HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

MEDICAL STAFF BYLAWS
January 28, 2020

Heart of the Rockies Regional Medical Center
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DEFINITIONS

For the purposes of these Bylaws Rules and Regulations, the following words and phrases are defined as:

ADMIT - means to order the admission of a person to the Medical Center for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a Medical Center bed overnight. For purposes of these Bylaws, Admission does not include an Observation Stay.

ADVANCED PRACTICE PROFESSIONALS (APPs) - means Advanced Nurse Practitioners (ANPs): Certified Registered Nurse Anesthetists, Nurse Practitioners, and Physician Assistants, granted clinical privileges at the Medical Center.

BOARD - means the Board of Directors of Heart of the Rockies Regional Medical Center.

CHIEF EXECUTIVE OFFICER - means the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.

CHIEF OF SERVICE – means the individual Active Staff or Active Outpatient Staff member appointed by the Chief of Staff and approved by the Medical Executive Committee to serve as the head of a Service.

CHIEF OF STAFF - means the Physician duly elected by the Medical Staff to serve as Chief of Staff of the Medical Staff.

DENTIST - means a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

MEDICAL CENTER - means Heart of the Rockies Regional Medical Center and shall include its facility based clinics and the Salida Hospital District's Hospital-Based End-Stage Renal Disease ("ESRD") Facility known as "Heart of the Rockies Regional Dialysis Center" (HRRDC).

MEDICAL EXECUTIVE COMMITTEE - means the Executive Committee of the Medical Staff.

MEDICAL STAFF - means the formal organization that includes all Physicians and Dentists who may be granted clinical privileges at the Medical Center.

OBSERVATION STAY - means a stay in the Medical Center for no more than forty-eight (48) hours for the purpose of (a) evaluating a patient for possible admission; (b) treating patients expected to be stabilized and released in no more than twenty-four (24) hours; or (c) extended recovery following a complication of an outpatient procedure. Only rarely will an Observation Stay exceed twenty-four (24) hours in length.

PATIENT CARE ENCOUNTER - shall mean acting in the capacity of the primary attending physician, in the capacity of a consulting physician, performing surgical procedures, and providing hospital-based services including, but not limited to pathology, radiology, or emergency services. A patient care encounter shall not, however, include orders for outpatient x-ray or laboratory testing which does not directly involve the ordering physician in the delivery of the service.

PHYSICIAN - shall mean a Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).

PRACTITIONER - means an appropriately licensed medical or osteopathic physician, dentist, podiatrist or Advanced Practice Professional.

PROFESSIONAL REVIEW ACTION - means an action, recommendation, or formal decision not to take action or make a recommendation, of a Professional Review Committee that is taken or made in the conduct of professional review activity and is based on the quality and appropriateness of patient care provided by, or the competence or professional conduct of, a Practitioner that affects or may affect adversely a Practitioner's clinical privileges or Medical Staff or Professional Staff membership in the Medical Center.

PROFESSIONAL REVIEW COMMITTEE - means any committee authorized by the Board to review and evaluate the competence, professional conduct of, or the quality and appropriateness of patient care provided by a Practitioner, including as appropriate to the circumstances, the Board, the Medical Executive Committee, any individual or committee engaged in conducting ongoing or focused professional practice evaluations, any Investigation Committee, any Hearing Committee, any Appellate Review Committee, the Chief Executive Officer, the Chief of Staff, any Service Chief, and any other person, committee, or entity having authority to make an adverse recommendation with respect to, or to take or propose an action against, any applicant or Practitioner when assisting the Board in a Professional Review Action.

SECTION - as used herein "Section" refers to specific sections of these Bylaws.

SERVICE - means an organizational unit of the Medical Staff whose members consist of Practitioners practicing in the same recognized specialty or specific practice area.

SPECIAL NOTICE - means written notification sent to the last known address of the recipient, as it appears in the records of the Medical Center, postage pre-paid by United States certified mail, return receipt requested.

ARTICLE I
NAME

1.1 The name of this organization shall be "Heart of the Rockies Regional Medical Center Medical Staff".

ARTICLE II
SCOPE, PURPOSES AND RESPONSIBILITIES

2.1 Scope.

A. These Medical Staff Bylaws and Rules and Regulations shall apply to all members of the Medical Staff and Advanced Practice Professional Staff of the Medical Center, including those providing services within its facility based clinics and those providing End Stage Renal Dialysis services within the Heart of the Rockies Regional Dialysis Center (HRRDC).

B. The Medical Center provides End Stage Renal Disease (ESRD) services in its HRRDC Facility through a Dialysis Support and Management Services Agreement with SRS-Salida, LLC ("SRS"). All Practitioners providing ESRD services at the Medical Center's HRRDC, including independent contractors of SRS, will be credentialed and privileged by the Medical Center, and are subject to these Medical Staff Bylaws and Rules and Regulations, in the same manner as for other Practitioners credentialed and privileged by the Medical Center regardless of whether such Practitioners are independently credentialed and privileged by SRS or by any other credentialing and privileging entity.

2.2 Purposes.

The purposes of the Medical Staff include:

A. Serving as the formal organizational structure through which the benefits of Medical Staff membership may be obtained and the obligations fulfilled,

B. Serving as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its members and Advanced Practice Professional Staff including services provided by healthcare professionals under contract with the Medical Center, and

C. Providing a means whereby issues concerning the Medical Staff may be discussed with the Chief of Staff, the Chief Executive Officer and the Board in a collaborative manner.

2.3 Responsibilities.

The responsibilities of the Medical Staff include:

A. Striving to ensure that all patients admitted to or treated in any of the Medical Center's facilities, departments, or Services, including HRRDC, shall receive appropriate care consistent with applicable professional standards of quality and the resources available at the Medical Center,

B. Promoting a high level of professional performance of all Practitioners through the appropriate delineation of the clinical privileges that each Practitioner may exercise in the Medical Center, as guided by the principles of continuous quality improvement, ongoing peer review, and

ethical practices,

C. Monitoring professional performance and quality of care of all Practitioners and, where indicated, taking appropriate corrective action,

D. Providing an appropriate educational setting that promotes continuous advancement in professional knowledge and skill,

E. Initiating and maintaining compliance with these Bylaws, and Rules and Regulations for self-governance of the Medical Staff, and

F. Participating in the call coverage needs of the organization as assigned by the Medical Center's Chief Executive Officer.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership.

Membership on the Medical Staff of Heart of the Rockies Regional Medical Center is a privilege which shall only be extended to physicians and dentists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer only those clinical privileges and prerogatives that have been granted by the Board in accordance with these Bylaws. Medical Staff membership and clinical privileges are not dependent solely on certification, fellowship, or membership in a specialty body or society.

3.2 Basic Qualifications and Responsibilities of Medical Staff

The basic qualifications of Medical Staff shall include Physicians and Dentists who:

A. Have a current unrestricted license to practice their profession in the State of Colorado, a DEA registration (if applicable to their profession), and acceptable malpractice insurance coverage in at least the minimum amounts as determined by the Board.

B. Have completed education and graduate training from a medical or osteopathic school meeting the standards of the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, a dental school meeting the standards of the Council on Dental Education of the American Dental Association, or a school of podiatry meeting the standards of the Council on Education of the American Podiatric Medical Association;

C. Have provided evidence of their background, experience, training and demonstrated current competency in his or her specialty for all privileges requested, sufficient to assure, in the judgment of the Board of Directors, that any patient treated by those in the Medical Center will be given appropriate, quality medical care;

D. Have a record that is free from Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals Entity;

E. Have a record that is free of felony convictions or occurrences that would raise questions of undesirable conduct which could injure the reputation of the medical staff or hospital; and

F. Have attested that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients.

G. Board certification or Board eligibility by a Board that is either a member of the American Board of Medical Specialties (ABMS) or recognized by the American Osteopathic Association (AOA), the American Board of Podiatric Medicine (ABPM) or a Dental Specialty Certifying Board in the Practitioner's primary specialty, is preferred.

The basic responsibilities of Medical Staff shall include Physicians and Dentists who:

A. Provide his/her patients with professional care at a generally recognized level of quality, appropriateness and efficiency;

B. Abide by all applicable state and federal laws and regulations, Medical Staff Bylaws, Rules and Regulations, and policies, and the generally accepted standards of medical ethics of his/her profession;

C. Discharge such staff, Service, committee and Medical Center functions for which he/she is responsible by appointment, election or otherwise;

D. Prepare and complete in timely manner the medical and other required records for all patients cared for in the Medical Center;

E. Avoid personal and professional conflicts of interest in the provision of patient care and fulfillment of functions and obligations as a member of the Medical Staff, and promptly report any such conflicts to the Chief of Staff;

F. Participate in all applicable quality improvement activities, including professional review and corrective action;

G. Agree to submit to proctoring, supervision, and/or practice evaluation as deemed necessary by the Medical Executive Committee; and

H. Provide timely care for all of his or her patients in the Medical Center.

3.3 Medical Staff Conditions of Appointment

Medical Staff members have a continuing obligation to promptly notify the Chief Executive Officer in writing immediately after and provide such additional information as may be requested regarding each of the following:

A. Revocation or suspension of his/her professional license or certification,

B. Imposition of terms of probation or other limitations or conditions of practice imposed by any State licensing authority,

C. Loss or suspension of staff membership at any hospital or other health care institution or after receiving any adverse disciplinary or corrective action at any hospital or health care facility,

D. Modification of any or all clinical privileges at any hospital or health care institution as a result of Professional Review Action, or the surrender of such privileges while under investigation by such institution in consideration for an agreement not to conduct such review or investigation,

E. Receipt of notice of a hearing to be held before the applicable State licensing authority to consider a complaint against the member,

F. Filing of any civil action in any state, federal or foreign court in which medical malpractice is alleged to have been committed by the member, but excluding any notice of claim that must, in accordance with applicable law, be filed prior to the commencement of a civil suit,

G. Payment or agreement to pay on his/her behalf or for his/her benefit any amount in full or partial settlement of a medical malpractice claim or action, including payments made under an insurance policy or self-insurance plan, or

H. Receipt of notice of any proposed, actual or pending debarment action, exclusion or other event that may make the member ineligible to participate in any state or federal health care program.

3.4 Duration of Appointment.

Initial appointment to the Medical Staff, except for Locum Tenens, shall be for a period of at least a one (1) year. Reappointments to any category of the Medical Staff shall be for a period of not more than two (2) years.

3.5 Provisional Status.

Provisional Staff members shall be eligible to serve on Hospital committees and may be invited to attend and serve on Medical Staff Committees, except the Medical Executive Committee, Medical Staff Performance Improvement Committee, and those portions of the meeting devoted to peer review of Medical Staff members. Provisional Staff members are not eligible to Chair a Medical Staff Committee or hold office. Provisional Staff members are not allowed to vote on matters presented at general and special meetings of the Medical Staff or Medical Staff Committees but shall be entitled to vote on matters of the Hospital Committee they serve and the Service of which he/she is a member. Provisional staff members must comply with established call coverage requirements.

A. Duration of Provisional Appointment. All initial appointments to the Medical Staff or any modification of clinical privileges at the request of an appointee shall be provisional for a period of twelve (12) months, unless further extended by the Medical Executive Committee. All initial appointments or modifications of clinical privileges shall be monitored in accordance with the Medical Staff policy regarding Focused Professional Practice Evaluation ("FPPE").

B. Assignment to Service. Each provisional status appointee shall be assigned to a Service where his/her performance shall be observed by the appropriate Service Chief, or designee, as assigned by the Medical Executive Committee. At least thirty (30) days prior to the end of the provisional appointment, the responsible Service Chief, or designee, shall submit a written recommendation to the Medical Executive Committee noting whether the appointee has satisfactorily completed the provisional term or whether provisional status shall be continued or terminated. After review, the Medical Executive Committee may recommend to the Board:

1. Termination of provisional status and advancement to full status,
2. Continuation of provisional status for an additional period not to exceed twelve (12) months, or
3. Denial of Medical Staff membership, clinical privileges or modification of clinical privileges for failure of the member to satisfactorily complete the provisional term.

C. Failure to Advance to Full Status. The failure to advance an appointee from provisional to full status at the termination of the provisional period of appointment (including any extension thereof) or denial of his/her request for a modification of clinical privileges shall entitle the appointee to the procedural rights set forth in Article IX of these Bylaws. The appointee shall be informed of the recommendation by Special Notice.

3.6 Leave of Absence.

A. Voluntary Leave of Absence. A Medical Staff member may request a voluntary leave of absence for any absence expected to exceed thirty (30) days by submitting a written request to the Medical Executive Committee and Chief Executive Officer setting forth the reason for the leave and the proposed starting date and duration of the leave. During a leave of absence, which may not exceed one (1) year, the member's clinical privileges and prerogatives shall be suspended and all obligations shall be waived. The member must provide evidence of current malpractice insurance coverage with occurrence coverage or tail coverage in the minimal amount required under these Bylaws during the leave of absence. A Medical Staff member, requesting a voluntary leave of absence extending beyond his/her reappointment period, shall reapply for and be granted Medical Staff membership and clinical privileges consistent with the reappointment process set forth in Article V of these Bylaws, prior to his/her return to service.

