been requested, a Special Notice shall be sent to the applicant. No such adverse recommendation will be forwarded to the Board of Directors until after the applicant has exercised or has waived his/her right to a hearing as provided in these Bylaws and the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors.

D. In taking action on the final recommendation of the Medical Executive Committee, as provided in Article 7, Section 2, Paragraphs B or C above, the Board of Directors may:

1. Adopt the recommendations of the Medical Executive Committee and act accordingly;

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

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

4. Grant Medical Staff membership and clinical privileges conditioned upon the performance of certain acts by the Member, including, but not limited to,

monitoring, special education or training, or such other provisions as may in the judgment of the Board of Directors, be advisable for proper patient care; or

5. Deny appointments to the Medical Staff and/or deny some or all of the requested clinical privileges.

E. In the event the final recommendation of the Medical Executive Committee is favorable to the applicant and the Board of Directors votes to deny the applicant membership on the Medical Staff and/or denies the applicant clinical privileges requested by him or her, then Special Notice of such decision shall be given to the applicant by the Chief Executive Officer. No further adverse action will be taken by the Board of Directors until after the applicant has exercised or has waived his/her right to a hearing as provided in these Bylaws and the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors.

F. When the Board of Directors' decision is final, it shall send Special Notice of such decision through the Secretary-Treasurer of the Medical Staff, to the Chief of Staff, and to the applicant.

SECTION 3
REAPPOINTMENT PROCESS

A. In order to be granted continuing Medical Staff membership and clinical privileges, it shall be the responsibility of the Member to supply the appropriate committees of the Medical Staff and the Board of Directors, with all of the current information required for initial appointment to the Medical Staff under the provisions of Article 7, Section 1 above. After submission of such information, the committees of the Medical Staff and the Board of Directors shall determine whether the Member continues to meet all of the standards required by these Bylaws. In order to secure the continuation of Medical Staff membership and clinical privileges, the Member must complete, sign and file with the Chief Executive Officer, or his/her designee, an application for reappointment in such form as the Board of Directors may require. It shall also be the responsibility of the Member to supply such other data as may be reasonably requested by representatives of the Medical Staff and/or the Board of Directors, within fifteen (15) days of request therefore, in order that each may make an informed judgment as to the Member's compliance with the standards required by these Bylaws. If any requested information is not obtained from the Member within such fifteen (15) day period, the subject application shall be deemed withdrawn from consideration and no further action will be taken on it.

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

1. The Chief Executive Officer, or his/her designee, shall cause to be provided via electronic means to the most recent email address found in the Hospital’s records, or mailed to the Member, at the most recent business address found in the Hospital's records, or shall hand deliver to the Member, an application for reappointment form.

2. The Member shall cause the completed application for reappointment to be signed and filed with the Chief Executive Officer, or his/her designee.

3. The completed application for reappointment, and such other information as may be requested by the Medical Staff or the Board of Directors, shall be forwarded to the Credentials Committee for review. The Credentials Committee shall take action thereon and shall make recommendations to the Medical Executive Committee concerning renewal of the applicant's Medical Staff membership and renewal, extension, or curtailment of his or her clinical privileges. In special circumstances where there are no individuals on the Credentials Committee with the appropriate qualifications to review the Member's completed application for reappointment, the Chief of Staff may appoint one (1) or more Members, if possible, or Practitioners from outside of the Medical Staff, if necessary, to serve on the Credentials Committee, for the specific purpose of helping the Credentials Committee make a recommendation on the Member.

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

5. The committees of the Medical Staff should complete their review of the completed application for reappointment, as outlined above, within one hundred twenty (120) days. Such time period is a guideline and does not create any right to have an application processed within a specified period of time.

C. In the event the recommendation of the Medical Executive Committee is favorable to the Member, the recommendation shall be forwarded to the Board of Directors for action in accordance with the Banner Health Medical Staff Expedited Review Policy.

D. In the event the recommendation of the Medical Executive Committee is adverse to the Member, in that the Medical Executive Committee recommends against continuation of the Member's Medical Staff membership or recommends against the granting of any or all requested clinical privileges, then Special Notice of such recommendation shall be given the Member in writing by the Chief Executive Officer. No such adverse recommendation will be forwarded to the Board of Directors until after the Member has exercised or has waived his/her right to a hearing as provided in these Bylaws and the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors.

E. In taking action on the final recommendation of the Medical Executive Committee as provided in Article 7, Section 3, Paragraphs C or D above, the Board of Directors may:

1. Adopt the recommendations of the Medical Executive Committee and act accordingly;

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

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

4. Grant Medical Staff membership and clinical privileges conditioned upon the performance of certain acts by the Member, including, but not limited to, monitoring, special education or training, or such other provisions as may in the judgment of the Board of Directors, be advisable for proper patient care; or

5. Deny reappointment to the Medical Staff and/or deny some or all of the requested clinical privileges.

F. In the event the final recommendation of the Medical Executive Committee is favorable to the Member, and the Board of Directors votes to deny the Member reappointment to the Medical Staff and/or denies the Member any or all clinical privileges requested by him or her, then written Special Notice of such decision shall be given to the applicant by the Chief Executive Officer. No further adverse action will be taken by the Board of Directors until after the Member has exercised or has waived his/her right to a hearing as provided in these Bylaws and the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors.

SECTION 4
LEAVE OF ABSENCE

A. A Member may be granted a leave of absence by the Medical Executive Committee for good cause, as determined by the Medical Executive Committee subject to the approval of the Board of Directors. The leave of absence shall be for a definitely stated period of time and during the period of the leave of absence, the clinical privileges, prerogatives, and responsibilities of the Member who has been granted such leave of absence shall be suspended.

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

1. Written request therefore;

2. The submission of a statement of the Member's professional activities during the leave of absence;

3. The submission of evidence of current licensure, Drug Enforcement Agency registration, liability insurance coverage and such other information as may be

requested by the Credentials Committee, the Medical Executive Committee and/or the Board of Directors at such time; and

4. A recommendation of approval from the Credentials Committee and the Medical Executive Committee to the Board of Directors. In acting upon a request for reinstatement, the Credentials Committee or the Medical Executive Committee may recommend reinstatement either in the same or in a different staff category, and may recommend limitation or modification of the Member's clinical privileges. Furthermore, said Medical Staff committees may evaluate the Member's statement of professional experience during the leave of absence, and shall have the discretion to determine whether the Member continues to meet the qualifications for membership required by these Bylaws and whether he or she continues to demonstrate the proficiency required for the clinical privileges he or she has requested.

