BYLAWS OF THE MEDICAL STAFF

OF

Medical Staff Bylaws Approved:

Medical Staff.................................................................9/16/2014
Board of Directors.......................................................9/29/2014
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PREAMBLE

WHEREAS, Parkview Medical Center (PMC) is a non-profit corporation organized under the laws of the State of Colorado; and

WHEREAS, its purpose is to serve as a general community medical center providing patient care, education and research; and

WHEREAS, the Organized Medical Staff (voting members) develop, propose amendments to and adopt the medical staff bylaws, rules and regulations and policies; and

WHEREAS, the Medical Staff enforces and complies with medical staff bylaws; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Medical Center and must accept and discharge this responsibility, subject to the ultimate authority of the Medical Center’s Governing Body, and that the cooperative efforts of the Medical Staff, President/Chief Executive Officer, and the Governing Body are necessary to fulfill the Medical Center’s obligation to its patients;

THEREFORE; the Physicians practicing in this Medical Center hereby organize themselves into the Medical Staff in conformity with these Bylaws.
DEFINITIONS

“Allied Health Professional” and “AHP” means a person holding a license, certification, registration, other legal credentials, or is otherwise trained as required by the State of Colorado, who is eligible to provide specified healthcare services at PMC under conditions specified in these Bylaws.

“Chief of Staff” means the Chief of Staff of PMC.

“Governing Body” means the Board of Directors of PMC.

“Locum Tenens” physicians means physicians who do not have a private practice in Pueblo County and who are contracted by PMC or members of the Medical Staff to provide interim medical services, to include on-call obligations, in the absence of the Medical Staff member or when additional temporary assistance is required.

“Medical Executive Committee” and “MEC” mean the executive committee of the Medical Staff, unless specific reference is made to the executive committee of the Governing Body.

“Medical Staff” means all licensed practitioners who are privileged to attend patients in PMC.

“Medical Staff Year” shall begin at the conclusion of the annual general fall meeting of the Medical Staff.

“Organized Medical Staff” means all licensed practitioners who are eligible to vote.

“PM/PI” means Performance Measurement/Process Improvement.

“Practitioner” means an appropriately licensed Medical Physician, Osteopathic Physician, Dentist, or Podiatrist authorized by State law with a statutory right to be eligible to practice.

“President/CEO” means the individual appointed by the Governing Body to act in its behalf in the overall management of PMC.

“Rules and Regulations” means the Medical Staff Rules and Regulations, as adopted and amended from time to time.
ARTICLE I

NAME

The name of this organization shall be “Parkview Medical Center Medical Staff.”

ARTICLE II

PURPOSES

The purpose of these Bylaws is as follows:

1. To facilitate that all patients admitted to, or treated in, any of the facilities, departments or services of PMC shall receive quality health care.

2. To ensure quality professional performance of all practitioners authorized to practice at PMC through the appropriate delineation of the clinical privileges that such practitioner may exercise at PMC through an ongoing review and evaluation of each practitioner’s performance at PMC.

3. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

4. To initiate and maintain rules and regulations for self-governance of the Medical Staff.
ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION I

NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege, which shall be extended only to professionally licensed Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Decisions regarding the granting or denying of Medical Staff membership or clinical privileges shall not be based on gender, race, color, religion, national origin, age, or disability. Reasonable accommodations will be made to the known physical or mental limitations of an otherwise qualified member or applicant unless such accommodations would impose an unacceptable risk to patients or hardship on the operations of PMC. In determining whether an accommodation would impose an unacceptable hardship on the operations of PMC, factors to be considered include, but are not limited to, department rules and standards, budget and resource limitations, and the nature, cost, and feasibility of the accommodation needed.

Members of Parkview Medical Center Medical Staff support patient safety, including willingness to speak up about safety issues, change practices to enhance safety, enhance teamwork, and follow the safety literature.

SECTION 2

QUALIFICATIONS FOR MEMBERSHIP

1. Only applicants licensed to practice in the State of Colorado, who can document their background, experience, training, demonstrated competence, and solid judgment, their adherence to the ethics of their profession, good reputation, and their ability to work with others to assure the Medical Staff and Governing Body that any patient treated by them at PMC shall be given proper medical care, shall be qualified for membership on the Medical Staff. No applicant shall be entitled to membership on the Medical Staff or the exercise of particular clinical privileges at PMC merely by virtue of the fact that he/she is duly licensed to practice Medicine, Osteopathy, Podiatry, or Dentistry in this or any other State, or that he/she is a member of any professional organization, or that he/she has in the past had, or presently has, such privileges at another facility.
All new applicants must have successfully completed a training program approved by Accreditation Council for Graduate Medical Education ("ACGME"), American Osteopathic Association ("AOA"), or American Dental Association ("ADA"). Applicants who are MD’s, DO’s, and DPM’s must be in the process of Board Certification or Board certified as defined by the American Board of Medical Specialties, American Board of Podiatric Surgery, or the AOA in order to be eligible to apply as a new applicant. If in the process of Board Certification at the time of initial appointment, the applicant must become Board certified within the time frame specified by the specialty board or 5 years, whichever is less.

Applicants completing training programs in foreign countries will be considered as meeting training requirements on an individual basis. Certifications from foreign certifying organizations, such as the Royal, French, and Italian Colleges of Physicians or Surgeons, as well as certification in Canada, will be considered on an individual basis.

Maintenance of Board certification is encouraged and may be required in department rules and regulations. If Board certified in more than one specialty, the medical staff member is encouraged to remain certified by the Board that best represents their primary practice. If Board certification expires and there is no departmental requirement and the Medical Staff member elects to not recertify, the member will be required to present documentation at reappointment of 50 hours of Category I CME.

Lifetime certified members must, at the time of reappointment, document 50 hours of Category I CME.

The Medical Executive Committee may grant a hardship waiver of all or part of continuing education requirement in cases of serious illness, military service, or other good cause provided that patient safety and welfare will not be jeopardized by the granting of the waiver.

a. A request for waiver must be made in writing, or electronic equivalent, with the application and with appropriate documentation and include a description of circumstances sufficient to show why compliance is impossible.

b. Waiver requests will be evaluated by the Medical Executive Committee on a case-by-case basis. The Medical Executive Committee will send written notification of its approval or denial of a waiver request. Denial of such a request is not considered an adverse action subject to hearing or appeal.