B. Medical Executive Committee Action. The Medical Executive Committee shall review the request for voluntary leave, confer with the Chief Executive Officer, and make a recommendation that the Board approve the leave for any reason acceptable to the Committee including, but not limited to, parental leave or leave to undertake additional medical education or training. If the Medical Executive Committee or Chief Executive Officer recommends denial of the request, the Medical Staff member may appeal the decision to the Board. The Board shall consider the appeal at its earliest opportunity and its decision shall be final.

C. Termination of Voluntary Leave of Absence. At least forty-five (45) days prior to the termination of a voluntary leave of absence, the member may request reinstatement of his/her clinical privileges and prerogatives by submitting a written request for reinstatement to the Chief Executive Officer for transmittal to the Medical Executive Committee. The request shall contain a brief written summary of his/her relevant activities during the leave. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member's clinical privileges and prerogatives. Failure, without good cause, to request reinstatement in accordance with this section shall be considered a voluntary resignation of Staff membership and clinical privileges and shall not entitle the member to the procedural rights set forth in Article IX of these Bylaws. A request for reinstatement of staff membership and clinical privileges following such voluntary resignation shall be submitted and processed in the same manner as an application for initial appointment.

D. Medical Leave of Absence. A Medical Staff member may apply for a medical leave of absence if, as a consequence of a diagnosed physical or mental health condition, he/she is unable to carry out the duties and responsibilities of staff membership for a period of time that is likely to exceed three (3) months. The affected Practitioner shall apply for a medical leave of absence using the format outlined for voluntary leaves of absence as set forth in these Bylaws. During the medical leave of absence, the member's staff obligations shall be waived. The Medical Executive Committee shall determine whether conditions should be attached to the member's reinstatement following the medical leave. A Physician's statement shall be provided prior to reinstatement, stating that the member is able to return to his/her previous level of activity either without conditions or with appropriate practice limitations related to the member's physical or mental health.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 Categories.

The Medical Staff shall be divided into Active, Active Outpatient, Courtesy, Consulting, and Honorary Staff categories.

4.2 Active Staff.

A. Qualifications. Active Staff shall consist of Medical Staff members who Admit, order an Observation Stay, attend and provide a significant portion of their clinical work at the Medical Center. In addition to the basic qualifications/responsibilities for Medical Staff membership set forth in Section 3.2, each Active Staff member shall:

1. Reside or have a clinic office within close proximity of the Medical Center to provide continuous care to his/her patients ; and respond in a timely manner to meet patient care needs;
2. Participate in the on call coverage requirements established for each specialty as determined by the Medical Executive Committee to assist in meeting the patient care needs of the community;
3. Serve on at least one Medical Staff committee and participate as necessary in conducting Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations as assigned by the Medical Executive Committee; and
4. Have a minimum of twenty-four (24) Patient Care Encounters in a calendar year.

B. Prerogatives of Active Staff Members. The prerogatives of the Active Staff shall include:

1. Physician members of the Active Staff may Admit patients to the Medical Center or order an Observation Stay without limitation,
2. Voting on all matters presented at general and special meetings of the Medical Staff, Medical Staff committees, and Service of which he/she is a member,
3. Serving as an officer of the Medical Staff, and
4. Serving as Committee Chair, Service Chief or other position within the organized Medical Staff.

4.3 Active Outpatient Staff.

A. Qualifications. Active Outpatient Staff shall consist of Medical Staff members who are regularly involved in outpatient care at the Medical Center and who utilize the Medical Center as the primary Medical Center for their patients requiring inpatient care. In addition to the basic qualifications/responsibilities for Medical Staff membership set forth in Section 3.2, each Active Outpatient Staff member shall:

1. Make acceptable arrangements for coverage of his/her patients who are admitted to the Medical Center; and
2. Participate, on an equitable basis, in providing care to unassigned patients requiring outpatient follow-up.

B. Prerogatives. The prerogatives of the Active Outpatient Staff shall include:

1. Voting on all matters presented at general and special meetings of the Medical Staff, Medical Staff committees, and Service of which he/she is a member,
2. Serving as an officer of the Medical Staff, and
3. Serving as Committee Chair, Service Chief or other position within the organized Medical Staff.

4.4 Courtesy Staff.

A. Qualifications. Courtesy Staff shall consist of Medical Staff members who do not focus a significant portion of their clinical work at the Medical Center. In addition to the basic qualifications/responsibilities for Medical Staff membership set forth in Section 3.2, each Courtesy Staff member shall:

1. Maintain active staff privileges in good standing at another facility;
2. Have a primary practice location that is not located close enough to the hospital for them to respond within 30 minutes in the event of an emergency; and
3. Has fewer than twenty-four (24) Patient Care Encounters in a calendar year. In the event a Courtesy member exceeds twenty-four (24) patient care encounters in a calendar year, the Medical Executive Committee shall have the option of advancing the member to the Active Staff category which will require the member to accept the responsibilities associated with that category.

B. Prerogatives. The prerogatives of the Courtesy Staff shall include:

1. Physician members of the Courtesy Staff may Admit patients to the Medical Center and order an Observation Stay for patients subject to the Patient Care Encounter limitation set forth in Section 4.4.A.3 of these Bylaws. At times of full Medical Center occupancy or of shortages of Medical Center beds or other facilities, as determined by the Chief Executive Officer, the admitting privileges of Courtesy Staff members shall be subordinate to those of Active/Active Outpatient Staff members, except for emergency admissions and
2. Attending meetings of the Medical Staff, Committees, and Service of which they are a member without voting rights or eligibility to hold Medical Staff office.

4.5 Consulting Staff.

A. Qualifications. Consulting Staff shall consist of Medical Staff members who provide consultation in the diagnosis and treatment of patients and the administration of clinical services at the Medical Center. Consulting Staff members shall meet the basic qualifications/responsibilities for Medical Staff membership set forth in Section 3.2.

B. Prerogatives. Consulting Staff shall not have admitting privileges or the prerogative to order an Observation Stay and shall not be entitled to vote, hold Medical Staff office, or serve on Medical Staff Committees. Consulting Staff are encouraged, but not required, to attend Medical Staff meetings, Service meetings and Medical Staff and Medical Center educational programs.

4.6 Honorary Staff.

A. Qualification. Honorary Staff shall consist of Medical Staff members who have retired from active hospital practice, who are recognized for their outstanding reputation, noteworthy contributions, or previous longstanding service to the Medical Center. Honorary staff members

do not apply for appointment or reappointment The Medical Executive Committee or Medical Staff may nominate individuals to Honorary Staff and such nominations shall be forwarded to the Board. The Board may approve, deny or terminate Honorary Staff status and its decision is final and not subject to the hearing and appellate review requirements set forth in these Bylaws.

B. Prerogatives. Honorary Staff shall not be eligible to Admit, order an Observation Stay or treat patients, vote, or hold Medical Staff office, but may be invited to attend and serve on hospital and Medical Staff Committees except the Medical Staff Performance Improvement Committee, the Medical Executive Committee, and those portions of the meetings devoted to peer review of Medical Staff members. Honorary Staff may attend general medical staff meetings.

ARTICLE V
ADVANCED PRACTICE PROFESSIONAL STAFF

5.1 Advanced Practice Professional Staff.

A. Qualifications. Advanced Practice Professional Staff shall consist of Physician Assistants and Advance Practice Nurses ("APN"), including: Certified Nurse Practitioners, and Certified Registered Nurse Anesthetists active in the care of patients at the Medical Center who meet the basic qualifications/responsibilities set forth in Section 3.2.

B. Prerogatives. Subject to Colorado licensing and certification requirements, Advanced Practice Professional Staff shall practice: (i) independently, (ii) as an employee of the Medical Center or as an employee of a member of the Active/Active Outpatient Medical Staff, or (iii) under the supervision of a Physician member of the Active/Active Outpatient Medical Staff. Advanced Practice Professional Staff are not members of the Medical Staff but may be encouraged to attend certain Medical Staff, Committee and Service meetings. They may be required to attend meetings involving review of patient care. They are not entitled to vote at Medical Staff, Service or Committee meetings, and they may not serve as Medical Staff Officers or as Service Chiefs. However, Advanced Practice Professionals shall be authorized to vote whenever serving on any committee conducting Professional Review Activities concerning the professional conduct, competence or the quality and appropriateness of patient care furnished by an Advanced Practice Professional with a scope of practice similar to theirs.

C. Additional Requirements for Physician Assistants.

1. Physician Assistants shall have at least one primary Physician supervisor and may have secondary Physician supervisors. Primary and secondary Physician supervisors shall be members in good standing of the Active/Active Outpatient Staff. Primary Physician supervisors shall be registered with the Colorado Board of Medicine. Primary and secondary Physician supervisors shall only delegate the authority to perform medical services to the Physician Assistant consistent with the rules of the Colorado Board of Medicine and within the scope of clinical privileges granted in accordance with the credentialing provisions of these Bylaws.

2. Active/Active Outpatient Staff members supervising Physician Assistants shall:
   a. Carry out supervisory responsibilities in accordance with applicable licensure/certification requirements set forth in the Rules of the Colorado Board of Medicine;
   b. Refrain from requesting that the Physician Assistant provide services beyond their

authorized clinical privileges at the Medical Center;

c. Maintain professional liability insurance in an amount established by the Board to cover any acts or omissions in supervising a Physician Assistant; and

d. Immediately notify the Chief of Staff if any of the following occur:

(1) Changes in the scope or nature of the medical services delegated to the Physician Assistant,

(2) Revocation, limitation or alteration by the applicable licensing authority of the Physician supervisor's authority to supervise the Physician Assistant, or

(3) The Physician supervisor's professional liability insurance is terminated or materially modified with respect to vicarious liability coverage arising out of the acts or omissions of the Physician Assistant being supervised.

D. Additional Requirements for Advance Practice Nurses. All Advance Practice Nurses shall:

1. Acknowledgement that he/she, in providing care to Medical Center patients,
2. Is responsible and accountable to a member of the Medical Staff, and
3. Ensure appropriate coordination and communication in the provision of care with a member of the Medical Staff.

ARTICLE VI
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1 Application for Initial Appointment.

A. Application. All applications for appointment to the Medical Staff or Advanced Practice Professional Staff shall be completed in its entirety, signed by the applicant, and submitted on the current Colorado Health Care Professionals Credentials Application. A complete application for appointment will include a current copy of the following documents:

1. Valid picture ID issued by a state or federal agency (for example, a driver's license),
2. State Professional License(s),
3. Federal Narcotics License (DEA) (if applicable),
4. Certificate of Insurance, in the amount acceptable by the Board,
5. A resume or curriculum vitae, whichever is appropriate, with complete professional history in chronological order by month and year,
6. Diplomas and/or certificates of completion (e.g. medical school, internship, residency, fellowship, dental or other healthcare professional school),
7. Specialty/Subspecialty Board Certification or letter from Board(s) stating status (if applicable),
8. Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable),
9. Military Discharge Record (Form DD-214) (if applicable),
10. Certificates Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP), if required per privilege delineation form.
11. CME transcripts/certificates,
12. Copies of training logs from residency and/or fellowship training programs if training completed within the past five (5) years or, in the event the training program did not require logs or more than five (5) years, a letter from the Director of the training program that attests to appropriate training for the privileges requested and clarifying applicant's competency to perform the requested privileges, and

13. All supplemental forms provided with the Application including the request for staff category, Service and clinical privileges for which the applicant wishes to be considered.

B. The completed application and all supporting documents submitted will become the property of the Medical Center.

C. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

6.2 Procedure for Initial Appointment.

A. Submission of Application. The Application shall be submitted to the Medical Staff Office as designee of the Chief Executive Officer. The Medical Staff Office shall verify current licensure, DEA (if applicable), education, relevant training, and current competence in writing and from the primary source wherever feasible or from a credentials verification organization ("CVO"). The Medical Staff Office shall also query the National Practitioner Data Bank, OIG/EPLS, applicants professional liability carrier(s) for claims history at a minimum of the ten (10) most recent years, perform a background check, and request responses from peer references listed on the Application. After receiving all verifying information and other information or materials deemed pertinent, the Medical Staff Office shall transmit the Application and all supporting documentation to the Medical Executive Committee for evaluation. The Application shall become incomplete if the need arises for new, additional or clarifying information anytime during evaluation.

B. Peer Recommendations. Peer recommendations provided by the applicant shall include written information regarding the applicant's current:

1. Medical/Clinical knowledge,
2. Technical and clinical skills,
3. Clinical judgment,
4. Interpersonal skills,
5. Communication skills, and
6. Professionalism.

C. Incomplete Applications. An incomplete Application will not be processed. Any Application which remains incomplete for one hundred eighty (180) days from the date of receipt by the Medical Staff Office will be declared incomplete. If membership and clinical privileges are still desired, a new Application will be required. Rejection for this reason shall not be subject to any of the procedural rights to hearing or appellate review as set forth in these Bylaws.