C. If such leave of absence extends beyond the Member's current appointment term, then, upon return, the Member must make formal application for reappointment to the Medical Staff and shall, upon applying for reappointment, supply the Hospital with all pertinent information concerning his or her activities during said leave of absence, including certification of honorable military service, letters of reference from his or her commanding officer(s) and/or director(s) of specialized training, and/or such other information as the Credentials Committee, the Medical Executive Committee or the Board of Directors may reasonably request.

D. If the reason for such leave of absence is health-related, a health status verification must be completed by the Member's personal physician prior to such Member's return. The provisions of the Physician Health Policy also will apply to the Member's return.

SECTION 5
REQUESTS FOR MODIFICATIONS OF APPOINTMENT

A. Practitioners engaged by the Hospital, either full-time or part-time, in administratively responsible capacities, but whose activities include clinical responsibilities, must have achieved and maintained Medical Staff membership through the same procedures applicable to all other Members. Continued Medical Staff membership may be made contingent on continued engagement by the Hospital, but, if so, such contingency must be stated in the Practitioner's contract with the Hospital at the time of contract/employment; provided, however, as follows:

1. That termination of the contract may cause elimination of Medical Staff membership or clinical privileges as specifically provided in the contract; and

2. That the contract of engagement may include a provision by which the Practitioner, including the Practitioner's associates and/or professional corporation, agrees that the Medical Staff appointment and clinical privileges of the contracted Practitioner or group shall be resigned (i.e., voluntarily terminated) as a matter of contract, rather

than under the procedures provided in these Bylaws and the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors.

B. As used herein, the term "clinical responsibilities" shall be construed to include direct medical care of patients by a Practitioner and/or supervision of the professional activities of other providers under such Practitioner's direction.

ARTICLE 8: CLINICAL PRIVILEGES

A. Except as provided in Article 8, Sections 3 and 4 below, every Member shall be entitled to exercise only those clinical privileges specifically granted to him or her by the Board of Directors.

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

SECTION 1
DENTISTS AND PODIATRISTS

Privileges granted to dentists and podiatrists shall be based on their training, experience and demonstrated current competence and judgment. The scope and extent of surgical procedures, if any, that each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chief of Staff, or his/her designee. All dental or podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician Member with appropriate clinical privileges shall be responsible for the care of any medical problem that may be present at the time of admission, or that may arise during the procedure or hospitalization.

SECTION 2
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.

SECTION 3
TEMPORARY PRIVILEGES

A. **Medical Staff Applicant - Temporary Privileges:** Upon receipt of a completed application for Medical Staff membership from an appropriately licensed Practitioner, upon

(1) verification of education and training, Colorado licensure, and malpractice liability coverage and claims information, (2) querying the National Practitioner Data Bank, (3) receipt of references attesting to current clinical competency, and (4) a recommendation for approval by the Credentials Committee and the Medical Executive Committee, the Chief of Staff and the Chief Executive Officer may grant temporary admitting and clinical privileges to the applicant for up to ninety (90) days.

B. **Care of a Specific Patient - Temporary Privileges:** Temporary clinical privileges may also be granted by the Chief Executive Officer to Practitioners who do not intend to become Members for the care of a specific patient under the following terms and conditions: The applicant for temporary clinical privileges shall advise the Chief of Staff of his or her qualifications and the extent to which he or she complies with the standards required by these Bylaws, and he or she shall furnish proof of education and training, licensure and proof of adequate professional liability insurance coverage. Under such circumstances, upon (1) verification of education and training, Colorado licensure, and malpractice liability insurance, (2) querying the National Practitioner Data Bank, (3) receipt of references attesting to current clinical competency, and (4) the written recommendation of the Chief of Staff, the Chief Executive Officer may grant temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than two (2) patients in any consecutive twelve (12) month period.

C. **Locum Tenens - Temporary Privileges:** A Practitioner may be granted temporary clinical privileges to serve as a locum tenens Practitioner under the following conditions:

1. Locum tenens Practitioners are Practitioners who provide periodic locum tenens coverage for a service. Locum tenens Practitioners shall have delineated clinical privileges issued as temporary privileges. Locum tenens Practitioners are not appointed to the Medical Staff and shall not be eligible to serve on Medical Staff committees, to vote or to hold office.

2. A member of the Active Staff desiring to utilize a locum tenens Practitioner shall advise the Chief Executive Officer of the name and address of the proposed locum tenens Practitioner, and the period of time during which the Member will be absent from the community. It is the responsibility of the Member to insure that the proposed locum tenens Practitioner complies, in all respects, with the provisions of these Bylaws.

3. Locum tenens coverage may be used to care for a specific patient at the Hospital, cover a service where there is a deficiency in the number of Practitioners or lack of coverage, or for other urgent needs.

4. The locum tenens Practitioner shall complete and sign an application for appointment to the Medical Staff and shall request temporary clinical privileges. The applicant shall meet the qualifications set forth in Article 3, Section 2 above. By signing the application, the locum tenens Practitioner agrees to be bound by these

Bylaws, the Rules and Regulations and applicable policies and procedures of the Hospital and the Medical Staff.

5. Upon (a) verification of education and training, Colorado licensure and malpractice liability insurance, (b) querying the National Practitioner Data Bank, and (c) receipt of references attesting to current clinical competency, the Chief Executive Officer may grant temporary privileges to a locum tenens Practitioner to care for patients in the Hospital, with the written recommendation of the Chief of Staff. Said temporary privileges shall not exceed the length of stay of the specific patient(s) or 120 consecutive days, whichever is less. The locum tenens Practitioner may be granted temporary privileges under this condition for no more than two instances in a twelve (12) month period after which the locum tenens Practitioner must apply for membership and/or privileges before providing additional patient care, treatment or services at the Hospital.