2. Acceptance of membership on the Medical Staff constitutes the staff member’s agreement that he/she will strictly adhere to the principles of ethics of his/her profession and to each provision contained in the bylaws.
3. Each member of the Medical Staff shall have evidence of current license in the State of Colorado on file at the Medical Staff office at all times. Should any member voluntarily or involuntarily relinquish any license to practice, or reduce or relinquish his/her drug registration he/she will notify the Medical Staff Services department. If the relinquishment or reduction is the result of an adverse action or in response to an investigation or to avoid an adverse action, the Practitioner shall immediately notify the Medical Staff Services department, at the time of relinquishment or reduction, even if under appeal.

4. Should any member voluntarily or involuntarily relinquish, reduce, limit or lose his/her clinical privileges at another hospital, he/she will notify the Medical Staff Services department of such action. If the relinquishment or reduction is the result of an adverse action or in response to an investigation or to avoid an adverse action, the Practitioner shall immediately notify the Medical Staff Services department, at the time of relinquishment, even if under appeal.

5. Any member may voluntarily terminate his/her membership from the Medical Staff.

6. Any qualification requirement in this Article or any other Article of these Bylaws not required by law or governmental regulation may be waived at the discretion of the Governing Body upon recommendation of the Medical Executive Committee, based on the committee’s determination that such waiver will serve the best interests of the patients of PMC.

SECTION 3

CONDITIONS AND DURATION OF APPOINTMENT

1. All appointments made to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, and revocations of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented qualifications obtained from reliable sources other than the Medical Staff.

2. Appointments to the Medical Staff shall not exceed 2 years, as necessary to coincide with the next scheduled reappointment of the clinical department to which the Medical Staff member is assigned.

3. When appropriate, temporary clinical privileges may be granted for a limited period of time by the President/CEO on the recommendation of the Chairperson of the applicable clinical department / service and / or the President of the Medical Staff. Primary source verification of licensure and/or current competence will be done prior to granting temporary privileges. Temporary privileges shall not be granted for more than 60 days. A request for extension of temporary privileges beyond the original 60 days requires a full application process. Recipients of temporary privileges are not afforded any protections under Article IX, Hearing and Appellate Reviews.
4. The reappointment process shall include the evaluation of the professional performance of the individual during his/her previous period of appointment by the Chairperson or his/her designee of each department for which the individual is seeking privileges.

5. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

6. Every application for appointment and reappointment shall be signed, or electronic equivalent, by the applicant and shall contain the applicant’s specific acknowledgement of every Medical Staff member’s obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Bylaws, rules, and regulations, to accept and carry out committee assignments, and to accept appropriate consultation assignments.

7. Any medical administrator or Practitioner whose contractual engagement with PMC requires membership on the Medical Staff will not have his/her Medical Staff privileges terminated without the same due process provided any other members of the Medical Staff.

8. When a Practitioner attains either the age of 59½ with an aggregate of 10 years of service in emergency back-up call at PMC, or the age of 55 with an aggregate of 15 years of service in emergency back-up call at PMC, he/she may choose to apply to the MEC to withdraw from providing emergency back-up call coverage or a reduced schedule of on-call days to the Emergency Department or Medical Staff office, whichever is appropriate. If approved by the MEC, the request will be forwarded to the Governing Body for action. If the request by the Practitioner is approved by both the MEC and the Governing Body, the Practitioner remains responsible for providing care for his/her own patients, whether inpatient or outpatient, though he/she may arrange for coverage by another Practitioner in an appropriate specialty.

9. A staff appointee may obtain a voluntary leave of absence by submitting written notice to the Medical Staff President, for transmittal to the appropriate Department Chair and the President/CEO. The notice must state the approximate time period of the leave, which may not exceed 2 years, except for military service. During the time period of the leave, the staff appointee’s clinical privileges, prerogatives, and responsibilities are suspended, but such suspension is not considered an adverse action reportable to any agency.

10. The staff appointee who has taken a voluntary leave of absence may request reinstatement by sending written notice to the MEC at least 30 days prior to the requested date of reinstatement. The staff appointee must submit a written summary of the relevant activities during the leave and evidence of current competence if the MEC and Governing Body so requests. If the leave was due to a medical condition, which prevented the Practitioner from practicing, the MEC and Governing Body may request the appointee to provide verification from his/her physician. The submitted information should indicate that he/she no longer has a condition, which will prevent him/her from safely exercising the clinical privileges requested. The MEC then makes a recommendation to the Governing Body concerning reinstatement.
ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

1. Clinical privileges are limited to those Practitioners who are members of the Medical, Podiatric, and Dental Staff as indicated below, and to those Allied Health Professionals supervised by the Medical, Podiatric, and Dental Staff as provided in Article V.

2. Members of each staff category shall be limited in their practice to the particular department(s) to which they are appointed, unless voted otherwise by the Medical Executive Committee. They shall limit the scope of their clinical activities to those specified in the signed statement delineating clinical privileges, or electronic equivalent, a copy of which accompanies their official notices of appointment to the Medical Staff.

3. The Medical Staff shall be divided into the following categories:
   a. Active
   b. Affiliate
   c. Non-privileged
   d. Honorary

SECTION 1

ACTIVE MEDICAL STAFF

1. Eligibility

The Active Medical Staff shall be composed of Practitioners who:

a. Meet the general qualifications for Medical Staff membership set forth in Article III;

b. Demonstrate a substantial commitment to the welfare and programs of PMC and the greater Pueblo community; and

c. At the time of initial application to Active Staff Status, reside within Pueblo County, unless the Practitioner obtains a waiver for the residency requirement consistent with process described in Article VI of these Bylaws.
2. Initial Appointment

   a. During the 1st year of the initial appointment to Active staff category, a Focused Professional Practice Evaluation (FPPE) is required that consists of at least 6 cases that are peer reviewed by an Active Medical Staff member within the department for which the Practitioner has been granted privileges. If the Practitioner is assigned privileges in more than one department at least 6 cases are to be reviewed in each department.

   b. Upon completion of the peer reviewed cases, the department chair will make recommendation to the Medical Executive Committee regarding moving the Practitioner into the Ongoing Professional Practice Evaluation (OPPE) process or continuing the FPPE.

   c. In the event of low volume for the first year of the initial appointment, the FPPE will continue until which time at least 6 cases have been reviewed or the Medical Executive Committee makes recommendation to move the practitioner to Non-Privileged staff category.