D. Medical Executive Committee Procedure. Upon receipt of the complete Application, the Medical Executive Committee shall proceed to evaluate the Application in the following manner:

1. Review the Application and examine all evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing to determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested. The Committee shall also evaluate the following:
   a. Challenges to the applicant's licensure or registration,
   b. Voluntary or involuntary relinquishment of any license or registration,
   c. Voluntary or involuntary limitation, reduction or loss of clinical privileges,

d. Any evidence of an excess number of professional liability actions resulting in a final judgment against the applicant,
e. Documentation as to the applicant's health status, and
f. Relevant Practitioner-specific data as compared to aggregate data, when available.

2. On reasonable grounds and in a manner consistent with the Americans With Disabilities Act and similar state laws require a physical, psychomotor, and/or mental health examination of the applicant by a Physician or Physicians satisfactory to the Committee and require that the results be made available for the Committee's consideration; and

3. If the recommendation for appointment and/or clinical privileges is favorable, recommend Service assignment and delineation of initial clinical privileges;

4. At its option require a meeting with the applicant, without legal counsel, to discuss any aspect of the Application, qualifications, or clinical privileges requested. A Physician seeking to employ an Advanced Practice Professional Staff applicant shall have the opportunity to appear before the Medical Executive Committee to discuss the proposed appointment and delineation of clinical privileges before the Committee makes its recommendation.

5. Within sixty (60) days of receipt of the application complete its review of the Application and supporting documentation. The Committee may defer action on the Application for up to an additional sixty (60) days to obtain further information or clarification from the applicant or others deemed reasonably necessary by the Committee in considering its recommendation.

6. If, after completing its review, the Committee's recommendation is favorable, it shall transmit its recommendation to the Board for consideration at the Board's next regularly scheduled meeting.

7. If, after completing its review, the Committee's recommendation is unfavorable and would entitle the applicant to a hearing pursuant to Article IX, of these Bylaws, the Committee's recommendation shall be forwarded to the Chief Executive Officer, who shall inform the applicant of the adverse recommendation by Special Notice. The Chief Executive Officer shall then hold the application until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Bylaws Article IX. If the applicant waives the right to a hearing, the Chief Executive Officer shall forward the unfavorable recommendation, together with the Application and all supporting documentation, to the Board.

E. Board Procedure.

1. The Board shall consider the Medical Executive Committee's recommendation at its next regularly scheduled meeting. The Board may, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which the Medical Executive Committee shall reconsider its recommendation.
2. If the Board's decision is adverse to the applicant in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly provide Special Notice to the applicant of his/her right to appeal the Board's adverse decision. The Board shall only take final action on the Application after applicant has exhausted or waived his/her procedural rights as provided in Article IX of these Bylaws.

F. Notice of Final Decision.

1. Notice of the Board's final decision shall be given to the Medical Executive Committee and, through the Chief Executive Officer, to the applicant by Special Notice.

2. A favorable decision shall include:
   a. Staff category to which the applicant is appointed,
   b. Service assignment,
   c. Delineation of clinical privileges granted, and
   d. Any special conditions attached to the appointment or clinical privileges.

G. Reapplication after Adverse Appointment Decision. An applicant who has received a final adverse decision regarding appointment shall not be eligible to re-apply to the Medical Staff for a period of three (3) years. Any such re-application shall be processed as an initial application.

6.3 Procedure for Reappointment.

A. Procedure for Reappointment. The Medical Staff Office, as designee of the Chief Executive Officer shall, at least ninety (90) days prior to the expiration date of each Medical Staff or Advanced Practice Professional Staff appointment, provide an Application for reappointment as provided in Section 6.1. Each member of the Medical Staff or Advanced Practice Professional Staff who desires reappointment shall, at least sixty (60) days prior to the expiration date of his/her appointment, submit, in accordance with Section 6.1, a completed Application for reappointment to the Medical Staff Office. Failure, without good cause, as determined solely at the discretion of the Medical Executive Committee, to submit a completed Application for reappointment within the time limits set forth herein may result in automatic termination of membership and clinical privileges at the expiration of the member's then current term, however that Practitioner may reapply. Such applications shall be treated as an application for initial appointment under Section 6.1. A completed application for reappointment will include a current copy of the following documents:

1. State Professional License(s),
2. Federal Narcotics License (DEA) (if applicable),
3. Current Certificate of Insurance, in an amount acceptable by the Board, and
4. Any certifications or advancements in training since initial appointment.

All supplemental forms provided with the Application including the request for staff category, Service and clinical privileges for which the applicant wishes to be considered.

B. Verification of Information. The Medical Staff Office, as designee of the Chief Executive Officer, shall, verify the information provided in the Application for reappointment and collect any additional information deemed relevant, including information regarding the applicant's professional activities, performance and conduct in the Medical Center. When collection and verification is accomplished, the Medical Staff Office shall transmit the information and supporting documentation to the Medical Executive Committee.

C. Medical Executive Committee Procedures. The Medical Executive Committee shall review the Application for reappointment and supporting documentation, including the results of Ongoing Professional Practice Evaluation ("OPPE") or any Focused Professional Practice Evaluation ("FPPE"). Following review the Committee shall forward its recommendation to the Board for consideration at the next regularly scheduled meeting. The Medical Executive

Committee may recommend that appointment be:

1. Renewed,
2. Renewed with modified staff category,
3. Renewed with changes in Service affiliation,
4. Renewed with modification of clinical privileges, or
5. Denied.

D. Board Procedures. Upon receipt of the Medical Executive Committee's recommendation, the Board shall follow the procedures set forth in Sections 6.2.E and F.

6.4 Requests for Modification of Appointment.

A member of the Medical Staff or Advanced Practice Professional may, either in connection with reappointment or at any other time, request modification of his/her staff category, Service assignment, or clinical privileges by submitting a written request to the Medical Executive Committee. Such request shall be processed in substantially the same manner as an Application for reappointment under these Bylaws.

6.5 Confidentiality and Reporting.

Professional Review Activity, including, but not limited to, actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to these Bylaws shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.

6.6 Professional Review Protection.

All minutes, reports, recommendations, communications and actions made or taken in carrying out Professional Review Activities pursuant to applicable law or these Bylaws are deemed to be covered by the provisions of C.R.S. § 12-36.5-105, 42 U.S.C. §§ 11101-11152, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

6.7 Employed or Contracted Physicians.

Nothing contained in these Bylaws shall be construed to discriminate with regard to Medical Staff membership and/or clinical privileges on the basis of whether a Physician is an employee of, a Physician with Staff privileges at, or a contracting Physician with the Medical Center. Provided, nevertheless, that this Section shall not affect the terms of any contract or written employment arrangement with the Medical Center that provides that a Physician's Medical Staff membership and/or clinical privileges are incident to or coterminous with the contract or employment arrangement or the Physician's association with a group holding such contract.

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES

7.1 Exercise of Privileges.

Medical Staff or Advanced Practice Professional Staff appointment or reappointment shall not, in itself, confer any clinical privileges or right to practice in the Medical Center. Each individual who has been given an appointment to the Medical Staff or Advanced Practice Professional Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board.

7.2 Temporary Privileges.

A. Temporary Privileges for Applicants and Members Requesting Additional or Modified Clinical Privileges.

1. In extraordinary situations the Chief Executive Officer, with the recommendation of the Chief of Staff or the Chief of Staff, as designee of the Chief Executive Officer, may grant temporary privileges to an applicant for a period of no more than one hundred twenty (120) days, if necessary to fulfill an important patient care, treatment, or service need or when an applicant for new privileges with a completed Application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Board. An "applicant for new privileges" shall include an individual who:

    a. Has submitted an initial Application for clinical privileges as a member of the Medical Staff or Advanced Practice Professional Staff;
    b. Currently holds clinical privileges and who is seeking one or more additional clinical privileges; or
    c. Is in the reappointment process and is seeking one or more additional privileges.

2. Temporary privileges may be granted only upon receipt of a complete Application which has been verified as to current licensure, current competence, relevant training or experience, ability to perform the privileges requested, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges, professional liability insurance coverage and history, and National Practitioner Data Bank Query of the applicant.

3. In exercising temporary privileges, the Practitioner shall act under the supervision of the Service Chief of the Service in which the applicant has requested or holds clinical privileges.

B. Temporary Clinical Privileges for Non-Applicants. In order to fulfill an important patient care, treatment and service need, temporary admitting and/or clinical privileges for care of a specific patient or patients may be granted by the Chief Executive Officer, with the recommendation of the Chief of Staff, or the Chief of Staff, as designee of the Chief Executive Officer, to a Practitioner who is not an applicant for appointment or reappointment, in the same manner and upon the same conditions as set forth in Section 7.2.A. Such privileges shall be restricted to the specific patients for which they are granted, and shall be restricted to the treatment of not more than two (2) patients per year by any Practitioner, after which such Practitioner shall be required to apply for membership on the Medical Staff or Professional Staff before being allowed to attend additional patients.

C. Termination of Temporary Privileges. On the discovery of any information or the occurrence of any event of a professionally questionable nature about a Practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the Chief Executive Officer or Chief of Staff may, after consultation with the responsible Service Chief, terminate any or all of a Practitioner's temporary privileges. With respect to Practitioner's holding temporary privileges while an initial or reappointment Application is pending, such temporary privileges shall be automatically terminated at such time as the Medical Executive Committee recommends denial of the Application or clinical privileges requested. In the event of any such termination, the Practitioner's patients then in the Medical Center shall be assigned to another Practitioner by the Service Chief with the consent of the substitute Practitioner. In cases where the Service Chief is not readily able to obtain the consent of a substitute Practitioner, the Service

Chief shall assign such patient to him/herself or another Practitioner of his/her choosing.

D. Procedural Rights of Temporary Privilege Applicants/Practitioners. A Practitioner shall not be entitled to the procedural rights afforded in Article IX of these Bylaws because of his/her inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

7.3 Emergency Privileges.

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to the danger, any Practitioner holding clinical privileges at the Medical Center, to the degree permitted by his/her license/certification and regardless of Service, staff status or clinical privileges, is authorized to do everything possible to save the patient's life or to save the patient from serious or permanent harm. Emergency privileges exercised under this provision shall be for a maximum of seventy-two (72) hours and are not renewable. After termination of such privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

7.4 Disaster Privileges.

A. Declaration of Disaster or Emergency. During a period when a medical emergency or disaster has been declared; the Medical Center's emergency or disaster management plan has been activated; and the Medical Center is unable to handle immediate patient care needs without additional support, it may be necessary for Practitioners who are not members of the Medical Staff or Advanced Practice Professional Staff to be granted clinical privileges to provide care at the Medical Center.

B. Granting Authority. In such circumstances, the Chief Executive Officer, Chief of Staff, or their designee may grant such privileges.

C. Identification. The Granting Authority must ascertain the identity of the Practitioner being granted disaster privileges by obtaining a copy of the individual's valid government-issued photo identification (for example, a driver's license or passport) and any one of the following:

1. Current picture hospital ID,
2. Current license, certification or registration to practice,
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other state or federal response organization or group,
4. Identification from a federal, state, or municipal entity indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances, or
5. Representation by a current member of the Medical Staff or Advanced Practice Professional Staff with personal knowledge regarding the Practitioner's identity.

D. Supervision. The Chief Executive Officer, Chief of Staff, or Chief of Service will pair a currently credentialed medical staff member (in the same specialty or as close of specialty as can be matched under the circumstances) with the practitioner being granted disaster privileges who will act only under the direct supervision of the credentialed medical staff member.

E. Verification Process. Verification of the credentials of Practitioners granted disaster privileges must be carried out as soon as the disaster is under control or within seventy-two (72) hours of

the Practitioners commencement of providing disaster medical services, whichever occurs first. If primary source verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances it shall be completed as soon as possible. In such extraordinary circumstances the Medical Center shall document the following:

1. The reason(s) why verification could not be performed within seventy-two (72) hours,
2. Evidence of the Practitioner's demonstrated ability to continue to provide adequate care, treatment and services, and
3. Evidence of the Medical Center's attempt to perform primary source verification as soon as possible.

F. ID Badges. Practitioners granted disaster privileges must wear Medical Center-issued identification at all times showing his/her disaster privileges.

G. Termination. Disaster privileges will be automatically terminated when the disaster is declared over, the immediate situation is under control, and members of the Medical Staff and Advanced Practice Professional Staff are able to resume patient care duties without disaster assistance. A Practitioner is not entitled to the procedural rights afforded by the Hearing and Appellate Review Procedures in Article IX of these Bylaws because of his or her inability to obtain disaster privileges or because of any termination or suspension of disaster privileges.

7.5 Locum Tenens.

The Chief Executive Officer or Chief of Staff, as designee, may grant an individual serving as a locum tenens for a member of the Medical Staff or Advanced Practice Professional Staff temporary clinical privileges to attend patients of that Practitioner for a period not to exceed one hundred twenty (120) days and only after receipt of a completed application for appointment. This grant of clinical privileges shall be considered in the same manner and upon the same conditions as set forth in Section 7.2.A, C and D.