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

E. **Disaster Management – Temporary Privileges**: Upon the recommendation of the Chief of Staff or another member of the Medical Executive Committee, the Chief Executive Officer or his/her designee may grant temporary privileges to a Practitioner who is volunteering in the event of a mass disaster, but only after the identity of the Practitioner has been verified. The minimum acceptable sources of identification for the Practitioner providing emergency care include (1) a current picture hospital ID card; (2) a current license to practice medicine in the United States, together with a government issued photo identification; (3) identification indicating that the volunteer Practitioner is a member of a Disaster Medical Assistance Team (DMAT), of the Medical Reserve Corps (MRC), or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); (4) identification indicating that the volunteer Practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a Federal, State, or municipal entity); or (5) verification of the Practitioner's identity by a current Member or Hospital employee. Whenever possible, Practitioners who are volunteering will be assigned to a Member for oversight of the care provided. Such temporary privileges shall last for the duration of the disaster or for ninety (90) days, whichever occurs first. Medical Staff Services will begin the verification process of the credentials of each volunteer Practitioner who receives disaster privileges as soon as the immediate situation is under control, and such verification process shall be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, if possible. If extraordinary circumstances, such as lack of communication means or resources, prevent the primary source verification from being completed within seventy-two (72) hours, Medical Staff Services shall document the reason for the delay, evidence of a demonstrated ability on the part of the volunteer Practitioner to provide adequate care, treatment and services, and 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 Article 7 Section 2 of these Bylaws. Furthermore, notwithstanding any existing delineation of privileges or scope of authority, Members, Hospital employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or the public health during a mass disaster.

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

SECTION 4
EMERGENCY MEDICAL SITUATIONS

In the event of a medical emergency, any Member, to the degree permitted by his or her license and regardless of Medical Staff status, shall be permitted to do everything reasonably possible to save the life of a patient, using every available facility of the Hospital. When such emergency situation no longer exists, such Member must request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or such Member desires not to request such privileges, the patient shall be assigned to an appropriate Member by the Chief of Staff. For the purposes of this Article 7, Section 4, an "emergency" is defined as a condition in which serious permanent harm or death would result to a patient and any delay in administering treatment would add to that danger.

SECTION 5
TELEMEDICINE PRIVILEGES

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

B. Any Practitioner who wishes to be considered for Telemedicine Privileges will provide the following documentation to Medical Staff Services or its designee:

1. Completed and signed application or reappointment form as the Board of Directors may require and clinical privileges form for telemedicine privileges;

2. Signed consent and release/authorization form;

2. Current Colorado license to practice medicine;

3. Curriculum Vitae;

4. Current copy of Drug Enforcement Agency and state controlled substance certificate, if applicable;

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

6. Evidence of no exclusion from any federal health care program;

7. Evidence of medical staff appointment and clinical privileges in good standing at another TJC accredited or equivalent hospital/organization;

8. Such additional information as may be requested by the Hospital.

C. The following verifications will be completed by Medical Staff Services or its designee:

1. Query to the National Practitioner Data Bank;

2. Query to determine that the Practitioner has not been excluded from any federal health care program;

3. Verification of the Practitioner's medical staff status at the Practitioner's primary TJC accredited or equivalent hospital/organization;

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

5. Verification of the Practitioner's current Drug Enforcement Agency status, when applicable; and verification of the Practitioner's current board status (when applicable).

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

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

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

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

F. A Practitioner who has been granted Telemedicine Privileges will immediately report to the Chief Executive the loss or suspension of any license, certificate or authorization described in Article 8, Section 5, Paragraph B above. Such loss or suspension will result in the immediate and automatic relinquishment of any and all Telemedicine Privileges with no right to a hearing or an appeal as outlined in these Bylaws.

If telemedicine services are being provided at the Hospital through a contracted group, it will be the responsibility of the contracted group to notify Medical Staff Services or its designee of any Practitioner who requires Telemedicine Privileges and of any Practitioner who no longer needs to maintain Telemedicine Privileges.

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

ARTICLE 9: OFFICERS OF THE MEDICAL STAFF

SECTION 1
CATEGORIES OF OFFICERS

The officers of the Medical Staff shall be:

A. Chief of Staff
B. Vice Chief of Staff
C. Secretary-Treasurer

SECTION 2
QUALIFICATIONS OF OFFICERS

The Chief of Staff, the Vice Chief of Staff, and the Secretary-Treasurer must be members of the Active Staff at the time of nomination and election, and as a condition of holding office, all officers must remain members of the Active Staff in good standing during their term of office. Failure to maintain such status shall result in immediate and automatic removal from office.

SECTION 3
ELECTION OF OFFICERS

Officers shall be elected at the annual meeting of the Medical Staff by the members of the Active Staff in accordance with Article 12 of these Bylaws.

SECTION 4
TERMS OF OFFICE

The term of office for all officers of the Medical Staff shall be a period of two (2) years, commencing with the first day of the Medical Staff Year following the officer's election, and continuing for two (2) years thereafter, or until a successor is qualified and elected. No officer of the Medical Staff shall be permitted to serve more than three (3) consecutive elected terms in the same office.

SECTION 5
VACANCIES IN OFFICE

A. An office of the Medical Staff shall be deemed "vacant" if the person elected to the office:

1. Resigns from membership on the Medical Staff;

2. Resigns as an officer of the Medical Staff;

3. Assumes a Medical Staff category other than Active Staff during the term of office;

4. Is removed from membership on the Medical Staff;

5. Is removed from office pursuant to Article 9, Section 7;

6. Requests, and is granted, a leave of absence from the Medical Staff;

7. Dies, or becomes disabled to the extent that the duties of the office cannot be fulfilled.

B. Any vacancy in office shall be filled by appointment by the Medical Executive Committee, with the following exceptions:

1. A vacancy in the office of the Chief of Staff, for whatever reason, will automatically be filled by the Vice Chief of Staff, who shall then serve out the remaining term.

2. A vacancy in the office of the Vice Chief of Staff or in the office of the Secretary-Treasurer, created by "removal from office" pursuant to Article 9, Section 7, shall be filled by the holding of a special election conducted by the Medical Executive Committee as provided in Article 12 of these Bylaws.

SECTION 6
DUTIES OF OFFICERS

A. The Chief of Staff shall serve as the highest elected officer of the Medical Staff and shall:

1. Call, preside at, and be responsible for the agenda of all regular, annual and special meetings of the Medical Staff;

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

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

4. Appoint from the Medical Staff all committee Chairs and all members to all standing, special, and multi-disciplinary Medical Staff committees except for the Medical Executive Committee, for those specifically designated committees in which the Chair position is specifically not appointed, and for those specifically designated committees in which member position(s) are specifically not appointed. In addition, the Chief of Staff shall appoint from the Medical Staff those Members that are needed to fill Medical Staff committee positions of Hospital committee(s) as requested by the Chief Executive Officer. All appointments, including the Chairs and members, to all standing committees shall be subject to approval by the Medical Executive Committee;

5. Be responsible for:

    a. the enforcement of these Bylaws;

    b. the enforcement of the Rules and Regulations;

    c. the implementation of sanctions where these are indicated; and

    d. the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested.

6. Represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer and to the Board of Directors;

7. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern to the Medical Staff and the Hospital;

8. Receive and interpret the policies and requests of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care; and be the spokesman for the Medical Staff in its external professional and public relations.

B. The Vice Chief of Staff shall:

1. Assume all of the duties and authority of the Chief of Staff in the Chief of Staff's absence or inability to act;

2. Automatically succeed the Chief of Staff if the office of the Chief of Staff should become vacant for any reason;

3. Serve as a member of the Medical Executive Committee; and

4. Serve as the Chair of the Bylaws Committee.

C. The Secretary-Treasurer shall:

1. Call Medical Staff meetings on order of the Chief of Staff;

2. Keep accurate and complete minutes of all Medical Staff and Medical Executive Committee meetings.

3. Attend to all correspondence of the Medical Staff and the Medical Executive Committee;

4. Be responsible for the maintenance of the records of the Medical Staff's finances and present at the annual Medical Staff meeting the condition of said finances;

5. Serve as a member of the Medical Executive Committee; and

6. Perform such other duties as ordinarily pertain to this office.

SECTION 7
REMOVAL OF MEDICAL STAFF OFFICERS

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

A. **Grounds for Removal:** Grounds for removal shall include, but shall not be limited to, mental or physical impairment; inability or unwillingness to perform the duties and responsibilities of the office; failure to continuously satisfy the qualifications for the office; imposition of an automatic or summary suspension; imposition of corrective action; conduct or statements damaging to the best interest of the Medical Staff or the Hospital, or to the goals, programs or public image of the Medical Staff or the Hospital; gross neglect; misfeasance in office; and serious acts of moral turpitude.

B. **Special Meeting:** A special meeting of the Active Staff shall be called as provided in Article 11, Section 3, for the purpose of considering and acting upon a written request for

the removal of one or more officers of the Medical Staff. In order to be effective, the notice of said special meeting must state that the purpose of said special meeting is to consider and act upon a request for the removal of one or more designated officer(s) of the Medical Staff.

C. **Quorum:** Fifty percent (50%) of the members of the Active Staff shall constitute a quorum for the purpose of conducting a special meeting held pursuant to the provisions of this Article 9, Section 7.

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

E. **Effective Date:** Removal of a Medical Staff officer shall be effective immediately.

F. **Vacancy:** Upon the creation of a Medical Staff office vacancy, caused by the removal of an officer, the provisions of Article 9, Section 5 shall apply to the filling of said vacancy.

ARTICLE 10: COMMITTEES OF THE MEDICAL STAFF

The following committees, unless otherwise designated by these Bylaws, shall be the standing committees of the Medical Staff. The members of these committees, with the exceptions of the Medical Executive Committee, and the Vice-Chief of Staff's position on the Bylaws Committee, shall be appointed by the Chief of Staff, subject to approval by the Medical Executive Committee. The Chief of Staff, or his or her designee, shall be an ex-officio member of all Medical Staff committees, unless otherwise specifically designated as a committee member. In addition, the Chief Executive Officer, or his or her designee, shall be an ex-officio member without voting privileges of all Medical Staff committees, unless otherwise specifically designated as a committee member.

1. Medical Executive Committee
2. Credentials Committee
3. Nominating Committee
4. Bylaws Committee
5. Quality Improvement Council
6. Peer Review Committee
7. Pharmacy and Therapeutics Committee

In addition, special committees may be appointed for a specific purpose(s) by the Chief of Staff, and said appointments will cease upon the accomplishment (or lack of accomplishment) of said special committee's purpose(s). All Medical Staff committees shall report to the Medical Executive Committee, and this reporting shall normally be accomplished by the submission of committee meeting minutes to the Medical Executive Committee.

The Chief of Staff shall also appoint Members to those Hospital (i.e., not Medical Staff) committees that require Medical Staff representation after written notification of such need is received by the Chief of Staff from the Chief Executive Officer.

These appointments are also subject to approval by the Medical Executive Committee, the same as for Medical Staff committee appointments.

The Hospital shall provide such secretarial and statistical assistance as may be required by the committees, as well as provide adequate meeting facilities, including meals at those committee meetings occurring during normal meal periods.

SECTION 1
MEDICAL EXECUTIVE COMMITTEE

There shall be a Medical Executive Committee (MEC) and such other standing and special committees of the staff responsible to the MEC as may from time to time be necessary and desirable to perform the staff functions listed in Paragraph B. below and elsewhere in these Bylaws. The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. The Medical Executive Committee includes physicians and may include other practitioners and any other individuals as determined by the Medical Staff. Composition and duties of the Medical Executive Committee are listed below.

A. **Composition**: The Medical Executive Committee shall be composed of the Chief of Staff (committee Chair), the Vice-Chief of Staff, the Secretary/Treasurer, the Chair of the Credentials Committee and the immediate past Chief of Staff. In the event the current Chief of Staff is serving a second consecutive term, then the immediate past Chief of Staff is the last Chief of Staff who is not the same person as the current Chief of Staff.

B. **Duties**:

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

2. To coordinate the activities and general policies of the various organizational divisions of the Medical Staff;

3. To review and act upon all committee appointments requiring approval that are made by the Chief of Staff;

4. To receive and act upon all Medical Staff committee reports;

5. To review the recommendations and appropriate supporting documents of the Credentials Committee regarding the credentials of all applicants for appointment and reappointment, and as a result of such review, to make recommendations to the Board of Directors for:

a. Medical Staff membership and delineation of clinical privileges, and

b. Reappointments and renewal of clinical privileges and/or changes in clinical privileges;

6. To request evaluations of Practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;

7. To take all reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of all Members, including the initiation of and/or participation in Medical Staff corrective action or review measures when warranted; and participate as required by these Bylaws and the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, in peer review proceedings;

8. To make, implement and enforce policies of the Medical Staff;

9. To serve as a liaison between the Medical Staff, the Chief Executive Officer and the Board of Directors;

10. To recommend action to the Chief Executive Officer on matters of a medical-administrative nature, and to advise the Chief Executive Officer concerning implementation of new departments, services, and other medical-administrative matters;