3. Privileges

   Active Medical Staff members:

   a. May admit, treat, and perform services for, PMC patients as delineated by the department to which the member is assigned;

   b. May vote on all matters presented at general and special meetings of the Medical Staff organization, provided they meet the meeting attendance requirements described in Article XIV, Section 5, of these Bylaws;

   c. May hold office in the Medical Staff organization and committees of which the Practitioner is a member; and

   d. Are afforded all protections under Article IX, Hearing and Appellate Reviews.

4. Responsibilities

   Active Medical Staff members shall:

   a. Satisfy the requirements of the department of which he/she is a member;

   b. Serve in rotation for Emergency Department (ED) or hospital inpatient call in the member’s specialty and shall be available for call for the ED or hospital inpatient on a scheduled basis, unless formally excused from such by the Medical Executive Committee;

   c. Provide quality patient care and participate in PM/PI and education programs. This includes the education of patients/families, coordination of care with other practitioners/personnel, and the accurate, timely, and legible completion of medical records; and

   d. Arrange appropriate on-call coverage and care for his/her patients.
SECTION 2

AFFILIATE MEDICAL STAFF

1. Eligibility

The Affiliate Medical Staff shall be composed of Practitioners who:

a. Meet the general Medical Staff membership requirements set forth in Article III;

b. Function as Locum Tenens Practitioners at PMC or whose primary practice is outside of Pueblo County;

c. Meet a specific hospital and/or community need as has been determined by the Governing Body; and

d. Complete an “Intended Practice Plan” that is approved by the MEC and the Governing Body.

2. Initial Appointment

a. During the 1st year of the initial appointment to the Affiliate staff category, a Focused Professional Practice Evaluation (FPPE) is required that consists of at least 6 cases that are peer reviewed by an Active Member of the Medical Staff within the Department that the practitioner has been granted privileges. In the event the practitioner is assigned privileges in more than one department, at least 6 cases are to be reviewed in each department.

b. Upon completion of the peer reviewed cases, the department chair will make recommendation to the Medical Executive Committee regarding moving the practitioner into the Ongoing Professional Practice Evaluation (OPPE) process or continuing the FPPE.

c. In the event of low volume for the first year of the initial appointment, the FPPE will continue until which time at least 6 cases have been reviewed or the Medical Executive Committee makes recommendation to move the practitioner to the Non-Privileged staff category.

3. Privileges

Affiliate Medical Staff members:

a. Shall be granted an initial appointment of 2 years unless a shorter period is requested by the applicant; or required by the Governing Board;

b. May admit, treat, and perform services for PMC patients, as delineated by the department to which the member is assigned;
c. May serve on committees and vote as members of such committees; however, Affiliate Medical Staff members are not eligible to participate on the Medical Executive Committee and may not vote on matters presented at General and Special meetings of the Medical Staff organization; but
d. Are afforded all protections under Article IX, Hearing and Appellate Reviews.

4. Responsibilities

Affiliate Medical Staff members shall:

a. Satisfy the requirements of the department of which he/she is a member;
b. Provide quality patient care and participate in PM/PI and educational programs; Affiliate Medical Staff members’ responsibilities for patient care are the same as those of the Active Medical Staff, which includes the education of patients/families, coordination of care with other practitioners/personnel, and the accurate, timely and legible completion of medical records;
c. Be required to serve in rotation for Emergency Department (ED) and inpatient hospital call in their specialty at the discretion of their department; and
d. Arrange appropriate on-call coverage for his/her patients with an Active Medical Staff member; the Affiliate Medical Staff member must have a mechanism to notify the hospital of the coverage arrangements.

SECTION 3

**NON PRIVILEGED MEDICAL STAFF**

Non-Privileged Medical Staff shall be composed of Practitioners who:

a. Meet the general Medical Staff membership requirements set forth in Article III;
b. Do not admit patients to PMC;
c. Are not retired; and
d. Reside in Pueblo County; if they do not, a waiver must be requested;
e. Provide at least 80% of their practice in Pueblo County, as determined on a yearly basis as follows:
1. Each Non-Privileged Medical Staff applicant shall complete and provide an annual attestation using a form approved by the MEC which states that, during the preceding year, the Practitioner provided at least 80% of his/her procedures in Pueblo County during the preceding year; each Non-Privileged Medical Staff Member shall submit the annual attestation on or before the deadlines established by the MEC;
   a. The MEC, in its discretion, may make exceptions for short-term noncompliance with the 80% requirement.

2. Privileges

   Non-Privileged Medical Staff members have no privileges at PMC and may not serve on committees, vote in the general Medical Staff meetings, or admit patients to PMC.

3. Responsibilities

   Non-Privileged Medical Staff members shall not be required to:
   a. Provide Emergency Department coverage; or
   b. Attend Medical Staff meetings.

SECTION 4

HONORARY MEDICAL STAFF

Honorary Medical Staff is defined as follows:

   a. An honor that the Medical Executive Committee and the Governing Body may bestow upon practitioners who have retired from practice and who are no longer credentialed or privileged by PMC. Honorary Staff Status affords the option for retired practitioners to attend general Medical Staff and department meetings in a non-voting capacity.

   b. Qualifications for Honorary Medical Staff:
       Any physician who is retired, residing in Pueblo County and who left Parkview in good standing will automatically qualify for Honorary Staff status.
ARTICLE V

ALLIED HEALTH PROFESSIONALS

SECTION 1

CONDITIONS OF ASSIGNMENT

Only Allied Health Professionals (AHP) holding a license, certification registration or other specified credentials, or are otherwise trained as required by the State of Colorado, shall be eligible to provide services at Parkview Medical Center under the following conditions. AHPs:

a. Are not members of the Medical Staff;
b. All Allied Health Professionals shall be classified into one of two categories:
   1. Category I - Allied Health Professional (AHP) – PA/APN
      These include only those persons who possess certification or registration as either a Physician’s Assistant (PA) or a licensed/certified Advance Practice Nurse (APN) that is performing in the roles and responsibilities of that specific level of licensure or certification.
      - Examples are, but not limited to:
        a. Certified Nurse Midwife
        b. Physician’s Assistant
        c. CRNA
        d. Neonatology Nurse Practitioner
        e. Nurse Practitioner – other specialties
      The Category One AHP shall be credentialed and privileged by Parkview Medical Center. The process for approval is the same as for a physician applicant or re-application.
   2. Category II - Allied Health Professional (AHP)
      These include all other physician extenders who do not possess a PA or APN license or certification and are NOT employees of Parkview Medical Center. The AHP shall be credentialed by the Medical Staff Services department, but shall not be privileged. The duties of this category of AHPs shall be designated in their assigned job descriptions that have been developed by Medical Staff Services, the medical staff sponsors, and Parkview Medical Center department directors supervising the areas where the Category II AHPs shall perform their duties. The job descriptions shall be comparable to any like job descriptions of Parkview Medical Center employees. The credentialing information shall be maintained in the Medical Staff Services department;
c. Must be sponsored by a member of the Active or Affiliate Staff. If the practitioner is in the first year of appointment sponsorship of an AHP shall be subject to approval by the Medical Executive Committee and by the Board of Directors;