7.6 Telemedicine Privileges.

A. Licensed independent Practitioners, or their employers, who provide medical information exchanged from distant sites to the Medical Center, via electronic communications, for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services shall have an agreement with the Medical Center pursuant to which they act as a contractor of services to the Medical Center and that describes the services to be provided in a manner that permits the Medical Center to be in compliance with the Medicare Conditions of Participation.. Distant site Practitioners shall be credentialed and privileged in either of the following mechanisms:

1. Verification of credentials and competence to render telemedicine services by the methods outlined in these Bylaws; or
2. Delegated credentialing verification using credentialing information from the distant site, if the distant site is a Joint Commission accredited hospital or ambulatory care organization, but maintaining the credentialing decisions of the Medical Center's Medical Staff and Board. The remote Practitioner must be privileged at the distant site for those services to be provided to the Medical Center.

B. Telemedicine Practitioners shall not be eligible to vote or to hold Medical Staff office. Any licensed independent Practitioner granted Telemedicine privileges shall be under the medical and administrative supervision of the Medical Staff. Telemedicine privileges shall be subject to the provisional appointment provisions of these Bylaws.

C. The Medical Staff shall review the performance of Practitioners exercising telemedicine privileges and shall provide the distant site with information that is useful in assessing the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum such information shall include:

1. Information regarding adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from telemedicine services provided, and
2. Complaints about the distant site Practitioner from patients, licensed independent Practitioners, or staff at the Medical Center.

D. Upon termination of a telemedicine service agreement pursuant to which a Practitioner is providing services, or if the Practitioner's employment with the distant site is terminated, the Practitioner's telemedicine privileges shall terminate. Such termination shall not be subject to the fair hearing and appeal provisions set forth in Article IX of these Bylaws.

7.7 Histories and Physical Examinations.

A. All Practitioners granted clinical privileges shall comply with the following requirements:

1. A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a Physician or other qualified licensed Practitioner in accordance with State law and Medical Center policy; and

2. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Physician or other qualified licensed Practitioner in accordance with State law and Medical Center policy.

ARTICLE VIII
COMPLAINT RESOLUTION AND CORRECTIVE ACTION

8.1 Complaint Resolution.

A. Complaint Resolution Process. An optional Complaint Resolution Process ("CRP") may be used to address documented allegations or concerns regarding a Practitioner's clinical performance, conduct or health that, upon initial identification, appear not to meet the criteria for corrective action. CRP provides an opportunity for preliminary review of certain complaints and may assist the Medical Executive Committee in determining whether further review or corrective action is warranted. As an alternative to CRP, complaints regarding Medical Center employed or contracted Practitioners shall be subject to the conflict resolution process set forth in the Medical Center's Policy entitled *Code of Conduct, Disruptive Behavior and Constructive Problem-Solving Conflict Resolution Process,* as may be amended from time-to-time.

B. Initiating a CRP. Any complaint regarding a Practitioner's competency, conduct, or health, may be submitted in writing to the Practitioner's Service Chief. Only written and signed

complaints shall be acted upon. The complainant shall be informed that his/her identity will be revealed to the affected Practitioner during the CRP. The affected Practitioner should understand that any retaliation against the complainant may be grounds for additional CRP or corrective action in accordance with the Bylaws.

C. Service Chief Review and Recommendation. The Service Chief shall review the complaint and make a preliminary recommendation whether the complaint should be managed through a CRP.

D. CRP Meeting. If the Service Chief determines that a CRP should be initiated, he/she shall forward the complaint to the Chief of Staff who shall provide a copy of the complaint to the affected Practitioner and schedule a complaint resolution meeting with the affected Practitioner, the Service Chief and any other persons that may be necessary or helpful in resolving the complaint. The goal of the meeting is to reach a resolution of the complaint.

E. Notice of CRP Meeting. The affected Practitioner shall be given at least five (5) working days' notice of the meeting, or such shorter notice if mutually agreed upon by the affected Practitioner and Service Chief.

F. Option to Participate in CRP. The affected Practitioner shall be advised that he/she has the option not to participate in the CRP and to have the matter resolved through the corrective action process set forth in the Bylaws.

G. Complaint Resolution Process Report. After the CRP meeting, the Service Chief shall record the results and his/her recommendations and forward a report to the Medical Executive Committee using the Complaint Resolution Process Report form, attached hereto as **Attachment A** and made a part of these Bylaws. The affected Practitioner shall be informed of the results and recommendations of the Service Chief and may rebut or comment on them in writing to the Medical Executive Committee.

H. Medical Executive Committee Review and Decision. The Complaint Resolution Report shall be reviewed by the Medical Executive Committee at its next regularly scheduled meeting. The Committee shall approve or reject the Complaint Resolution Report. If approved, the disposition and documentation of the complaint shall be considered satisfactory and final. If rejected, the Medical Executive Committee shall notify the affected Practitioner of its rationale for rejecting the Report and its alternative recommendations or actions.

I. CRP Does Not Limit Executive Committee Action. The CRP findings and recommendations shall not limit the Medical Executive Committee from recommending or taking further action regarding the allegations/concerns.

8.2 Corrective Action.

A. Criteria for Initiation of Corrective Action. Corrective Action may be requested by the Chief Executive Officer, Chief of Staff, a Service Chief or Board Chair whenever, on the basis of reasonable information and belief, the activities or professional conduct of any Practitioner with a staff appointment or clinical privileges are considered to:

1. Be detrimental to patient safety or likely to affect adversely the delivery of quality patient care in the Medical Center,
2. Violate bylaws, policies, rules or standards adopted by the Medical Staff, the Medical Center or the Board,
3. Be disruptive to the operations of the Medical Center or materially impede the orderly

and efficient administration of the Medical Center's affairs, including the inability or failure of the Practitioner to work collegially with others, as more specifically defined in the Medical Center's Code of Conduct and Professional Expectations Policy, or

4. Fail to meet and satisfy the qualifications for staff status or to fulfill the responsibilities of staff status provided in these Bylaws.

B. Request and Notice. All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chair of the Medical Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action and shall keep the Chief Executive Officer fully informed of all actions taken in conjunction therewith.

C. Medical Executive Committee Preliminary Review. The Medical Executive Committee shall conduct a preliminary review of a request for corrective action at its next regularly scheduled meeting or at an earlier meeting called for that purpose.

D. Notice. The Chief Executive Officer shall notify the affected Practitioner within two (2) business days by Special Notice, after the Medical Executive Committee has preliminarily considered the request.

E. Investigation. After completing its preliminary review, the Medical Executive Committee shall either reject the request for corrective action, if it determines that the request lacks a factual basis, or direct that an investigation concerning the grounds for the request be undertaken. The Medical Executive Committee may elect to conduct the investigation or it may appoint an Investigating Committee to conduct the investigation.

F. Conduct of the Investigation. In order to evaluate the request for corrective action the investigation shall include the following:

1. Review of all documentation relevant to the request,
2. Interviews with the person(s) making the request,
3. Interviews with persons who may have knowledge bearing on the request, and
4. Pursuant to Section 8.2.H, a meeting with the affected Practitioner.

G. Investigating Committee. If the Medical Executive Committee elects to impanel an Investigating Committee, the Chief of Staff or his/her designee shall assign three (3) Practitioners from the affected Practitioner's Service to serve as committee members. If assigning three (3) Practitioners from the same Service is not possible, the Chief of Staff shall assign members from other Services as necessary in order to impanel a three (3) person committee.

H. Meeting with Practitioner. The investigation shall include a meeting with the affected Practitioner. The Practitioner will be given Special Notice of the meeting at least five (5) business days before such meeting, unless the Practitioner agrees to shorter notice. Notice shall include the date, time, and place of the meeting, a statement of the issue(s) involved, and a statement that the Practitioner's appearance is requested. The meeting shall not constitute a hearing, shall be preliminary in nature, and need not be conducted according to the procedural rules provided with respect to hearings as set forth in Article IX of these Bylaws, but shall afford the Practitioner a fair opportunity to respond to questions and to address the allegations set forth in the request for corrective action. The interview shall constitute a peer-to-peer interaction and neither the affected Practitioner nor the investigating committee shall be represented by counsel during the interview.

I. Report of the Investigating Committee. If an Investigating Committee is appointed, it shall forward a written report of its investigation to the Medical Executive Committee as soon as practical after its investigation has been completed, but no event later than sixty (60) days after referral by the Medical Executive Committee.

J. Resources Available. The Medical Executive Committee or the Investigating Committee, in conducting its investigation, shall have available the full resources of the Medical Staff and the Medical Center, and the authority to use outside consultants as deemed necessary if approved by the Medical Executive Committee and the Chief Executive Officer.

K. Impartial Physical and/or Mental Evaluation. If relevant to the issues raised in the request for corrective action, the Medical Executive Committee may require the affected Practitioner to submit to an impartial physical and/or mental health evaluation. The Medical Executive Committee may require the Practitioner to submit to such evaluation within thirty (30) days of its request subject to the following conditions:

1. Failure of the Practitioner to submit to an impartial physical or mental evaluation without good cause shall result in immediate suspension of the Practitioner's staff status and all clinical privileges until the evaluation is obtained and the results are reported to the Medical Executive Committee.
2. The impartial evaluator who will conduct the examination shall be selected by the Medical Executive Committee. However, the Medical Executive Committee shall consider input from the affected Practitioner regarding its selection of the evaluator.
3. Fees for an evaluation under this Section shall be paid by the Medical Center.
4. The evaluator's report shall be submitted to the Chief of Staff, who shall share the results with the Medical Executive Committee at its next meeting following receipt of the report.

L. Medical Executive Committee Action. The Medical Executive Committee shall act as soon as practical after the conclusion of the investigative process, but in no event later than ninety (90) days after receipt of the request for corrective action. Medical Executive Committee action may include, but is not limited to, the following:

1. Reconvening the Investigating Committee to address specific issues;
2. Rejecting the request for corrective action;
3. Modifying the request for corrective action;
4. Issuing, a letter of reprimand;
5. Recommending additional education and/or training;
6. Recommending individual medical/psychiatric treatment or counseling;
7. Recommending a retrospective review of cases and/or other review of professional behavior, but without special requirements of prior or concurrent or direct supervision;
8. Imposing terms of probation or a requirement for proctoring or consultation;
9. Recommending to the Board reduction, suspension, or revocation of any part or all of the clinical privileges granted; and/or
10. Recommending reduction, suspension, or revocation of staff membership.

8.3 Summary Suspension.

A. Criteria and Initiation. The Chief of Staff or the Chief Executive Officer or, in the absence of the Chief of Staff and Chief Executive Officer, the Board Chair shall have the authority to summarily suspend all or a portion of the clinical privileges of any Practitioner whenever he/she perceives that there is a substantial likelihood that failure to do so may result in: (1) injury or damage to the health or safety of any patient, employee or other person present in the Medical

Center or (2) disruption of the orderly operations of the Medical Center. A summary suspension is precautionary in nature and shall not imply a final finding of responsibility for the matters giving rise to the suspension. The Chief Executive Officer shall be notified immediately of any such summary suspension which shall become effective immediately upon imposition. The Chief Executive Officer shall promptly notify the affected Practitioner by the most expeditious manner, including, but not limited to, in person, telephone call, or email, and shall also provide Special Notice of the summary suspension to the Practitioner.

B. Medical Executive Committee Action. As soon as possible, but not more than ten (10) days after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may recommend modification, continuation or termination of the terms of the summary suspension.

C. Procedural Rights. Unless the Medical Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Practitioner shall be entitled to the expedited procedural rights to a hearing as provided in Article IX of these Bylaws. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision by the Board.

8.4 Automatic Suspension.

A. License. Action by the appropriate state licensing board or agency revoking or suspending Practitioner's professional license, or loss or lapse of state license to practice for any reason, shall result in voluntary relinquishment of all Medical Center clinical privileges as of that date, until the matter is resolved and the license restored. In the event the Practitioner's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted.

B. Drug Enforcement Administration ("DEA"). Practitioners who are required to have DEA number whose DEA number is revoked or suspended shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. As soon as possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. The Medical Executive Committee may then take such further action as is appropriate to the facts disclosed in its investigation.

C. Failure to Complete Medical Records. Absent mitigating circumstances as defined herein, failure to complete medical records in a timely fashion as defined in the Bylaws, Rules and Regulations of the Medical Staff shall result in automatic suspension of the Practitioner's privileges to perform non-emergent procedures and Admit new patients. The suspension shall be effective until all delinquent medical records are completed. The Chief Executive Officer may temporarily stay imposition of the suspension in order to meet a patient care need. For the purpose of enforcing this Section 8.4.C, justified reasons for delay in completing medical records shall include, without limitation, the following mitigating circumstances:

1. The attending Physician or any other individual contributing to the record is ill, on vacation, out of town, or otherwise unavailable for a period of time,
2. The Practitioner is awaiting the results of a late report which is necessary for completion of a discharge summary and establishment of a final diagnosis, or
3. The Practitioner has dictated the reports and is waiting for Medical Center personnel to transcribe them.