11. To make recommendations on Hospital management matters (for example, long range planning, equipment needs, etc.) to the Board of Directors through the Chief Executive Officer;

12. To make recommendations regarding off-site and/or contracted sources for needed patient care services to the Chief Executive Officer;

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

14. To report on the above functions, and any other information pertinent to the Medical Staff, at each Medical Staff meeting;

15. To participate in the review of cases that are referred to the Medical Executive Committee;

16. To identify disease processes or treatments that could be improved and to develop protocols, standing orders and/or pathways for those disease processes or treatments;

17. To implement changes in the care delivered and in the practice of medicine, based on the findings of peer review and quality monitoring, and to evaluate the effectiveness of those changes;

18. To Communicate to the Medical Staff proposed changes to the Professional Review/Corrective Action Plan, Rules and Regulations of the Medical, Dental and Podiatric Staff and the Rules and Regulations for Allied Health Personnel. In cases of a documented need for urgent amendment, the Executive Committee and Board of Directors may provisionally adopt the urgent amendment without prior notification of the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If there is no comment within 15 days, the amendment stands. If there is a conflict and *40% o*f the Active Staff oppose the amendment, the Medical Executive Committee will utilize the conflict resolution process set forth in Article 3, Section 5. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board of Directors for action.

19. To review the findings from the monitoring of medical records at a minimum, to both the adequacy and appropriateness of the medical records as a group, as well as the adequacy and appropriateness of the medical records of individuals with clinical privileges;

20. To review, not less than annually, the adequacy and appropriateness of the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems, as appropriate, for medical record purposes;

21. To prepare no less frequently than annually a list of abbreviations and symbols that are permitted to be used in the medical record;

22. To coordinate the education programs of the Medical Staff for those individuals with clinical privileges; and

23. To be responsible for the Medical Staff library, including the selection of texts and/or periodicals that make up the Medical Staff library.

C. **Meetings:** Meetings of the Medical Executive Committee shall be held monthly at a date and place determined by the Chief of Staff upon notice to all committee members.

D. **Removal of Members of the Medical Executive Committee**. Any member of the Medical Executive Committee may be removed by following the same procedure for removal of Medical Staff Officers set forth in Article 9, Section 7 above.

SECTION 2
CREDENTIALS COMMITTEE

A. **Composition:** The Credentials Committee shall consist of the Chair of the Credentials Committee and three (3) members of the Active Staff. Each of the members of the Credentials Committee shall have been a member of the Active Staff for a minimum of one (1) year. The Chief Nursing Officer/Associate Administrator Patient Care Services shall be an ex-officio member assisting with the Allied Health Professionals.

B. **Duties:** The duties of the Credentials Committee shall be as specified in these Bylaws, and shall include review and evaluation of all applicants for Medical Staff membership and clinical privileges, and shall also include review and evaluation of all applicants for reappointment to the Medical Staff and clinical privileges.

The Credentials Committee shall perform those functions set forth in Article 7 of these Bylaws and shall be responsible for formulating policies and procedures for recommendation to the Medical Executive Committee, which shall be subject to final approval by the Board of Directors, concerning the use of Allied Health Professionals on a categorical basis. Current competence of such individuals shall be sufficient to permit their functioning in the following areas:

1. Participating directly in the management of patients under the supervision or direction of a Member; and

2. Within the limits established by the Medical Staff and the Board of Directors, and consistent with the applicable State Practice Acts, the writing of orders and the recording of reports and progress notes in patient medical records.

3. In serving as the "oversight committee" for the monitoring and regulation of the activities of Allied Health Professionals, the Credentials Committee shall have authority to exercise those functions and responsibilities which are more particularly set forth in Article 5 of these Bylaws.

C. **Meetings:** Meetings of the Credentials/ Committee shall be held as often as needed, at a date and place determined by the Chair upon notice to all committee members.

SECTION 3
NOMINATING COMMITTEE

A. **Composition:** The Nominating Committee shall consist of the past three (3) Chiefs of Staff (if available).

B. **Duties:** The Nominating Committee shall submit prior to the time of the quarterly meeting of the Medical Staff in September, a written slate of nominations for those officers of the Medical Staff whose elective terms will expire at the end of the then-current Medical Staff

Year, if there are terms expiring, and after nominations of qualified candidates have been closed, elections shall proceed as hereinafter provided in Article 12 of these Bylaws.

C. **Meetings:** Meetings of the Nominating Committee shall be held not less than once each year, prior to the September meeting of the Medical Staff, at a date and place determined by the Chair upon notice to all committee members.

SECTION 4
BYLAWS COMMITTEE

A. **Composition:** The Bylaws Committee shall consist of a Chair and two (2) members of the Active Staff. Each member of the Bylaws Committee shall serve for a minimum of one (1) year. The Vice Chief of Staff shall serve as Chair of the Bylaws Committee.

B. **Duties:** The Bylaws Committee shall review these Bylaws and the Rules and Regulations of the Medical Staff for consideration of revisions and amendments, and shall consider and act upon any written proposals for revisions and/or amendments that may originate from the Medical Executive Committee or any Member.

C. **Meetings:** Meetings shall be held as needed, but not less than once each year to review these Bylaws and the Rules and Regulations of the Medical Staff, at a date and place determined by the Chair or a majority of the committee members upon notice to all committee members.

SECTION 5
QUALITY IMPROVEMENT COUNCIL

A. **Composition**: The Quality Improvement Council shall consist of a Chair, who is a member of the Active Medical Staff, at least three (3) additional Active staff members, and others involved with the quality improvement program at the Hospital, including, but not limited to, the following: the Chief Executive Officer, the Facility Medical Director, Chief Nursing Officer/Associate Administrator Patient Care Services, and the Directors of Quality/Risk Management and Health Information Services, The Chair shall be elected by physician members of the Quality Improvement Council, and in the event of a tie vote, shall be determined by the Chief of Staff.

B. **Duties:**

1. The Quality Improvement Council shall be the committee of the Medical Staff that is responsible for formulating, adopting and participating in an overall Hospital quality improvement program. Said program shall be forwarded for approval by the Medical Executive Committee and to the Board of Directors, as necessary. Said program shall be designated to include the following:

a. Identification of important or potential problems, or related concerns, in the care of the patient, maintaining a safe patient environment and in reducing liability.

b. Objective assessment of the cause and scope of problems or concerns, including the determination of priorities of both investigating and resolving problems. Ordinarily, priorities shall be related to the degree of impact on patient care that can be reasonably expected if the problems remain unsolved.

c. Implementation through appropriate officers of the Medical Staff and/or the Hospital of the decisions or actions that are designed to eliminate, insofar as is reasonably possible, identified problems.

d. Monitoring of activities designed to assure that the desired result has been achieved and sustained.