d. May function and provide patient care to patients under the limits of the sponsor(s) or supervising physician for Category I through privileges granted by the Board of Directors pursuant to the Bylaws and Rules and Regulations of Parkview Medical Center or for Category II AHPs through their specific job description elements;

e. Be credentialed for a period of no more than two (2) years. The sponsor will provide for ongoing assessment of continued competence and will complete a competence assessment at least every two (2) years at the time of reappraisal, using a form provided by Parkview Medical Staff office. The Category I AHPs shall have an on-going professional practice evaluation (OPPE) performed using the same timing criteria as the physician members of the medical staff. The measurement criteria for the OPPE shall be developed and approved by the Medical Staff Services Department and the medical staff sponsoring physicians for each type of Category I AHP; and

f. Shall function in Parkview Medical Center as the agent of their sponsor(s) and/or supervising physician, who accept(s) liability and responsibility for the AHPs actions and medical care.

SECTION 2

CONDITIONS OF ALLIED HEALTH PROFESSIONAL STATUS

AHPs are philosophically seen as physician care extenders and, within the limits of their training and areas of expertise, may provide a variety of services as well as perform a number of functions. Additional regulations governing the actions of the AHP will be found in the Rules and Regulations of the clinical departments of the Medical Staff. Amendments to said Bylaws and Rules and Regulations would supersede all previously written regulations.

a. The AHP may not admit, discharge, provide initial consultations or transfer patients to his/her care unless such privilege is delineated in Department Rules and Regulations. When requested by the sponsoring or supervising physician and under his/her direction, the Category I AHP may, within the scope of his/her privileges, attend a patient in the Medical Center. A Certified Nurse Midwife (Category I AHP) may admit and discharge patients with notification of their sponsoring or supervising physician.

b. No AHP may provide services in the emergency room or operating room unless the sponsoring or supervising physician is physically present in the department.
SECTION 3

CREDENTIALING

(See Medical Staff Policy “Credentialing of Allied Health Practitioners”)

TEMPORARY APPOINTMENT

When appropriate, temporary clinical privileges may be granted to Category I AHPs for a limited period of time by the Chief Executive Officer on the recommendation of the Chairperson of the applicable clinical department/service or the President of the Medical Staff. Primary source verification of licensure and/or current competence will be done prior to granting temporary privileges. Privileges shall not be granted for more than sixty-days. A request for extension of privileges beyond the original sixty-days requires a full application process.

SECTION 4

PREROGATIVES OF THE ALLIED HEALTH PROFESSIONALS

1. Provide specified patient care services solely under the supervision or direction of the physician sponsor and/or supervising physician of the Medical Center; AHPs may not supervise or be the sole proctor or evaluator of another AHP.

2. Service as non-voting members on the Medical Center committees as requested; and

3. Exercise such other prerogatives as shall be afforded to the Category I AHPs pursuant to Colorado Law as a group or to any specific category of AHPs by resolution or written policy duly adopted by the Medical Staff or by any of its departments or committees and approved by the Medical Executive Committee of the Medical Staff and the Governing Body.

SECTION 5

RESPONSIBILITIES OF THE ALLIED HEALTH PROFESSIONAL

1. Maintain professional competence within his/her area of expertise to assure proper care (and supervision for Category I AHPs) of each patient at PMC. The AHP must provide proof of current licensure or certification as applicable.

2. Participate, when requested to do so, in patient care studies and other PM/PI activities as required and in discharging such other staff functions as may be required from time to time.

3. Complete patient medical records in a timely manner as outlined in the Medical Staff Bylaws and Rules and Regulations. Failure to do so will result in suspension of ability to function at Parkview Medical Center until said records are complete.
4. The AHP will be governed by the Medical Staff Bylaws and Rules and Regulations with regard to conduct of care.

5. Once Category I AHPs granted privileges or Category II AHPs are given the ability to provide patient care, the AHP must obtain a security badge from the Parkview Employment Office with their photograph and listing the individual's name and title. This badge must be worn at all times when in the medical center.

SECTION 6

RESPONSIBILITIES OF THE PHYSICIAN SPONSOR

Those practitioners who employ, sponsor, or supervise an AHP shall be required to provide the following:

1. Assist the AHP in completing the application, sign the application, and submit a letter listing specific privileges being requested;

2. Sign a statement assuming responsibility for all actions and conduct of the AHP while on the Medical Center premises (included in application);

3. Supervise all aspects of the care rendered by the AHP. Participate in the quality review upon reapplication of the AHP;

4. Assist in scheduling the non-employed AHPs for an orientation with Medical Staff Services;

5. Provide proof that his/her liability insurance will adequately cover sponsorship of the non-Parkview employed AHP; and

6. Co-sign required documentation within the time limits established by the Bylaws, Rules and Regulations and/or Policies of the Medical Staff.

SECTION 7

CORRECTIVE ACTION AND RIGHT TO HEARING AND APPELLATE REVIEWS

1. Category II AHPs who provide services within Parkview Medical Center pursuant to a letter of agreement between their sponsoring physician and the Medical center have not been granted privileges and, as such are not entitled to fair hearing and appeal in the event of an adverse action taken by the Medical Staff or the Medical Center.

2. Category I AHPs who have been granted privileges by the Governing Body of Parkview Medical Center shall have the right to a hearing when any disciplinary action against him/her results in restrictions of privileges or termination.
3. Such notice shall be delivered in person or by certified mail and shall:

   a. Advise the Category I AHP of his/her right to a Hearing pursuant to the provisions applicable to Allied Health Professionals of the Medical Staff Bylaws;

   b. Specify the number of days following the date of receipt of notice within which a request for a Hearing be submitted;

   c. State that failure to request a Hearing within the specified time period shall constitute a waiver of rights to a Hearing and to an Appellate Review on the matter; and

   d. State that upon receipt of his/her Hearing request, the Category I AHP will be notified of the date, time and place of the Hearing and the grounds upon which the adverse action is based.