D. Procedural Rights. A Practitioner under automatic suspension by operation of Section 8.4 shall not be entitled to the procedural rights provided in Article IX of these Bylaws.

ARTICLE IX
HEARING AND APPELLATE REVIEW PROCEDURE

9.1 Hearings.

A. Hearing Right following an Adverse Recommendation. Whenever a Practitioner receives notice of an Adverse Recommendation, as defined in Section 9.2, he/she shall be entitled to a hearing before an ad hoc Hearing Committee of the Medical Staff established in accordance with Section 9.5.A. The affected Practitioner shall have thirty (30) days following the date of the receipt of the notice of an Adverse Recommendation to request a hearing. The request for hearing shall be made in writing and shall be submitted to the Chief Executive Officer. In the event the affected Practitioner does not request a hearing within the time and in the manner as set forth above, he or she shall be deemed to have waived the right to the hearing and to have accepted the Adverse Recommendation. The Adverse Recommendation shall then be forwarded to the Board and it shall become effective upon final approval by the Board. If the Adverse Recommendation following such hearing is still adverse to the Practitioner, he/she shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

B. Adverse Board Decision. When the Board is considering taking Adverse Action that is either contrary to a favorable recommendation of the Medical Executive Committee under circumstances where no prior right to a hearing existed, or being made on the Board's own initiative without benefit of a prior recommendation by the Medical Executive Committee, the affected Practitioner shall be entitled, upon request, to a hearing by an ad hoc Board Hearing committee appointed by the Board, in accordance with Section 9.5.B, before the Board takes final action or renders a final decision.

C. Exceptions. Actions or recommendations of the Medical Executive Committee or the Board that are not Adverse Actions, as defined in Section 9.2, shall not entitle the affected Practitioner to a hearing or appellate review. Examples of actions or recommendations that do not trigger rights to a hearing or appellate review include, but are not limited to, the issuance of a warning, a letter of admonition, and a letter of reprimand. In addition, the denial, termination or reduction of temporary privileges shall not give rise to any right to a hearing or appellate review.

9.2 Adverse Actions or Recommendations.

For purposes of these Bylaws the following recommendations or actions are deemed Adverse Actions:

A. Denial of initial Medical Staff appointment,
B. Denial of reappointment to the Medical Staff,
C. Suspension of Medical Staff membership,
D. Revocation of Medical Staff membership,
E. Denial of requested advancement in Medical Staff category,
F. Reduction in Medical Staff category,
G. Denial of requested clinical privileges,
H. Reduction of clinical privileges,
I. Suspension of clinical privileges, other than automatic suspensions pursuant to Section 8.4,

J. Revocation of clinical privileges,
K. Proctoring that requires either or both the prior approval of the proctor or the presence of the proctor during the exercise of clinical privileges, and
L. Terms of probation.

9.3 Initiation of Hearing.

A. Notice of Adverse Recommendation on Action. The Chief Executive Officer shall be responsible for giving Special Notice of an adverse recommendation or decision to any affected Practitioner who is entitled to a hearing or an appellate review by Special Notice.

B. Waiver by Failure to Request a Hearing.

1. The failure of a Practitioner to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter.

2. When the waived hearing of appellate review relates to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Board, the same shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Board provided for in Article IX of these Bylaws. In either of such events, the Chief Executive Officer shall notify the affected Practitioner of his/her status by Special Notice.

9.4 Hearing Prerequisites.

A. Notice of Hearing. Within ten (10) days after receipt of a request for a hearing the Medical Executive Committee or the Board, whichever is applicable, shall schedule and arrange for the hearing and shall, through the Chief Executive Officer, notify Practitioner of the time, place and date of the hearing by Special Notice. The hearing date shall not be less than ten (10) days nor more than sixty (60) days from the receipt of the request for hearing; provided, however, that a hearing for a Practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, after receipt of the request for hearing.

B. Statement of Charges. The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative charts being questioned, if relevant, and/or other reasons or subject matter that was considered in making the adverse recommendations or decision.

9.5 Composition of Hearing Committee

A. Medical Executive Committee. When the hearing relates to an adverse recommendation of the Medical Executive Committee the hearing shall be conducted by an *ad hoc* Hearing Committee of not less than three (3) members of the Medical Staff or, if necessary, Professional Staff, appointed by the Chief of Staff in consultation with the Medical Executive Committee. One of the members so appointed shall be designated as Chair by the Chief of Staff. No Medical Staff or Professional Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed as a member of the hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff or Professional Staff. In no case shall any individual who is in direct economic competition with the affected Practitioner serve on the Hearing Committee. Practitioners who are not members

of the Medical Staff or Professional Staff but are members of the medical staff of another Colorado hospital may be appointed, if it is not possible to designate a hearing panel from Medical Staff or Professional Staff members.

B. By the Board. When a hearing is related to an adverse decision of the Board that is contrary to the recommendation of the Medical Executive Committee, the Board shall appoint an ad hoc Board Hearing Committee to conduct such hearing and shall designate one of the members of his/her committee as Chair. The committee shall be made up of at least three (3) voting members, two of whom shall be Board members. The Chief Executive Officer shall also serve on the Hearing Committee as an *ex officio* member without vote. At least one representative from the Medical Staff or Professional Staff, if necessary, shall be included on this committee if feasible. In no case shall a Medical Staff or Professional Staff member who is in direct economic competition with the affected Practitioner or who participated in the adverse recommendation serve as a member of the ad hoc Board Hearing Committee. Practitioners who are not members of the Medical Staff or Professional Staff may be appointed, if necessary, to assure that no Medical Staff or Professional Staff member who is in direct competition with the affected Practitioner or who participated in the adverse recommendation serves on the committee.

9.6 Hearing Procedure.

A. Committee Presence. All members of the ad hoc Hearing Committee or the ad hoc Board Hearing Committee must be present when the hearing takes place, and no member may vote by proxy.

B. Records. An accurate record of the hearing must be kept. The mechanism for recording the hearing shall be established by the ad hoc Hearing Committee or ad hoc Board Hearing Committee, and may be accomplished by use of a court reporter, electronic recording unit, or by detailed transcription.

C. Personal Presence. The personal presence of the affected Practitioner shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 9.3.B.1 and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 9.3.B.2.

D. Postponement. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc Hearing Committee or ad hoc Board Hearing Committee. Granting of such postponements shall only be for good cause shown and in sole discretion of the hearing committee.

E. Presiding Officer. The Chair of the hearing committee shall preside over the hearing. In the alternative a hearing officer may be appointed by the hearing committee after consultation with the Chief of Staff or Board Chair, as applicable. A hearing officer may or may not be an attorney at law but must be a person familiar with Medical Staff organization, governance and corrective action with documented experience participating as an advocate in Medical Staff corrective action hearings or serving as a hearing officer in such hearings. He/she shall act in an impartial manner as the presiding officer. If requested by the hearing committee, he/she may participate in its deliberation, but he/she shall not be entitled to vote. The presiding officer shall preside over the hearing, determine the order of procedure, assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and maintain decorum.

F. Representation. The affected Practitioner shall be entitled to be represented by an attorney or other person of the Practitioner's choice. Likewise, the Board or Medical Executive Committee may in its discretion, seek counsel and representation by an attorney.

G. Rights of Parties. During the hearing, the parties shall have the right to:

1. Call, examine and cross-examine witnesses;
2. Introduce and present evidence determined to be relevant by the Chair of the ad hoc Hearing Committee or ad hoc Board Hearing Committee without regard to its admissibility in a court of law;
3. Question any witness on any matter relevant to the issue of the hearing (If the affected Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross examination);
4. Challenge any witness;
5. Rebut any evidence; and
6. Submit a written statement at the close of the hearing within a time period prescribed by the Chair of the ad hoc Hearing Committee or ad hoc Board Hearing Committee.

H. Procedure and Evidence.

1. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action.

2. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members, another Medical Staff member, or legal counsel to represent it at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Board, when its action has prompted the hearing, shall appoint one of its members or legal counsel to represent it at the hearing to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation, action, or proposed decision or action, but the affected Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation, action, or proposed decision or action, by an appropriate showing that the adverse recommendation, action, or proposed decision or action, charges or grounds involved lack sufficient factual basis or that the basis of any action based thereon is arbitrary, unreasonable or capricious.

I. Recesses and Adjournment. The ad hoc Hearing Committee or ad hoc Board Hearing Committee may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of the presentation of oral and written evidence, and upon expiration the time period within which the parties were allowed to submit written statements in accordance with Section 9.6.G.6, the hearing record shall close and the hearing shall adjourn. The ad hoc Hearing Committee or ad hoc Board Hearing Committee shall, within ten (10) days after adjournment of the hearing, conduct its deliberations outside the presence of the parties.

J. Number of Reviews. Notwithstanding any other provisions of these Bylaws, no Practitioner shall be entitled as a matter of right to more than one hearing before either an ad hoc Hearing Committee or an ad hoc Board Hearing Committee and to one appellate review with respect to review of an Adverse Action recommendation.

9.7 Hearing Committee Report and Further Action.

A. Hearing Committee Report. Within ten (10) days after adjournment of the hearing, the ad hoc Hearing Committee or ad hoc Board Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation considered by it, to the Medical Executive Committee or to the Board, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or the proposed decision or action of the Board.

B. Action on Hearing Committee Report. Within thirty (30) days after receipt of the report of the ad hoc Hearing Committee or ad hoc Board Hearing Committee, the Medical Executive Committee or the Board, as the case may be, shall consider the same and affirm, modify, or reverse its prior recommendation or action in the matter. The Medical Executive Committee or Board shall forward its recommendation, together with the hearing record, the ad hoc committee report, including copies of any documentary evidence included in the hearing record, to the Chief Executive Officer.

C. Notice. The Chief Executive Officer shall promptly send a copy of the report and recommendation to the affected Practitioner by Special Notice with copies to the Chief of Staff and the Board Chair.

D. Effect of Favorable Decision.

1. Adopted by the Board. If the Board affirms the recommendation pursuant to Section 9.7.B, the recommendation becomes a final decision of the Board and is not subject to further consideration.

2. Adopted by the Medical Executive Committee. The Chief Executive Officer shall promptly forward the Medical Executive Committee's recommendation, pursuant to Section 9.7.B, together with all supporting documents, to the Board for its final action. The Board may adopt or reject the Medical Executive Committee's recommendation in whole or in part or may refer the matter back to the Medical Executive Committee for further consideration. The referral shall be in writing and shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may require that: (i) an additional hearing by the ad hoc Hearing Committee be conducted to consider additional evidence or clarify issues that are in doubt, or (ii) the Medical Executive Committee carry out other proceedings or take other actions that the Board may require. The Medical Executive Committee shall then forward its reconsidered recommendation to the Chief Executive Officer and Board Chair. The Chief Executive Officer shall promptly send the affected Practitioner Special Notice, informing him/her of the Medical Executive Committee's reconsidered recommendation. If, after review of the Medical Executive Committee's reconsidered recommendation, the Board's decision is favorable to the affected Practitioner, its decision shall be final, and not subject to further consideration. If the Board's decision is adverse to the affected Practitioner, the Chief Executive Officer shall inform the affected Practitioner by Special Notice of his/her right to request appellate review as provided in Sections 9.8 and 9.9.

9.8 Initiation and Prerequisites of Appellate Review.

A. Request for Appellate Review. A Practitioner shall have fifteen (15) days following receipt of an adverse recommendation under Sections 9.7.B or 9.7.D.2 to file a written request for

appellate review. Such request shall be delivered to the Chief Executive Officer either in person or by Special Notice, and may include a request for a copy of the report and record of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation. The request for appellate review may include a request to file a written memorandum in support of the appeal and/or to present oral argument to the Board during the appellate review.

B. Waiver by Failure to Request Appellate Review. A Practitioner who fails to request appellate review within the time and in the manner specified in Section 9.8.A waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 9.3.B.

C. Notice to Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. Within fifteen (15) days after receipt for such request, the Board shall schedule and arrange for such review, including a time and place for oral argument if such has been requested, which shall not be less than twenty-five (25) days nor more than sixty (60) days from the date of receipt of the appellate review requested provided, however, that an appellate review for a Practitioner who is under suspension then in effect shall be held as soon as the arrangements for it may reasonably be made. At least five (5) days prior to the appellate review, the Chief Executive Officer shall notify the Practitioner by Special Notice of the time, place and date of the review. The time for appellate review may be extended by the Board for good cause.

D. Appellate Review Panel. The appellate review shall be conducted by the Board or at the Board's discretion by an Appellate Review Panel composed of at least three (3) Board members, appointed by the Chair. If a Panel is appointed, one of its members shall be designated as Chair.

9.9 Appellate Review Procedure.

A. Nature of Proceedings. The appellate review shall be based upon the record of the hearing before the ad hoc Hearing Committee or ad hoc Board Hearing Committee, as the case may be, the committee's report and recommendation, and all subsequent recommendations or actions by the Medical Executive Committee or Board thereon. The Board or Appellate Review Panel shall also consider any written statements submitted pursuant to Section 9.9.B, oral argument allowed under Section 9.9.D, and/or such other materials as may be presented and accepted under Section 9.9.E.