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

f. To review all medical records (or a representative sample) to insure that:

1. The medical record reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in Hospital progress of the patient, and the condition of the patient at discharge,

2. The medical record contains sufficient information to identify the patient, support the diagnosis, and justify the treatment, and documents the results accurately,

3. If the medical record contains abbreviations or symbols, only those abbreviations or symbols that have been approved by the Medical Staff are used, and

4. The medical record fulfills the specific medical record requirements as specified in the Rules and Regulations, including the timely completion of the medical records;

g. Being the Committee to propose a Quality Improvement Plan for adoption by the Medical Executive Committee and the Board which is intended to achieve the foregoing goals.

h. Recommend Medical Staff and HIMS policies to improve documentation of patient care.

i. Make utilization reports and recommendations to the Medical Executive Committee and Hospital Administration, for the optimum utilization of

hospital resources and facilities, commensurate with quality patient care and safety.

2. It shall be the responsibility of the Quality Improvement Council to propose policies and procedures for adoption by the Medical Executive Committee and the Board of Directors, as necessary, that are intended to achieve the foregoing goals.

3. It is the intent of these Bylaws that all information given to the Quality Improvement Council, the local advisory board, the Board of Directors and others as necessary, as well as the record of actions and proceedings of the Quality Improvement Council shall be confidential and shall be protected from disclosure.

C. **Meetings:** Meetings of the Quality Improvement Council shall be held no less than quarterly at a date and place determined by the Chair upon notice to all committee members.

D. **Reports:** Comprehensive quarterly reports will be provided to the Medical Executive Committee and the Chief Executive Officer.

SECTION 6
PEER REVIEW COMMITTEE

A. **Composition:** The Peer Review Committee membership shall consist of a member of the Medical Executive Committee, who shall be the Chair of the Peer Review Committee, and three (3) members of the Active Staff and/or members of the Associate staff as deemed necessary by the Chief of Staff and with approval by the Medical Executive Committee.

B. **Duties:** The duties of the Peer Review Committee shall include the following:

1. Retrospective and concurrent chart review. This review shall include the clinical performance of all individuals with clinical privileges.

2. Monitoring and evaluation of the appropriateness and quality of the care and treatment provided to patients, including patient experience survey results, patient grievances and behavioral concerns.

3. Identification of utilization issues.

4. Identification of interdepartmental trends.

5. Review the findings from monitoring of medical records specifically related to adequacy and appropriateness of the medical records of individuals with clinical privileges.

6. Review of surgical procedures and an appropriate sampling of invasive, diagnostic and therapeutic procedures performed at the Hospital in order to determine the

acceptability and appropriateness of the procedure, and, as to surgical procedures, the consistency among the pre-operative, post-operative and pathological diagnosis. All cases in which a major discrepancy may exist between preoperative and postoperative (including pathologic) diagnoses shall be evaluated. The Peer Review Committee may consult with individual Members and request written justification for the treatment and/or invasive diagnostic procedure performed.

6. Review of blood usage, including, without limitation, the following:

   a. Evaluation of the appropriateness of all cases in which patients were administered transfusions (including whole blood and blood components);

   b. Evaluation of all confirmed transfusion reactions;

   c. Review of the adequacy of transfusion services to meet the needs of patients; and

   d. Review of the ordering practices for blood and blood products.

   When the review of cases referenced in item (a) above consistently supports the justification and appropriateness of blood use, then the review of an adequate sample of cases is acceptable. All confirmed transfusion reactions shall be evaluated. In addition, screening mechanisms may be used to identify problems in blood usage, but, if used, such mechanisms (i.e., the criteria, etc.) must be documented in writing and must be clinically valid.

The above review functions shall be performed on an ongoing basis and shall be reported to the Medical Executive Committee no less frequently than once each quarter.

C. **Meetings:** Meetings of the Peer Review Committee shall be held at least quarterly, at a date and place determined by the Chair upon notice to all committee members.

D. **Reporting:** The findings, conclusions and recommendations from the monitoring and evaluation of care shall be documented in writing and reported to the Medical Executive Committee and the Quality Improvement Council as indicated in the Peer Review Committee structure flow chart. The Peer Review Committee does not set policy, but rather makes recommendations to the Medical Executive Committee.

SECTION 7
PHARMACY AND THERAPEUTICS COMMITTEE

A. **Composition:** The Pharmacy and Therapeutics Committee shall consist of a Chair, appointed from the Active Staff, two (2) members appointed from the Medical Staff, and the Hospital pharmacy director. The Chief Nursing Officer/Associate Administrator Patient Care Services shall serve as an ex-officio member of the Pharmacy and Therapeutics Committee without voting privileges.

B. **Duties:** The Pharmacy and Therapeutics Committee shall be responsible for (i) the development of policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and in-vivo diagnostic testing materials, (ii) the development and maintenance of a drug formulary, (iii) the evaluation of protocols concerned with the use of investigational drugs when a specific written request for use of such drug(s) has been received from an individual with clinical privileges, and (iv) the definition and review of all significant untoward drug reactions. In addition, the Pharmacy and Therapeutics Committee shall function as the "central forum" wherein the Medical Staff, the laboratory and the pharmacy can coordinate the selection of antibiotics used in standard susceptibility testing in the laboratory.