4. Request for Hearing

   The Category I AHP shall have fourteen (14) days following his/her receipt of a notice to file a written request for a Hearing. Such requests shall be delivered to the President/Chief Executive Officer of the Medical Center or the President of the Medical Staff either in person or by certified mail.

5. Waiver by Failure to Request a Hearing

   A Category I AHP who fails to request a Hearing within fourteen (14) days following his/her request of a notice to file a written request for a Hearing waives any right to such a Hearing and to any Appellate Review to which he/she might otherwise have been entitled.

6. Notice of Time and Place of Hearing

   Upon receipt of a timely request for hearing, the President/Chief Executive Officer of the Medical Center shall deliver such request to the President of the Medical Staff. At least seven (7) days prior to the Hearing, the President/Chief Executive Office shall send the Practitioner special notice of the time, place and date of the Hearing. The Hearing date shall not be less than seven (7) or no more than forty-five (45) days from the date of receipt of the request for Hearing.

SECTION 8

CONDUCT OF HEARING

1. Hearing Committee

   The Medical Executive Committee, if requested within the required time frame, shall conduct a Hearing.
2. Personal Presence

The personal presence of the Category I AHP who requested the Hearing shall be required. The Category I AHP who fails without good cause to appear and proceed at such Hearing shall be deemed to have waived his/her right to Hearing and Appeal.

3. Presiding Officer

The President of the Medical Staff or designee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the Hearing have a reasonable opportunity to present relevant oral and documentary testimony.

4. Representation

The Practitioner who requested the Hearing shall be entitled to be accompanied only by his/her sponsor.

5. Record of Hearing

A record of the Hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter.

6. Postponement

Request for postponement of a Hearing shall be granted by the Medical Executive Committee only upon showing a good cause and only if the request therefore is made as soon as is reasonably practical.

7. Hearing Report

The Medical Executive Committee shall decide to uphold the adverse action or reverse the action. The AHP will be notified of the outcome.

8. Appeal

a. If the result of the Medical Executive Committee continues to be adverse to the Category I AHP, the notice shall inform the Category I AHP of his/her right to request an Appellate Review by The Governing Body.

b. The Category I AHP shall have seven (7) days following the receipt of notice to file a written request for an Appellate Review. Such request shall be delivered to the President/Chief Executive Officer either in person or by certified or registered mail.

c. A Category I AHP who fails to request an Appellate Review within the time and in the manner specified above waives any right to such review.
d. Upon receipt of a timely request for Appellate Review, the President/Chief Executive Officer shall deliver such request to the Governing Body. As soon as practical, the Governing Body shall request the Appeals Committee of the Board to schedule and arrange for an Appellate Review which shall commence no more than twenty-one (21) days from the date of receipt of the Appellate Review request provided. At least seven (7) days prior to the Appellate Review, the President/Chief Executive Officer shall send the Category I AHP notice of the time, place and date of the review. The time for the Appellate Review may be extended by the Appeals Committee of the Board for good cause if the request therefore is made as soon as is reasonably practical.

e. The Category I AHP 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. The statement shall be submitted to the Appeals Committee of the Board through the President/Chief Executive Officer at least (7) days prior to the scheduled date of the appellate review, except if the Appeals Committee of the Board waives such time limit. A written statement in reply shall be submitted by the Medical Executive Committee and the President/Chief Executive Officer shall provide a copy thereof to the Category I AHP at least four (4) days prior to the scheduled date for the Appellate Review.

f. The Chairperson of the Appeals Committee of the Board of Directors shall be Presiding Officer. Those members of the Appeals Committee of the Board who may have initiated the adverse action or participated in the Medical Executive Committee Hearing will be excused as members of the Appeals Committee of the Board for the purposes of the appeal process. The Board of Directors shall appoint a replacement.

g. The Appeals Committee of the Board, in its sole discretion, shall allow the parties of their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put before him/her by any member of the Appeals Committee of the Board.

h. New or additional matters of evidence, not raised or presented during the original Hearing or in the hearing report and not otherwise reflected in the record, may be introduced at the Appellate Review only with permission of the Appeals Committee of the Board of Directors following an explanation by the party requesting the consideration of such matters or evidence as to the extraordinary reasons it was not presented earlier and comments by the opposing party, if any.
i. The Appeals Committee of the Board may recess the review of proceedings and reconvene the same 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 statements, if allowed, the Appellate Review shall be closed. The Appeals Committee of the Board of Directors shall thereupon, at a time convenient to itself, conduct its deliberations outside those deliberations, and the Appellate Hearing shall be declared finally adjourned.

j. The decision of the Appeals Committee of the Board of Directors is final. The Appeals Committee of the Board may affirm, or reverse the Medical Executive Committee. The Category I AHP and his/her sponsor will be notified of the action of the Appeals Committee of the Board of Directors by certified letter.
ARTICLE VI

PROCEDURE FOR APPOINTMENT, ASSIGNMENT, REAPPOINTMENT AND REASSIGNMENT

SECTION I

APPLICATION FOR APPOINTMENT AND ASSIGNMENT

1. All applications for appointment and assignment to the Medical Staff shall be in writing, or electronic equivalent, signed by the applicant, or electronic equivalent, and shall be submitted on the approved Parkview Medical Center application form. Individuals in administrative positions who desire Medical Staff membership with privileges are subject to the same procedures as all other applicants. The “completed application” shall require detailed information concerning the applicant’s professional qualifications and shall include:

a. The names of least two (2) persons (at least one from last hospital/clinic affiliation) who have had extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant’s professional competence and ethical character, reference letters should not be from a current or potential partner;

b. Information as to whether the applicant’s membership status and/or clinical privileges have been revoked, suspended, reduced, or not renewed at any other hospital or institution;

c. Proof of malpractice insurance in an amount specified by the Board of Directors as appropriate to the staff category;

d. A brief summary of all professional liability action against the applicant, including the nature of any settlement made;

e. Information as to whether applicant’s:
   - Membership in local, state or national medical societies, and/or
   - License to practice any medical profession, and/or
   - License to prescribe drugs in any jurisdiction has ever been suspended or terminated;

f. A statement of physical and mental capabilities;

g. Preference of which clinical department is desired for assignment for voting purposes. No person shall be assigned to more than one (1) clinical department for voting purposes;
h. The application shall require proof of a current valid narcotic license by each person who desires to prescribe narcotics and may also require information as to whether the applicant’s narcotic license has ever been suspended or revoked and recent information concerning the applicant’s malpractice experience, including a consent to the release of information from his present and past malpractice insurance carriers, and from all institutions where applicant has trained or practiced;

i. The applicant will produce evidence of current licensure, relevant training and/or experience and current competency with information from the primary source whenever feasible; and

j. The Applicant will produce evidence of a valid Visa, if applicable.