B. Written Statements. The Practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Board or Appellate Review Panel through the Chief Executive Officer at least fifteen (15) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Executive Committee or by the Board, and if submitted, the Chief Executive Officer shall provide a copy thereof to the Practitioner at least seven days prior to the scheduled date of the appellate review.

C. Presiding Officer. The Chair of the appellate review body shall be the presiding officer. He/she shall determine the order of the procedure during the review, make all required rulings, and maintain decorum.

D. Oral Argument. The Board or Appellate Review Panel, in its sole discretion, may allow the parties or their representatives to personally appear and make oral argument in favor of their

respective positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Board or Appellate Review Panel.

E. Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The Board or Appellate Review Panel, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

F. Recesses and Adjournment. The Board or Appellate Review Panel may recess the appellate review and reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral argument, if allowed, the appellate review shall be closed. The Board or Appellate Review Panel thereupon, at a time convenient to itself, shall conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

G. Action Taken.

1. If the appellate review is conducted by the Board, it may affirm, modify, or reverse its prior decision or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified disputed issues.

2. If the appellate review is conducted by an Appellate Review Panel, the Panel shall, within seven (7) days after adjournment of the appellate review, either make a written report to the Board recommending that the Board affirm, modify, or reverse its prior decision, or refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee reconsider its recommendation or consider taking such further action as the Appellate Review Panel requests. Within ten (10) days after the Appellate Review Panel's receipt of the Medical Executive Committee's reconsidered recommendation the Panel shall make its recommendation to the Board as provided above.

9.10 Final Decision by Board.

A. Within thirty (30) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall forward it to the Medical Executive Committee and, through the Chief Executive Officer, to the affected Practitioner by Special Notice. If the decision is in accordance with the Medical Executive Committee's last recommendation in the matter, the decision shall be immediately effective and final and shall not be subject to further hearing or appellate review. If the decision is contrary to the Medical Executive Committee's last recommendation, before the decision is made final, the Board shall refer the matter to the Medical Center Joint Conference Committee for further review and recommendation.

B. Joint Conference Committee Review. Within fifteen (15) days of its receipt of a matter referred to it by the Board pursuant to Section 9.10.A, the Joint Conference Committee shall convene to consider the matter and shall submit its recommendation to the Board. At its next meeting following the receipt of the Joint Conference Committee's recommendation, the Board shall make its final decision which shall be immediately effective and final and subject to no further hearing or appellate review. The Chief Executive Officer shall send Special Notice of this final

decision to the affected Practitioner.

9.11 Time Frames.

All reasonable steps will be taken to adhere to the time frames set forth in this Article. However, the times may be deviated from for good cause as determined by the Medical Executive Committee or the Board in the exercise of sound discretion. The Medical Executive Committee or Board may delegate the authority to deviate from these time frames in appropriate circumstances to the Chief of Staff, the Chief Executive Officer, an ad hoc hearing committee or others who have responsibilities under these Bylaws. The affected Practitioner may request a deviation and such a request may be granted for good cause.

ARTICLE X
OFFICERS

10.1 Officers of the Medical Staff.

A. Identification. The officers of the Medical Staff shall be:
   1. Chief of Staff,
   2. Vice Chief of Staff, and
   3. Secretary-Treasurer

B. Qualification. Officers must be members of the Active/Active Outpatient Staff at the time of nomination and election and must remain members in good standing during his/her term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

C. Nominations.
   1. By Medical Executive Committee. The Medical Executive Committee shall submit to the Medical Staff Secretary one or more qualified nominees for each office. The names of such nominees shall be reported to the Medical Staff at least fifteen (15) days prior to its annual meeting.
   2. By other means. Nominations may also be made from the floor at the time of the annual meeting of the Medical Staff.

D. Election. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Staff and Active Outpatient Staff are eligible to vote. Voting shall be by secret ballot if requested by any voting member. Voting by proxy shall be permitted for those voting members excused from attendance at the meeting by the Chief of Staff for good cause shown. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election will be held by successive balloting, such that the name of the nominee receiving the fewest votes is omitted from each successive slate until a majority vote is obtained by one nominee.

E. Term of Office. Each officer shall serve a two-year term, commencing on the first day of the Medical Staff year following his/her election. Generally, an officer shall serve no more than two consecutive terms, but may serve additional consecutive terms upon a two-thirds (2/3) vote of the Medical Staff at an election as provided for in Section 10.1.D. Each officer shall serve until the end of his/her term and a successor is elected.

F. Vacancies in Elected Office. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve as Chief of Staff until a successor is elected. A vacancy in the office of Secretary-Treasurer shall be filled by the Medical Executive Committee. A vacancy in the office of Vice Chief of Staff shall be filled at a Special Meeting of the Medical Staff by special

election following the procedures set forth in Sections 10.1.C and D.

G. Duties of Elected Officers.

1. Chief of Staff. The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff. The Chief of Staff shall:

   a. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Medical Center;
   b. Be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Medical Center of the patient care audit and other quality maintenance functions delegated to the Medical Staff;
   c. Be responsible for the enforcement of Medical Staff Bylaws and Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances when corrective action has been requested against a Practitioner;
   d. Represent the views, policies, needs and grievances of the Medical Staff to the Board and to the Chief Executive Officer;
   e. Receive and interpret the policies of the Board to the Medical Staff;
   f. Appoint committee members to standing, special and multi-disciplinary Medical Staff committees and Medical Staff representatives to Medical Center management committees;
   g. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
   h. Serve as Chair of the Medical Executive Committee;
   i. Be responsible for the educational activities of the Medical Staff;
   j. Be the spokesman for the Medical Staff in its external professional and public relations; and
   k. Serve as Chief of Staff of the Medical Center's HRRDC ESRD Facility.

2. Vice Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee. In the temporary absence of the Chief of Staff, he/she shall assume all duties and have the authority of the Chief of Staff. For the purposes of this subsection, "temporary absence" shall mean the inability of the Chief of Staff to fulfill his/her duties for a period in excess of five (5) days or for whatever shorter period may be requested by the Chief of Staff.

3. Secretary-Treasurer. The Secretary-Treasurer shall be a member of the Medical Executive Committee. His/her duties shall be to:

   a. Give proper notice of all Medical Staff meetings on order of the appropriate authority;
   b. Assure that accurate and complete minutes for all Medical Staff meetings are recorded; and
   c. Perform such other duties as ordinarily pertain to his/her office.

H. Removal of Officers. Elected officers of the Medical Staff may be removed for failure to satisfactorily meet the qualifications for Officers of the Medical Staff set forth in Section 10.1.B, or for failure to carry out the duties of Officers of the Medical Staff as set forth in Section 10.1.H. Removal shall occur by a two-thirds (2/3) vote of the Active Staff and Active Outpatient Staff present at any special or regular meeting at which a quorum is present and where the agenda includes the proposed action as an agenda item.

10.2 Medical-Administrative Officers.

The Chief Executive Officer or Board may, after considering the advice and recommendations of the Medical Executive Committee, appoint Practitioners to Medical-Administrative Officer positions within the Medical Center to perform such duties as prescribed by the Medical Executive Committee and the Board. To the extent that a Medical-Administrative Officer performs any clinical function, he/she must become and remain a member of the Medical Staff in good standing.

ARTICLE XI
SERVICES

11.1 Medical Staff Organizational Service Structure.

The Medical Staff shall be organized into the following Services headed by a Chief of Service and shall function under the Medical Executive Committee:

A. Surgical Services (which will include Surgery, Anesthesia, Laboratory and Pathology;

B. Medical Services/Trauma (which will include oversight responsibilities for Pharmacy & Therapeutics, Rehab Services, Infection Control, Trauma, Emergency Services, ICU, Radiology, Respiratory Therapy, ESRD Services and hospital-based clinics);

C. Obstetric Services, and

D. Such other Services as the Medical Executive Committee may designate from time-to-time.

11.2 Membership, Meetings and Voting.

A. Membership. The membership of each Service shall consist of those Practitioners collectively appointed by the Chief of Staff and approved by the Medical Executive Committee. Additionally, the appropriate Nurse Manager and/or Clinical Manager of the hospital-based clinics and of the associated hospital Service (i.e.: Surgical Services Nurse Manager as a member of the Surgical Services Service, ICU Nurse Manager as a member of the Medical Services/Trauma Service, Nurse Manager of the Family Birthing Center as a member of the Obstetric Services Service, etc.), and at least one representative of the Medical Center Administration will be standing members of these Services as *ex officio* members without a vote and appointed by the Chief Executive Officer.

B. Meetings. Each Service shall meet at least quarterly or as called by its Chief of Service and should be held, if possible, no more than two (2) weeks prior to the next regularly scheduled Medical Executive Committee meeting and a written record of its proceedings shall be maintained.

C. Quorum and Voting. Fifty percent (50%) of the voting members of a Service, but not less than two (2) members, shall constitute a quorum at Service meetings. Proxies shall be permitted for the purpose of establishing a quorum or for voting for those voting members excused from attendance at the meeting by the Chief of Service.

11.3 Chief of Service/Vice Chief of Service Qualifications, Selection and Term of Office

A. Qualifications. Each Chief of Service or Vice Chief of Service shall be a member of the Active Staff or Active Outpatient Staff and a member of the Service which he/she is to head; and shall

be qualified by training, experience, interest and demonstrated current ability in the clinical area covered being covered.

B. Selection. Each Chief of Service or Vice Chief of Service shall be appointed by the Chief of Staff and approved by the Medical Executive Committee.

C. Term of Office. A Chief of Service or Vice Chief of Service shall serve at the request of the Chief of Staff. Removal of a Chief of Service or Vice Chief of Service may also be initiated by two-thirds (2/3) majority vote of all Active Staff and Active Outpatient Staff members of the Service, but no such removal shall be effective unless and until it has been approved by the Board .

11.4 Functions of Chief of Service. A Chief of Service shall:

A. Account to the Medical Executive Committee for all professional and administrative activities within his/her Service;

B. Develop and implement in cooperation with the Medical Executive Committee, programs for credentials review and privileges delineated, continuing medical education, concurrent monitoring of practice and retrospective patient care audit;

C. Provide guidance on the overall medical policies of the Medical Center and making specific recommendations and suggestions regarding his/her own Service in order to assure quality patient care;

D. Maintain continuing review of the professional performance of all Practitioners with clinical privileges assigned to his/her Service and report regularly thereon to the Medical Executive Committee;

E. Enforce the Medical Staff Bylaws and Rules and Regulations and Medical Staff and Service policies within his/her Service;

F. Establish an equitable roster of on-call responsibility for members of the Service;

G. Implement within his/her Service actions taken by the Medical Executive Committee;

H. Participate in every phase of administration of his/her Service through cooperation with the Nursing Service and Medical Center administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques; and

I. Lead the ongoing quality improvement activities of the Service and participate in organization-wide quality improvement activities, including, but not limited to, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

11.5 Vice Chief of Service.

The Vice Chief of Service shall serve as Chief of Service in the absence of the Chief of Service.

11.6 Functions of Services.

A. Establishment of Criteria. Each Service shall establish its own criteria, consistent with the Bylaws of the Medical Staff, for the granting of clinical privileges to Practitioners within the Service.

B. Specific Reviews. Each Service shall include in the review process consideration of: (i) deaths, (ii) patients with infections, (iii) complications, (iv) errors in diagnosis and treatment, and (v) proper utilization of Medical Center facilities. The review of surgical matters shall also include a comprehensive tissue review for justification of all surgery performed, whether tissue was removed or not, for acceptability of the procedure chosen, and for agreement or disagreement between preoperative and pathological diagnosis.

C. ESRD Functions. With respect to ESRD services, Medical Services/Trauma shall be responsible for (i) supervising and evaluating the quality of the medical records within the Medical Center's HRRDC ESRD Facility to ensure that they satisfy the requirements of 6 C.C.R. 1011-1 Chapter 15, Sections 5.3.5 and 6.3, and (ii) reviewing systematically the work of the Medical Staff with respect to the quality of medical care provided within the Medical Center's HRRDC ESRD Facility

ARTICLE XII
COMMITTEES AND FUNCTIONS

12.1 General Considerations.

Committees are delegated to perform such functions and to carry out such responsibilities of the Medical Staff as outlined in these Bylaws and to provide a forum for the ongoing review of clinical care rendered by the Medical Staff. Committees also provide assistance to the Medical Staff and the Board in complying with the goals and objectives of Medical Center-wide and Medical Staff quality improvement plans. Unless otherwise provided for in these Bylaws, all committees shall report to the Medical Executive Committee, which shall provide general oversight of all such committees.
In addition to the committees established pursuant to these Bylaws, the Medical Executive Committee may, by resolution, establish additional Medical Staff committees to perform one or more of the required Medical Staff functions. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on such Medical Center management committees as are established to perform such functions. Whenever these Bylaws require that a function be performed or that a report or recommendation be submitted to a named Medical Staff committee and no such committee exists, the Medical Executive Committee shall perform such function or receive such report.