The Pharmacy and Therapeutics Committee shall also perform the following specific functions:

1. Pharmacy Functions:

    a. Serve as an advisory group to the Medical Staff and the Hospital pharmacist on matters pertaining to the choice of available drugs;

    b. Make recommendations concerning drugs to be stocked on the nursing units and other services;

    c. Develop and periodically review a drug formulary for use in the Hospital;

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

    e. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and

    f. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

2. Medical Staff Functions:

    a. Evaluate drug usage, based upon criteria established by the Pharmacy and Therapeutics Committee, as an ongoing, planned and systematic process. This evaluation shall include drugs used for therapeutic and prophylactic purposes as well as drugs used empirically. The primary purpose of this review is to assure that the drugs are used appropriately, safely and effectively.

    b. Establish a process to monitor and evaluate selected drugs that are chosen specifically for review. When choosing said drug(s) for review, the following shall be used as criteria in the selection process:

i. Known or suspected drugs(s) that cause adverse reactions or drug interference with other drug(s) in a manner that presents a significant health risk;

ii. The drug is generally used in patients who may be a high risk for adverse reactions because of age, disability, etc.;

iii. The drug has been designated through the Hospital's infection control program or other quality improvement activities, for monitoring and evaluation, and/or;

iv. The drug(s) is one of the most frequently prescribed drugs.

c. The process for monitoring and evaluating the above shall reflect objective criteria, current knowledge and clinical experience, and may include screening mechanisms to identify drug(s) for more intensive evaluation;

C. **Meetings:** Meetings of the Pharmacy and Therapeutics Committee shall be held no less than quarterly, at a date and place determined by the Chair upon notice to all committee members.

D. **Reporting:** The Pharmacy and Therapeutics Committee shall make written reports of the above review and evaluations, and while fulfilling the above responsibilities, the Pharmacy and Therapeutics Committee does not set policy, but rather makes recommendations to the Medical Executive Committee which are then acted upon by the Medical Executive Committee.

ARTICLE 11: MEETINGS

SECTION 1
ANNUAL MEETING

A. The annual meeting of the Medical Staff shall be held in December, at which time the retiring officers shall make such reports as may be indicated.

B. The results of the election of officers and members to fill vacancies on the Medical Executive Committee will be announced as provided in Article 12 of these Bylaws.

SECTION 2
GENERAL MEDICAL STAFF MEETINGS

General Medical Staff meetings shall be held quarterly in March, June, September and December, unless otherwise specified and announced by the Medical Executive Committee.

SECTION 3

SPECIAL MEETINGS

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

SECTION 4
QUORUM

Fifty percent (50%) of the assigned or elected physician members with voting rights shall constitute a quorum for the purpose of transacting such business of the Medical Staff as is permitted by these Bylaws. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even if less than a quorum exists at a later time in the meeting.

If a member of the committee has an absence excused by the Chair of the committee, such member will not be counted in the quorum requirement.

SECTION 5
ATTENDANCE

Participation by Members is important for the effective operation of the Medical Staff. Members of the Active Staff are expected to attend Medical Staff committee meetings and General Medical Staff meetings.

SECTION 6
ACTION WITHOUT MEETING

Action may be taken without a meeting by the Medical Staff or any Medical Staff committee, upon the request of the Chief of Staff, the Chair of such Medical Staff committee or by a majority of the current members of such Medical Staff committee, by presentation of the question to each member eligible to vote, in person or by mail, or by electronic means, and by recording their votes. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that could constitute a quorum.

ARTICLE 12: ELECTIONS

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

B. The Nominating Committee, as provided for in Article 10, Section 3 of these Bylaws, shall submit a slate of nominees no later than the September General Medical Staff meeting, at which time, additional nominations may be made. The name of at least one (1) qualified nominee shall be submitted by the Nominating Committee for each elected office of the Medical Staff.

C. Election of officers so nominated shall be by simple majority vote by those Members who are eligible to vote. The mechanism of voting shall be by written ballot, with these ballots distributed, collected and tabulated by the Medical Executive Committee. Ballots will be distributed by October 15 and will be due to be returned by November 1.

D. The written ballots will be counted at the November Medical Executive Committee meeting, with installation of officers at the December General Medical Staff meeting.

E. If more than two (2) nominees for any one (1) office of the Medical Staff appear on the slate of nominees, and no nominee receives a simple majority of the votes cast for such office, then all of the nominees except for the two (2) receiving the highest vote totals shall be dropped, and a second vote shall be taken. In the event that such second vote is required, the voting mechanisms specified in Article 12, Paragraph C above shall continue to apply, except that the time frames shall be adjusted accordingly.

F. Except as otherwise provided in these Bylaws for the filling of vacancies, the term of offices of the Medical Staff shall begin on the first day of the Medical Staff Year.

ARTICLE 13: DUES AND ASSESSMENTS

Annual dues are not regularly assessed for the Medical Staff. If the need should arise for a special assessment, as determined by the Medical Executive Committee, such special assessment shall not be levied unless approved by a simple majority vote of the members of the Active Staff at any regular, annual or special Medical Staff meeting. In the event that such vote passes, the Medical Executive Committee will determine the percentages (0-100%) of the special assessment that are applicable to Associate Staff, Community Based Staff and Allied Health Professionals. Honorary Staff members shall not be required to pay any special assessment(s).

Failure to pay in full said special assessment(s) within two (2) months of notification (billing) shall be cause for automatic suspension of Medical Staff membership and clinical privileges. If said special assessment(s) is not paid in full by the end of the second (2nd) month following notification of delinquency of said payment, the delinquent Member will not be eligible for reappointment to the Medical Staff, unless such non-payment is specifically excused in writing by the Medical Executive Committee or the Board of Directors.

Utilization of the special assessment(s) shall be determined by the Medical Executive Committee, taking into consideration the expressed wishes of the Medical Staff. The Secretary-Treasurer shall use standard accounting practices in recording receipts and disbursements from the Medical Staff account. Additionally, the Secretary-Treasurer shall prepare and distribute at the annual Medical Staff meeting an itemized report of the receipts, disbursements and balance of the Medical Staff account.

ARTICLE 14: RULES AND REGULATIONS, FAIR HEARING PLAN, PROFESSIONAL REVIEW/CORRECTIVE ACTION PLAN, AND MEDICAL STAFF POLICIES

SECTION 1
GENERAL CONSIDERATIONS

The Medical Staff shall adopt the Rules and Regulations, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, the Professional Review/Corrective Action Plan, and such policies as may be necessary for the proper conduct of the Medical Staff's work. The Rules and Regulations, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, and the Professional Review/Corrective Action Plan and policies have the same force and effect as these Bylaws.

SECTION 2
REVISIONS

A. The Rules and Regulations, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, and the Professional Review/Corrective Action Plan, may be revised by:

1. The Medical Executive Committee upon the recommendation of any committee of the Medical Staff, subject to approval by the Medical Staff as evidenced by a majority vote of those Active Staff members present at any general, annual or special meeting of the Medical Staff, and approval of the Board of Directors.