2. The completed application shall be submitted along with an application fee. All information on the application will be verified before processing. Additional information will be obtained as deemed necessary by the Medical Center from the American Medical Association Physician master File, the American Osteopathic Association, the Federation of State Medical Boards Physician Disciplinary Databank and other sources as appropriate. Information will be obtained from the National Practitioner Data Bank (NPDB). After collecting references and materials deemed pertinent, the application and supporting materials shall be submitted to the Chairperson of the Department or Department Qualifications Committee. The Chairperson of the Department or Qualifications Committee, review and recommendation, shall forward the application to the Credentials Committee for review and recommendation, following which the application will be forwarded for action to the Medical Executive Committee and then to the Board of Directors.

3. In applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his application, authorizes the Medical Center to consult with members of the Medical staff of other facilities with which the applicant has been associated and with others who may have information bearing on his competence, character, and ethical qualifications; consents to the hospital’s inspection of records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as of his/her moral and ethical qualifications for staff membership. Each applicant also releases from any liability all representatives of the Medical Center and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating for applicant his/her credentials, and release from any liability all individuals and organizations who provide information to the Medical Center in good faith without malice information concerning the applicant’s competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

It shall be permissible for qualified Department/Committee representatives of the Medical Staff to review the medical records of the applicant for appointment and reappointment to the Medical Staff.

All applicants for appointment to the Medical Staff shall have the right, upon written request, to appear to give testimony to any Committee reviewing the application.
4. The application form shall include a statement that the applicant has received and read the Bylaws Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges, pledge to provide continuous care, and to be bound by the terms thereof without regard to whether he/she is granted membership and/or privileges in all matters relating to the consideration of his/her application. Voluntary or involuntary termination, reduction, or loss of clinical privileges shall be reported to the Medical Center as outlined in Article III, Section 2.4.

5. Previously successful or currently pending challenges to any licensure or registration (DEA) in any jurisdiction or the voluntary relinquishment of such licensure or registration shall be reported to the Medical Center.

SECTION 2

INITIAL APPOINTMENT PROCESS

1. Within 90 days, unless otherwise extended for good cause, after receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the applicant and shall determine, through information contained in references provided by the applicant and from other sources available to the committee, whether the applicant has established and meets all the necessary qualifications for category of Medical Staff or AHP membership and the clinical privileges requested by him/her. The Credentials Committee shall seek clinical Department recommendations. The application for appointment shall include the recommendations of at least two (2) peers who are not and are not then contemplating to become associated. The Credentials Committee shall submit to the Medical Executive Committee the completed application and its recommendations.

2. Within forty-five days after receipt of the completed application, written report and recommendations of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Governing Body that the applicant can be appointed to the Medical Staff or AHP staff or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

3. When recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.

4. When the recommendation of the Medical Executive Committee is favorable to the physician, the President of the Medical Staff shall promptly forward it together with supporting documentation to the Governing Body.
5. When the recommendation of the Medical Executive Committee is adverse to the physician, either in respect to appointment or clinical privileges, the President of the Medical staff shall promptly notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the Practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in these Bylaws.

6. If after the Medical Executive Committee has considered the report and recommendations of the Hearing Committee and the hearing record as provided in the bylaws, the Medical Executive Committee’s reconsideration recommendation is favorable to the practitioner, it should be processed in accordance with this section, paragraph 4. If such recommendation continues to be adverse, the President of the Medical Staff shall promptly notify the Practitioner by certified mail, return receipt requested. The President of the Medical Staff shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any actions thereon until after the Practitioner has exercised or has been deemed to have waived his/her rights to an Appellate Review as provided in the Bylaws.

7. At its next regular meeting, after receipt of a favorable recommendation, the Governing Body or its Medical Relations Committee shall act in the matter unless otherwise extended for good cause. If the Governing Body’s decision is adverse to the Practitioner in respect to either appointment or clinical privileges, the President/Chief Executive Officer or his/her designee shall promptly notify the Practitioner of such adverse decision by certified mail, return receipt requested. Such adverse decision may be held in abeyance until the Practitioner has exercised or has been deemed to have waived his/her rights under these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer.

8. At its regular meeting, after all the Practitioner’s rights under the Bylaws have been exhausted or waived, unless otherwise extended for good cause, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body’s decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the Executive Committee of the Medical Staff for further consideration. Any such referral back shall state the reasons and shall state a time limit within which a subsequent recommendation to the Governing Body shall be made and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the Governing Body shall make a final decision. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.

9. When the Governing Body’s decision is final, it shall send notice of such decision through the President/Chief Executive Officer or his/her designee to the Secretary of the Medical Staff and a certified mail copy to the Practitioner, return receipt requested.
SECTION 3

APPLICATION FOR REAPPOINTMENT

1. All applications for reappointment to the Medical Staff shall be in writing, or electronic equivalent, signed by the applicant, or electronic equivalent and shall be submitted on a form prescribed by the Governing Body after consultation with the Medical Executive Committee. The reappointment application shall require detailed information concerning the applicant's professional qualifications and shall include:

   a. Information as to whether the applicant's membership status and/or clinical privileges have been revoked, suspended, reduced or not renewed at any other hospital or institution;

   b. A brief summary of all professional liability action against the applicant since the last reappointment, including the nature of the settlement made if settled;

   c. Information as to whether applicant's membership in any organization, or applicant's license to practice his profession or to prescribe drugs in any jurisdiction is under investigation or has been suspended or terminated;

   d. A statement of physical and mental capabilities as it relates to his/her ability to perform the privileges requested;

   e. Information regarding continuing education or further training that would be considered in continuation of current or addition of new privileges; and

   f. Reappointment shall be acted upon by the Board of Directors or designated committee within ninety (90) days of receipt of a completed application prior to their reappointment date.

2. The application shall require proof of a current valid narcotic license by each person who desires to prescribe narcotics and may also require information as to whether the applicant’s narcotic license has ever been suspended or revoked. Additional information will be obtained from the National Practitioner Date Bank (NPDB), Colorado Board of Medical Examiners (COBME), and other agencies as deemed necessary.