12.2 Appointment, Composition, Terms, Removal and Vacancies.

A. Appointment and Composition. Committees shall be comprised of members of the Active, Active Outpatient, and Courtesy Staff and may include, where appropriate, representation from Advanced Practice Professional Staff, Administration, and any other Medical Center department deemed appropriate to the function(s) of the committee. Unless otherwise specifically provided, Medical Staff members shall be appointed by the Chief of Staff and administrative staff members shall be appointed by the Chief Executive Officer. The Chief Executive Officer, or designees, shall serve as *ex officio* members without vote on all committees, unless expressly provided otherwise in these Bylaws.

B. Term and Prior Removal. Unless otherwise specifically provided, a committee member shall continue as such until his/her successor is elected or appointed. A Medical Staff or administrative staff committee member, other than one serving as *ex officio*, may be removed by a majority vote of that committee's members. .

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

D. Volunteer Non-Voting Committee Members. Nothing in these Bylaws shall preclude Committee Chairs, in consultation with and approval from the Chief of Staff and Chief Executive Officer, from inviting retired Physicians or other qualified individuals with relevant professional experience and expertise to serve, on an *ad hoc* basis, as non-voting volunteer consultants to a Medical Staff Committee, provided such invitation is memorialized in writing.

12.3 Meetings, Quorum, Minutes & Attendance.

A. Meetings. A committee established under this Article shall meet as often as is necessary to discharge its assigned duties, but no less than quarterly, except that the Medical Executive Committee shall meet every other month.

B. Quorum and Voting. Fifty percent (50%) of the voting members of a committee, but not less than two members, shall constitute a quorum at any meeting of a committee. Attendance for purposes of a quorum may be established by proxy and voting by proxy shall be allowed for those voting members excused from attending by the committee Chair, for good cause shown. *Ex officio* members of committees shall not be entitled to vote on matters before the committee

C. Minutes. Minutes of all meetings shall be prepared by the secretary of the committee or his/her designee and shall include a record of attendance, the agenda, discussions, decisions made, remedial actions and follow-up on all issues considered. Minutes shall be signed by the committee chair, approved by the attendees, and a permanent file of the minutes of each committee meeting shall be maintained.

12.4 Medical Executive Committee.

A. Composition. The Medical Executive Committee shall consist of at least five (5) Medical Staff members eligible to vote, including the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, Chair of the Performance Improvement Committee, and one (1) at-large member of the Medical Staff appointed by the Chief of Staff. The Chief of Staff shall serve as the Chair and preside at meetings, unless another member has been designated by the Chief of Staff to do so. The Chief Executive Officer, and VP-Patient Care Services shall be *ex-officio*, non-voting members of the Committee.

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

1. Act for the Medical Staff at intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
2. Be accountable to and report to the Medical Staff and the Board;
3. Review and act on reports and recommendations of all Medical Staff committees, Services, officers and other assigned activity groups;
4. Review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges and in connection therewith and obtaining and considering the recommendations of the appropriate Service Chief and assuring that privileges granted are supported by evidence of clinical experience and competence;
5. Make recommendations concerning appointments and privileges to the Board;
6. Organize, oversee and ultimately be accountable to the Board for the quality management activities of the Medical Staff and Advanced Practice Professional Staff;
7. Implement disciplinary processes as specified in these Bylaws, and oversee any remedial actions required as result of such processes;
8. Investigate any reported breach of the Medical Staff Bylaws and Rules and Regulations, professional ethics, standards of behavior, or clinical competence by any member of the

Medical Staff or Advanced Practice Professional Staff;

9. Make recommendations on medical-administrative matters and Medical Center operations;
10. Review, as deemed necessary, the Bylaws, Rules and Regulations, policies, procedures, and forms promulgated in connection therewith;
11. Promote Medical Staff/Medical Center administration relationships;
12. Inform the Medical Staff of the accreditation program and accreditation status of the Medical Center;
13. Participate in identifying community health needs and in setting Medical Center goals and implementing programs to meet those needs; and
14. Present to the Medical Staff qualified candidates for elective positions in the Medical Staff organization when nominations are made.

D. Meetings. The Medical Executive Committee shall meet every other month.

12.5 Medical Staff Performance Improvement Committee.

A. Composition. The Medical Staff Performance Improvement Committee shall be composed of: (i) an appointed Chairman who will automatically be a member of the Medical Executive Committee, (ii) each of the Service Chiefs and their Vice-Service Chief, (iii) at least one (1) member of the EKG Panel, (iv) the Quality Manager, and (v) a representative of Hospital Administration, (vi) a member of the Advanced Practice Professional Staff as may be required by law from time-to-time, and (vii) such other administrative and nursing representatives as shall be appointed by the Chief Executive Officer. The representatives of administration and nursing shall serve *ex-officio*, without vote.

B. Duties. The duties of the Medical Staff Performance Improvement Committee shall include the following:

1. Adopting, subject to the approval of the Medical Executive Committee and the Board, specific programs and procedures for reviewing, evaluating, and maintaining the quality and appropriateness of patient care, patient safety, and patient satisfaction within the Medical Center, including mechanisms for: (i) establishing objective criteria; (ii) measuring actual practice against the criteria; (iii) peer analysis of practice variations; (iv) taking appropriate action to correct identified problems; (v) following up on action taken; and (vi) reporting the findings and results of the audit activity to the Medical Executive Committee and Board;

2. Measuring, assessing and seeking improvement in the following areas
   a. Use of medications,
   b. Use of blood or blood components,
   c. Operative and other procedures,
   d. Appropriateness of clinical practice patterns,
   e. Use of information about adverse credentialing decisions.

3. Reviewing and acting upon factors affecting the quality and appropriateness of patient care provided by members of the Medical Staff and Advanced Practice Professional Staff in the Medical Center and in its affiliated medical practices; and

4. Reviewing the findings and results of working groups as defined in the Medical Center's Performance Improvement Plan, including an appropriate Quality Improvement Organization ("QIO") or equivalent entity, and recommending corrective action, if necessary.

C. Meetings. The Medical Staff Performance Improvement Committee shall meet as often as necessary, but at least four (4) times per calendar year, and a written record of its proceedings shall be maintained and reviewed by the Medical Executive Committee.

12.6 Utilization Management Committee.

This committee shall be a subcommittee of and report to the Medical Executive Committee and shall conduct utilization review in accordance with the Medical Center's Utilization Review Plan.

A. Composition. The Utilization Management Committee shall consist of: (i) a Physician member of the Medical Staff who shall serve as the Subcommittee Chair, (ii) a minimum of two (2) additional Physician members of the Medical Staff nominated by the Chief of Staff and approved by the Medical Executive Committee, (iii) the VP-Patient Care Services, (iv) the VP-Finance, and (v) a representative from the Case Management Department appointed by the Chief Executive Officer. A representative from Home Health shall also be a member on an *ad hoc* basis as necessary.

B. Duties. The duties of the Utilization Management Committee shall include the following:
   1. Overseeing the utilization review functions in the Medical Center;
   2. Developing and reviewing the findings of a utilization review plan that is appropriate to the Medical Center and that meets the requirements of state and federal law and any applicable accreditation organizations. Such plan must include provision for at least: (i) review of admissions and of continued Medical Center stay; (ii) discharge planning; and (iii) data collection and reporting;
   3. Requiring that the utilization review plan is in effect, known to members of the Medical Staff and Advanced Practice Professional Staff and functioning at all times;
   4. Conducting such studies, taking such actions, submitting such reports, and making such recommendations as are required by the utilization plan;
   5. Reviewing and evaluating medical records to determine that they: (i) properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; (ii) are sufficiently complete at all times as to facilitate continuity of care and communications between all those providing patient care services in the Medical Center; (iii) meet the standards of patient care usefulness and of historical validity required by the staff and by acknowledged authorities, including The Joint Commission; and (iv) are adequate, in form and content, to permit patient care audit and other quality maintenance activities to be performed; and
   6. Recommending individual cases to the Medical Staff Performance Committee for further review or action.

D. Meetings. The Utilization Review Committee shall meet at least four (4) times per medical staff year, and shall maintain a written record of its proceedings, which shall be reviewed by the Medical Executive Committee.

12.7 Informatics Advisory Committee.

This committee shall be a subcommittee of and report to the Medical Executive Committee.

A. Composition. The Informatics Advisory Committee shall consist of a Physician member of the Medical Staff who shall serve as Chair, one (1) representative from each of the Primary Care practices affiliated with the Medical Center, at least one (1) surgical representative, and one (1) anesthesia provider appointed by the Chief of Staff and approved by the Medical Executive Committee. It shall also include: the VP-Patient Care Services, VP-Finance, and a representative from the Information Systems Department. Additional members of the Medical

Staff, Advanced Practice Professional Staff or Medical Center staff may be invited to attend and participate in *ad hoc* work groups as may be necessary to provide guidance and recommendations on specific areas which may be impacted by technology and its use within the Medical Center.

B. Duties. The Informatics Advisory Committee shall serve as a vehicle to facilitate implementation and manipulation of technology used within the Medical Center to facilitate patient care. Its duties shall include, but not be limited to, the following activities related to technology use within the Medical Center:

1. Managing change;
2. Evaluating physician-focused benefits;
3. Evaluating and assisting to ensure clinical knowledge-based content;
4. Incorporating the Physician care process;
5. Communicating with peers regarding technology;
6. Assisting in training and support;
7. Evaluating vendor system design from the Physicians' perspective;
8. Developing and presenting to the Medical Executive Committee for consideration and adoption, proposed Medical Staff guidelines, policies, and/or rules and regulations to facilitate Medical Staff participation in the use of technology; and
9. Submitting periodic reports to the Medical Staff through the Medical Executive Committee including, at least, a summary of the findings of and specific recommendations resulting from Committee's activities.

C. Meetings. The Committee shall meet only as often as necessary, but not less than twice each year. A permanent record of its proceedings shall be maintained and reviewed by the Medical Executive Committee.

12.8 Pharmacy & Therapeutics Committee.

This committee shall be a subcommittee of and report to the Medical Services/Trauma Committee.

A. Composition. The Pharmacy & Therapeutics Committee shall consist of at least two (2) Active or Active Outpatient Staff members and appropriate representatives of other Services and representatives of pharmacy and nursing.

B. Duties. The duties of the Pharmacy & Therapeutics Committee shall include developing and maintaining surveillance over drug utilization policies and practices, including the following:

1. Assisting in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Medical Center;
2. Advising the Medical Staff and the Medical Center's pharmaceutical department on matters pertaining to the choice of available drugs;
3. Making recommendations concerning new drugs to be stocked on the nursing unit floors and by other Services;
4. Developing and reviewing periodically a formulary or drug list for use in the Medical Center;
5. Evaluating clinical data concerning the use and control of investigational drugs and of research in the use of recognized drugs;
6. Maintaining a permanent record of all activities relating to the pharmacy and therapeutics function and submitting periodic reports and recommendations to the Medical Executive Committee concerning drug utilization policies and practices in the Medical Center and

in the associated Physician practices; and

7. Evaluating drugs with respect to their cost and recommending use of less costly and appropriate alternatives.

C. Meetings. The committee shall meet as frequently as its duties require but not less than four (4) times per year. A permanent record of its proceedings shall be maintained and reviewed by the Medical Services/Trauma Committee.

12.9 Practitioner Health & Advocacy Committee.

A. Composition. The Medical Executive Committee shall serve as the Practitioner Health & Advocacy Committee.

B. Duties. The Practitioner Health & Advocacy Committee shall meet as necessary, and shall carry out the following objectives:

1. Education of Medical Staff, Professional Staff and Medical Center employees on issues related to Practitioner health and impairment;
2. Encouraging, initiating, or assisting any endeavor to improve the health and well-being of all Practitioners; and
3. Identifying and providing assistance to any Practitioner whose ability to provide safe and/or competent medical care to patients may be compromised due to personal or work related stress, medical or psychological impairment, alcohol, chemical or substance abuse/dependency, or other potentially impairing condition.

C. Purpose. The purpose of this process is assistance and rehabilitation, rather than discipline, in order to aid a Practitioner in retaining or regaining optimal professional functions, consistent with protection of patients. Nothing in this Section is intended to preclude or limit the use of the regular corrective action process under these Bylaws whenever such action is deemed necessary and appropriate.

D. Referrals. The Practitioner Health & Advocacy Committee may receive referrals from any source, including self-referral. Upon receipt of the referral, a subcommittee of two members of the Committee who have no, or limited conflict of interest, will be delegated to review the referral. This review shall include:

1. Contact with the referral source(s) to learn specific details of the precipitating event(s), including names of witnesses, if any, who will be contacted; and
2. A discussion of the referral with the identified Practitioner.