2. By a majority vote of those Active Staff members present at any general, annual or special meeting of the Medical Staff, which includes changes, additions, or deletions to the Rules and Regulations, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, and the Professional Review/Corrective Action Plan, and with approval by the Medical Executive Committee and the Board of Directors.

3. In lieu of a Medical Staff meeting, changes to the Rules and Regulations, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, and the Professional Review/Corrective Action Plan may be approved by the Medical Staff by a signed ballot with approval indicated by at least a majority of the Active Staff. Proposed changes are to be specifically identified as deletions from, or additions or modifications to, the current version of the Rules and Regulations, the Fair Hearing Plan, as supplemented and modified by the Appellate Review Policies adopted by the Board of Directors, or the Professional Review/Corrective Action Plan, as the case may be. An explanation, if indicated, should also be distributed with the proposed changes. Any such changes approved by signed ballot shall become effective only after approval by the Board of Directors.

B. Medical Staff policies may be revised by:

1. The Medical Executive Committee upon the recommendation of any committee of the Medical Staff, subject to approval by the Medical Staff as evidenced by a majority vote of those Active Staff members present at any general, annual or special meeting of the Medical Staff.

2. By a majority vote of those Active Staff members present at any general, annual or special meeting of the Medical Staff, which includes changes, additions, or deletions to Medical Staff policies, and with approval by the Medical Executive Committee.

3. In lieu of a Medical Staff meeting, changes to any Medical Staff policies may be approved by the Medical Staff by a signed ballot with approval indicated by at least a majority of the Active Staff. Proposed changes are to be specifically identified as deletions from, or additions or modifications to, the current version of such Medical Staff policies. An explanation, if indicated, should also be distributed with the proposed changes.

ARTICLE 15: ADOPTION AND AMENDMENT OF BYLAWS

SECTION 1
MEDICAL STAFF RESPONSIBILITY

A. The Medical Staff shall have the responsibility to formulate, adopt and recommend to the Board of Directors, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the adoption and amendment of the related manuals and protocols developed to implement various sections of these Bylaws.

SECTION 2
DIRECT COMMUNICATION TO THE BOARD OF DIRECTORS

A. Direct Communication to the Board of Directors.
Medical Staff members may communicate with the Board of Directors regarding any Medical Staff rule, regulation or policy adopted by the Medical Staff or the Medical Executive Committee by submitting comments or concerns with the Medical Staff's Report to the Board of Directors.

B. Conflicting Recommendations**.**
The Medical Staff shall have the ability to adopt Bylaws, rules and regulations and propose the same directly to the Board of Directors. Where the Medical Staff votes to recommend directly to the Board of Directors an amendment to the Bylaws, Corrective Action/Fair Hearing Plan, Credentials Policy and Procedures Manual or Rules and

Regulations that is different from what has been recommended by the Medical Executive Committee:

1. Medical Executive Committee Review
   The Medical Executive Committee will review the amendment at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Medical Executive Committee. The Medical Executive Committee may create a subcommittee to consider the proposed amendment and make recommendations to the Medical Executive Committee.

2. Medical Staff Reconsideration
   Where the Medical Executive Committee proposes language that is acceptable, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Board of Directors.

3. Board of Directors Action
   The Board of Directors will review all recommendations for amendments to the Bylaws, Corrective Action/Fair Hearing Plan, Credentials Policy and Procedures Manual or Rules and Regulations, and will take final action. The Board has final authority to resolve differences between the Medical Staff and the Medical Executive Committee.

SECTION 3
METHOD OF ADOPTION AND AMENDMENT

Except as set forth in Section 2 above, Medical Staff Bylaws may be adopted, amended or repealed by the following actions:

A. General Procedure: The Medical Staff shall cause the Bylaws to be reviewed at least annually to determine whether any amendments should be considered for adoption. Unless any amendments are being proposed directly to the Board under Section A. of these Bylaws, any proposed amendment shall first be submitted to and/or considered by the Bylaws Committee as set forth under the procedures below. The Bylaws of the Medical Staff and amendments thereto must be approved by the Board prior to becoming effective.

B. Submission of Amendments: A proposed amendment of these Bylaws may be submitted to the Bylaws Committee by a Member or the Chief Executive Officer. The Bylaws Committee shall review the proposed amendment in accordance with the provisions of these Bylaws. The Chair of the Bylaws Committee shall then present the proposed amendment to the Medical Executive Committee. The Medical Executive Committee shall review the proposed amendment at its next regular meeting or at a special meeting called for that purpose. The Medical Executive Committee shall make recommendations for approval or denial of the proposed amendment and present its recommendations at the next annual meeting of the Medical Staff or at a special meeting called for that purpose.

C. Notice to Medical Staff. A written copy of the proposed amendments to these Bylaws shall be distributed to the Medical Staff at least seven (7) days before the meeting at which such proposed amendments shall be discussed.

D. Adoption of Amendments: To be adopted, an amendment shall require a two-thirds (2/3rds) vote for approval by the Active Staff present. All amendments presented to a meeting of the Medical Staff shall be recorded in the minutes of the Medical Staff meeting and forwarded to the Board of Directors for consideration at its next meeting or at a special meeting called for that purpose. Amendments approved by the Medical Staff by the required two-thirds (2/3rds) majority do not become effective until they are approved by the Board of Directors.

E. Adoption by Ballot: In lieu of a Medical Staff meeting, changes to these Bylaws may be approved by the Medical Staff by a signed ballot with approval indicated by at least two-thirds (2/3rds) of the Active Staff. An affirmative vote may be cast either by marking the ballot "yes" and returning it to the Medical Staff Services Department or by discarding the ballot. A negative vote may be cast by marking the ballot "no" and returning it to the Medical Staff Services Department. Proposed changes are to be specifically identified as deletions from, or additions or modifications to, the current version of these Bylaws. An explanation, if indicated, should also be distributed with the proposed changes.

F. Minor Changes to Bylaws: The Medical Executive Committee may make minor corrections and Bylaw changes when such correction or change is necessary due to spelling, punctuation, grammar, context or if required by the law. No prior notice of such change is required. All changes thus made will be reported at the next regular Medical Staff meeting. Any such amendment approved by the Medical Executive Committee shall become effective only after approval by the Board of Directors.

These Bylaws were adopted and recommended to the Board of Directors by the Active Staff on

_____.

_____
Chief of Staff

Date:_____

Approved by the Board of Directors of Banner Health on: November 10, 2016.