3. The applicant will produce evidence of a valid Visa, if applicable.
SECTION 4

REAPPOINTMENT PROCESS

1. Prior to the scheduled Governing Body meeting at which the Practitioner's credentials are to be reviewed, the appropriate Department or Department Qualifications Committee, the Credentials Committee, and the Medical Executive Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal, including the comments of the chairperson of the clinical department to which the Practitioner is assigned, for the purpose of determining recommendations for reappointment to the Medical Staff and for granting of clinical privileges for the ensuing period. The Department Chair or Chair of the Qualifications Committee of the Department shall forward a recommendation to the Credentials Committee, which shall submit its recommendations in writing, or electronic equivalent, to the Medical Executive Committee. This will occur during the same monthly meeting cycle that the recommendations are scheduled for transmission to the Governing Body.

Where non-reappointment or change in clinical privileges is recommended, the reason for such recommendation shall be in writing, or electronic equivalent.

2. Each recommendation by the Department, Credentials Committee and Medical Executive Committee concerning the reappointment and/or renewal of privileges of a Medical Staff member and granting of clinical privileges shall be based upon, but not limited to, the individual’s professional performance, judgment, and clinical and/or technical skills, as indicated in part by the results on PM/PI activities, professional liability filings, actions and final judgments or settlement; his/her ethics and conduct; his/her participation in staff affairs; his/her compliance with medical center bylaws and the Medical Staff Bylaws and Rules and Regulations; his/her cooperation with Medical Center personnel; his/her cooperation with the Medical Center in securing reasonable compensation for its services within a reasonable time period; his/her use of the Medical Center’s facilities for his/her patients; his/her relations with other practitioners; peer review; and his/her general attitude towards patients, the Medical Center and the public. Departmental and/or major clinical service recommendations are part of the basis for the development of recommendations for continued membership on the Medical Staff and/or the delineation, termination, or revocation of individual clinical privileges. Such periodic appraisals shall include consideration of physical and mental capabilities as they relate to the Practitioner’s ability to perform the privileges requested, as well as proof of malpractice insurance in an amount specified by the Board of Directors. A written record of all matters considered in each physician’s reappointment appraisal shall be made a part of the permanent files of the Medical Center.
3. Prior to the scheduled Governing Body meeting at which the Practitioner’s credentials are to be reviewed, the Medical Executive Committee shall make written recommendations to the Governing Body, through the President of the Medical Staff, concerning the reappointment, non-reappointment, and or clinical privileges for each practitioner then scheduled for periodic appraisal. Where non-reappointment or change in clinical privileges is recommended, the reason for such recommendation shall be in writing, or electronic equivalent.

4. Extensions beyond the two-year appointment period are not allowed.

5. Failure to submit paperwork on time for reappointment may result in a requirement to reapply and the applicant will be charged the fee for an initial application.

6. It is Parkview Medical Center’s policy to process all applications with equal standards only after the medical staff office has obtained a completed verified application. It is the intent of this policy to review applications and gather all primary source verification information necessary for the Credentials Committee and all other committee’s to have an accurate picture of the applicant and their verified history of training and work in order to make a knowledgeable decision on their ability to serve on the medical staff at Parkview. All policies and procedures for the Credentialing and Re-Credentialing of applicants to the Medical Staff at Parkview Medical Center are reviewed and revised no less often than every two years by the Director of Medical Staff Services, the Vice President of Medical Affairs, the Chief Executive Officer and sent to the Credentials Committee, Medical Executive Committee, Medical Relations Committee and the Parkview Board of Directors for final approval.

7. Upon receipt of a new application request, the applicant is mailed all the pertinent information currently approved and requested for new applicants.

8. A checklist is included for the ease of the applicant to assure the application is complete on the first submission. Upon receipt of a complete application, the Parkview Medical Staff Services office begins processing the applicant’s information and history.

9. Please refer to the specific process policies:

- MSS.710 – Criminal Background Search as Part of Medical Staff Credentialing
- MSS.720 – Primary Source Verification for Credentialing
- MSS.750 – Fast Track Credentialing
- MSS.765 – Temporary Privileges for Applicants to the Medical Staff at Parkview Medical Center
- MSS.766 – Credentialing and Monitoring of Volunteer Physicians during a State of Disaster
- MSS.770 – Time Frame for Appointment and Reappointment
10. After all processing is complete, the Credentialing Coordinator completes a checklist to assure all information has been received; there are no gaps that have not been explained; and there is no conflicting information. That is completed on the fast track form and physician profile sheet.

11. If the applicant has signed an application, or electronic equivalent, and the applicant did not complete the application, it will be returned to the applicant for correction or completion; or if the applicant signed the application, or electronic equivalent, and Parkview received it more than sixty (60) days after the application’s signature date, the applicant will be asked to sign a new attestation of application with the current date that is reflective of the time it was actually delivered or mailed to Parkview Medical Center Medical Staff Office. All applications are completed in less than one hundred and eighty (180) days from the date of applicant signature. No primary verifications will be accepted that are dated more than one hundred and eighty (180) days prior to approval by the final committee review. No letters of recommendation dated more than 1 year prior to application will be accepted for committee review.

12. Requests for changes to any Credentialing or Re-Credentialing Policies will be directed to the Director of Medical Staff Services and routed through the personnel and committees as stated in the policy statement. All requests for changes will be acted upon within ninety (90) days.

SECTION 5

REQUEST FOR WAIVER OF RESIDENCY REQUIREMENT

The residency requirement for Active Medical Staff members may be waived by the Governing Board of Directors on a case-by-case basis upon receipt of a written recommendation of the Medical Executive Committee. The process for obtaining a waiver of the residency requirement is as follows:

1. Prior to submission of an initial application for the Active Medical Staff, the Practitioner shall submit a written letter clearly describing, in detail, the Practitioner’s basis for requesting waiver of the residency requirement.

2. The Medical Executive Committee and Governing Board of Directors shall each make a determination on the Practitioner’s request within 30 days of receipt of such request. The Governing Board of Directors final determination will be sent to the Practitioner at the address provided via certified mail, return receipt requested. The Governing Board of Directors will provide a brief explanation of its reasoning in its written determination.