E. Report. Upon completion of its review the subcommittee shall prepare a detailed written report, which shall be reviewed by the Committee. If after review of the subcommittee report, the Committee determines that the facts support a conclusion of a Practitioner health issue causing an impairment, or potentially impairing condition, in clinical performance or actions/activities which impact others, sufficient to compromise, or threaten to compromise, patient, staff, or public safety, or lower the quality of care below prevailing standards, or support a conclusion of impairment due to alcohol, chemical or substance use or abuse, a referral will be made to the Colorado Medical Society's Colorado Physician Health Program or other appropriate resource. The Committee may also recommend further remedial action.

F. Remedial Action. The Committee may implement remedial action or recommend that it be implemented by the Chief Executive Officer, without engaging in the corrective action process, through execution of a confidential written agreement with the affected Practitioner. The

agreement shall provide that any breach of the agreement may result in summary suspension and corrective action under the terms of these Bylaws. The agreement may be modified by agreement of all parties upon recommendation of the Practitioner Health & Advocacy Committee. The agreement shall remain in effect until the Practitioner Health & Advocacy Committee recommends change or discontinuation. If either is recommended, a written agreement for review and monitoring of activities will be substituted including a detailed delineation of the monitoring process. Final discontinuation of remediation will be recommended by the Practitioner Health & Advocacy Committee and shall be subject to approval by the Medical Executive Committee.

If a Practitioner refuses to comply with the agreement or if the Practitioner Health & Advocacy Committee determines that the Practitioner has failed to comply with the terms of the agreement, it shall immediately notify the Chief Executive Officer. In accordance with the terms of the agreement, clinical privileges may be summarily suspended and a corrective action process initiated as provided in these Bylaws.

G. Records. All records of the Committee shall be kept in a separate secure file in the Medical Staff office. Such files shall be maintained separately from Credentials or Personnel files. Confidentiality will be maintained except as limited by law, ethical obligation, or when the safety of a patient is threatened and access to this file will be limited to members of the Practitioner Health & Advocacy Committee for as long as written remedial agreements are not breached. If a breach occurs, the file may be reviewed as a part of the corrective action process.

12.10 Joint Conference Committee.

A. Composition and Membership Criteria. The Joint Conference Committee shall consist of four (4) voting members including the Chairperson of Board, the Chief of Staff, and two (2) At-large members including: one (1) member of the Board appointed by the Board Chairperson and one (1) member of the Active/Active Outpatient Staff appointed by the Chief of Staff. The Chief Executive Officer shall serve as an *ex officio* non-voting member of the Committee

The At-large members shall serve a term of two (2) years and shall not serve more than two (2) terms consecutively. Membership terms shall be based on a calendar year. If a vacancy occurs prior to completion of a two-year term a member shall be appointed to fill the unexpired term. For the purpose of determining eligibility for re-appointment, fulfillment of that vacancy for more than six (6) months shall be considered a full two-year term.

The Chairmanship of the Committee shall be for a term of one (1) year and shall alternate between the Chairperson of the Board and the Chief of Staff.

B. Duties. The Joint Conference Committee shall meet as necessary and shall have the following authority and responsibilities:

1. Acting as a medical-administrative-governance liaison committee between the Board, the Medical Staff, and Medical Center Administration;
2. Acting as the deliberative body on matters of policy, Medical Staff Bylaws, Rules and Regulations, including resolution by supermajority vote of any conflict between the Board and the Medical Staff regarding the adoption or revision of Medical Staff Bylaws, Rules and Regulations. A supermajority vote shall require the affirmative vote of at least three (3) members of the Committee;
3. Acting as a forum for reviewing and identifying issues requiring collaboration between the Board and the Medical Staff and referring such issues to appropriate Medical Staff or Board Committees for further action;

4. Acting as a source of education on topics which may have significance to Medical Center/Medical Staff relationships; and
5. Acting on agenda items from the Chairperson of the Board, Chief of Staff, and Chief Executive Officer.

12.11 Representation on Medical Center Committees.

Medical Staff functions and responsibilities relating to liaison with the Board and Medical Center administration, Medical Center accreditation, and disaster planning shall be discharged by the appointment of Medical Staff members to Medical Center management committees as are established to perform those functions. One of the Medical Staff representatives to each such committee shall be designated as the Chair of the Medical Staff delegation to that committee. Appointments of Medical Staff members to any Medical Center management committees shall be made, and such committees shall operate, in accordance with the Medical Center's Bylaws and the written policies of the Medical Center.

ARTICLE XIII
MEETINGS OF THE MEDICAL STAFF

13.1 General Staff Meetings.

A. Regular Meetings.

1. The Medical Executive Committee shall, by standing resolution, designate the time and place for all regular Medical Staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the Medical Staff in the same manner as provided in Section 13.3 for notice of meetings.
2. A regular annual Medical Staff meeting will be held each year in the month of January.
3. The Medical Staff shall meet as a whole at least four (4) times a year.

B. Order of Business and Agenda. The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

1. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting,
2. The delivery of administrative reports from the Chief Executive Officer, the Chief of Staff, Services and committees,
3. The election of officers and or representatives to Medical Staff and Medical Center committees, when required by these Bylaws,
4. Reports by responsible officers, committees, and Services on the overall results of patient care audit and other quality maintenance activities of the Medical Staff and the fulfillment of the other required Medical Staff functions,
5. Recommendations for improving patient care within the Medical Center, and
6. New business.

C. Special Meetings. Special meetings of the Medical Staff may be called at any time by the Board, the Chief of Staff, or upon written request of not less than one-fourth (1/3) of the members of the Active/Active Outpatient Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.2 Committee and Service Meetings.

A. Regular meetings. Committees and Services may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be no less than as required by these Bylaws.

B. Special Meetings. A special meeting of any committee or Service may be called by, or at the request of, the Chief of Service or Chair thereof, the Board, the Chief of Staff, or by one-third (1/3) of the current members of the Service or committee. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.3 Notice of Meetings.

Written or printed notice stating the place, date and time of any general Medical Staff meeting, special Medical Staff meeting, or of any regular committee or Service meeting not held pursuant to resolution shall be delivered either personally or by email to each person entitled to be present thereat not less than four (4) days nor more than ten (10) days before the date of such meeting. Notice of Service or committee meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered forty-eight (48) hours after deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice as his/her address appears on the records of the Medical Center. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 Quorum.

The presence of two-thirds (2/3) of the voting members of the Active/Active Outpatient Staff by person or proxy at any regular or special meeting shall constitute a quorum for the purposes of amendment to these Bylaws. The presence of fifty percent (50%) of such members by person or proxy shall constitute a quorum for the transaction of all other business. Proxies shall be permitted for the purpose of establishing a quorum or for voting for those voting members excused by the Chief of Staff from attendance at the meeting for good cause shown.

13.5 Manner of Action.

Except as otherwise specified, the actions of a majority of the members present and voting at a meeting at which a quorum is present in person or by proxy shall be the action of the group. Action may be taken without a meeting by a Service or committee by a written instrument setting forth the action so taken signed by each member entitled to vote thereat.

13.6 Minutes.

Minutes of all meetings shall be prepared by the secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. The minutes shall be signed by the presiding chair, approved by the attendees, forwarded to the Medical Executive Committee, and made available to the Medical Staff. A permanent file of the minutes of each meeting shall be maintained.

13.7 Attendance Requirements.

A. Regular Attendance. Each Medical Staff member required to attend meetings under Article V of these Bylaws shall be required to attend:

1. At least fifty percent (50%) of the required four (4) regular Medical Staff meetings per year and fifty (50%) of all other Medical Staff meetings duly convened pursuant to these Bylaws, and

2. At least fifty percent (50%) of the required Service and committee meetings of which they are a member.

B. Special Appearance. A Practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular Service or committee meeting shall be so notified. The Chair of the meeting shall give the Practitioner at least ten (10) days advance written notice of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, Special Notice shall be given and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he/she was given such notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner's clinical privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or of the Board or through corrective action, if necessary.

13.8 Continuing Education

There shall be a program of continuing education for all Medical Staff and Advanced Practice Professional Staff members, designed to keep staff informed of pertinent developments in the diagnostic and therapeutic aspects of patient care, treatment and services and to provide other appropriate medical education to staff. Such educational session shall include, among other issues, the assessment and management of pain. The Medical Staff Office shall be responsible for the coordination and scheduling of professional education programs for the Medical Staff and Advanced Practice Professional Staff. Educational sessions shall be held at least four (4) times per year.

ARTICLE XIV
GENERAL PROVISIONS

14.1 Staff Rules and Regulations.

Subject to approval by the Board, the Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Medical Staff and Advanced Practice Professional Staff member in the Medical Center. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular Medical Staff meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a two-thirds (2/3) vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

14.2 Professional Liability Insurance.

Each Practitioner granted clinical privileges in the Medical Center shall maintain in force professional liability insurance and shall provide evidence of such coverage as part of his/her initial and reappointment applications. Minimum acceptable coverage will be $1,000,000 per incident and $3,000,000 in the aggregate.

14.3 Construction of Headings.

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

ARTICLE XV
ADOPTION AND AMENDMENT OF BYLAWS, RULES AND REGULATIONS, AND POLICIES

15.1. Regular Review of Bylaws.

These Bylaws shall be reviewed by the Medical Executive Committee not less than annually for consideration of revisions that may be necessary or advisable.

15.2 Authority to Propose Amendments.

The Medical Executive Committee, Officers of the Medical Staff, and voting Medical Staff Members shall have the authority to propose amendments to these Bylaws Rules and Regulations, and policies of the Medical Staff.

15.3 Medical Executive Committee Review and Recommendation.

Proposed amendments shall be referred to the Medical Executive Committee which shall review and make a recommendation to the Medical Staff for approval, rejection, or modification.

15.4 Medical Staff Approval of Recommendation.

Affirmation or rejection of a Medical Executive Committee recommendation to amend the Bylaws shall be by majority vote of the voting Medical Staff Members. Affirmation or rejection of a Medical Executive Committee recommendation to amend Medical Staff Rules and Regulations or Medical Staff Policies, shall be by majority vote of the voting Medical Staff members present at any regular or special Medical Staff meeting at which a quorum is present.

15.5 Urgent or Technical Action by Medical Executive Committee.

In the event of a documented need for a technical clarification or an urgent amendment to the Medical Staff Bylaws and Rules and Regulations is necessary to comply with law or regulation, the Medical Executive Committee may provisionally approve such urgent amendments and submit such to the Board for provisional approval without prior notification to the Medical Staff. The Medical Executive Committee shall then notify the Medical Staff immediately after submitting any such technical clarification or urgent amendment and seek Medical Staff approval pursuant to Section 15.4.

15.6 Medical Staff Disagreement with Medical Executive Committee Action.

The voting Medical Staff members may propose revisions to any amendment provisionally approved pursuant to Section 15.5.

15.7 Medical Executive Committee and Medical Staff Disagreement.

Should the Medical Staff, at a meeting at which a quorum was present, and acting by a two-thirds (2/3) vote for Bylaws amendment or a majority vote for Medical Staff Rules and Regulations and Policies amendments, reject the recommendations of the Medical Executive Committee made pursuant to Section 15.5, the matter shall be referred by either the Medical Staff or the Medical Executive Committee to the Medical Center's Joint Conference Committee for further consideration.

15.8 Medical Staff Authority to Adopt.

The Medical Staff has the right to adopt Medical Staff Bylaws, Rules and Regulations, and Policies, and

amendments thereto, and to propose them directly to the Board without review or recommendation from the Medical Executive Committee. Such direct action requires approval of two-thirds (2/3) of the voting Medical Staff Members for Bylaws changes or a majority vote for Medical Staff Rules and Regulations and Policies changes.

15.9 Board Approval.

Upon approval of amendments to the Bylaws, Rules and Regulations, or Medical Staff policies, the Chief of Staff, acting on behalf of the Medical Staff, shall propose such amendments directly to the Board. Such amendments shall be effective only when approved by the Board. In the event that the Board does not approve such proposed amendments, the matter will be referred to the Joint Conference Committee for further deliberations and recommendations.

15.10 Board Amendment Initiation.

The Medical Staff Bylaws, Rules and Regulations, or policies shall not be unilaterally amended by either the Board or the Medical Staff.

ADOPTED by the Full Medical Staff at its meeting on January 9, 2020.

Daniel A. Wardrop, MD, Chief of Staff

ADOPTED by the Board of Directors at its meeting on January 28, 2020.

Debbie Farrell, Chairman, Board of Directors

Attachment A

COMPLAINT RESOLUTION PROCESS REPORT

Practitioner ID #: _____
Date Allegation/Concern identified: _____
Date Service Chief notified: _____
Date CRP meeting: _____

Participants:

_____

_____

Summary of Meeting:

_____

_____

_____

Finding: ☐ Concern/Allegation Substantiated

☐ Lack of Evidence to either Support or Reject the Concern/Allegation

☐ Concern/Allegation Unsubstantiated

Recommendation:

_____

_____

_____

_____ _____
Service Chief Date

Medical Executive Committee Review

The Medical Executive Committee reviewed this CRP Report on _____and:

☐ approved the resolution of this concern/allegation

☐ rejected the resolution of this concern/allegation (Document reason below)

Comments:

_____

_____

_____