3. Any member of the Medical Executive Committee or Governing Board of Directors who practices the same specialty as the Practitioner who submits a waiver request shall recues himself / herself from the process of granting or denying the waiver request.
4. In determining whether to grant or deny the waiver request, the Medical Executive Committee and Governing Board of Directors shall each consider the following factors:

   a. Community need for the Practitioner’s services. Factors bearing upon community need include, but are not limited to:
      
      i. Studies indicating the current and expected numbers of Practitioners having the same specialty in the relevant geographic area;
      
      ii. The population demographics of the relevant geographic area, including disease or illness specific data that bears upon Practitioner’s specialty;

   b. PMC’s need for the Practitioner’s services, including the number of Practitioners who are members of the Medical Staff having the same specialty;

   c. Practitioner’s ability to satisfy call coverage requirements for the given specialty;

   d. The nature of the Practitioner’s practice (e.g., whether the Practitioner is a hospital-based physician), and specifically whether Practitioner’s practice would typically require follow-up care or care coordination to properly meet the needs of PMC’s patients; and

   e. Any other factors deemed to be important by either the Medical Executive Committee or the Governing Body of the Board of Directors.

5. Denial of a requested waiver of residency requirement does not entitle the Practitioner to any of the protections under Article IX, Hearing and Appellate Reviews. However, the Practitioner may request reconsideration of the Medical Executive Committee or Governing Board of Directors decision to deny a requested waiver of the residency requirement by filing a written request for reconsideration within 15 days of the issuance of the denial, in which case the MEC shall render a decision regarding the request for reconsideration within 30 days from its receipt of a timely request. The Governing Board of Directors shall not be required to hold an in-person hearing for such an appeal. Further, the Governing Board of Directors decision on appeal shall be binding and not subject to further appellate review.
ARTICLE VII

CLINICAL PRIVILEGES

SECTION 1

CLINICAL PRIVILEGES

1. Every Practitioner practicing in the Medical Center by virtue of Medical Staff membership shall, in connection with such practice and every other practitioner granted clinical privileges, be entitled to exercise those categories or types of Clinical Privileges specifically granted to him/her by the Governing Body, except as provided in Section 2.

2. Every initial application for staff membership must contain a request for the specific categories or types of clinical privileges, including the privilege to admit patients, desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, experience, demonstrated competence, references and any other relevant information requested, including an appraisal by the Clinical Department in which such privileges are sought.

Categories of types of clinical privileges in each Clinical Department shall be defined periodically by the members of such Department, subject to the provisions in the above paragraph. It is expected that it would only be in a very unusual situation that a physician would be granted unlimited privileges in more than one Department.

Periodic re-determination of clinical privileges and the increase or curtailment of the same shall be based upon the direct observation of care provided when reasonably obtainable, review of the records of patients treated in this or other facilities, and review of the records by the Medical Staff which document the evaluation of the member's participation in the delivery of medical care. Applications for additional clinical privileges must be in writing, or electronic equivalent, and should be processed in the same manner as applications for initial appointment. See associated privileging process details in Rules and Regulations and Credentialing policy MSS.717.5 Granting of Privileges.
3. HISTORY AND PHYSICAL

a. A medical history and physical examination shall be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. For H&Ps completed before admission or registration, an update to the H&P must be documented within 24 hours of admission and prior to any surgery or procedure requiring anesthesia and may be recorded in the first progress note. The medical history and physical examination must be completed and documented by a physician, or other qualified licensed individual credentialed and privileged medical staff member or allied health professional in accordance with state law and hospital policy.

b. When podiatric surgeons or oral surgeons admit patients for inpatient care or same day surgery with pre-existing medical or psychological conditions that need to be managed, a consultation shall be obtained from an MD or DO upon admission. If a medical condition develops during the hospitalization, a consultation shall be obtained from an MD or DO to manage the medical care.

c. Dental admission shall have an H&P completed by a doctor of medicine or osteopathy if the dentist is not an oral surgeon.

d. An H&P shall be completed by a medical physician for psych admissions.

e. H&P needs to include all components set forth below. For an emergency situation, the H&P need not be on the chart prior to surgery, but should follow once the patient is out of imminent danger. An observation admission shall also have a history and physical completed, or a detailed admission note containing a history of the current problem, reason for admission and plan of care.

f. For elective surgeries and medical admissions, the physician’s office H&P is acceptable if it has been completed within the time frames set forth above. The office H&P shall include all components set forth below.

g. If a patient is readmitted within 30 days with same or related condition, the physician shall indicate any history and physical changes in the first progress notes and completes the H&P update form. The previous medical center H&P shall be readily available in the unit record.

h. The prenatal office notes are acceptable, as part of the H&P. The physician shall document any updates in the H&P from the last prenatal visit to admission to the hospital by completing the obstetrical H&P form. This form completed in its entirety is acceptable for patients going to surgery either for cesarean or tubal ligation.
i. The history portion of the H&P shall include the chief complaint; details of present illness and when appropriate, an assessment of the patient's emotional, behavioral, and social status; relevant past medical/surgical history; allergies; medications; family history; and social history; age appropriate psychosocial assessment (may refer to nursing assessment); and review of systems.

j. For pediatric patients, in addition to e above, the H&P shall include an appropriate assessment of the patient's developmental age versus chronological age; immunizations status; educational needs and list of daily activities; and patient's family involvement in the treatment plan and continuous care of the patient (may refer to nursing assessment).

k. The physical examination shall be a comprehensive, current examination by the physician with in-depth examination and documentation noted for the specific problem under examination.

l. A statement listing the assessment/impression shall be included.

m. A course of action planned for the patient while hospitalized shall be included. There is a periodic review of the treatment plan and changes to the plan shall be documented in the progress notes.

n. A brief history and physical is required for outpatients outside of the operating room, who are undergoing invasive procedures which place them at a significant risk and/or who will be receiving conscious sedation. This H&P must be completed and on the record prior to the procedure. The history and physical must contain at a minimum the reason for the procedure, significant medical problems, medications, allergies, vital signs, and examination of the heart, lungs and body system or part where the procedure will be performed.

SECTION 2

EMERGENCY PRIVILEGES

For the purpose of this section an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In case of emergency, any practitioner to the degree permitted by his/her license and regardless of service or staff status, shall be permitted and assisted to do everything possible to save the life of the patient, or to save the patient from serious harm using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the necessary privileges to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.
SECTION 3

DISASTER PRIVILEGES

Disaster privileges may be granted to volunteer physicians reporting when a disaster plan has been implemented if the incident commander determines that the organization is unable to meet immediate patient needs. Disaster privileges must be granted by both Chief Executive Officer or the Command Center Administrator and the Vice President for Medical Affairs or Medical Staff President or, in their absence, the Medical Staff Vice President, Medical Staff Secretary or Credentials Chair.

See associated process details in Credentialing Policy MSS.766 Credentialing Volunteer Physicians/Other Licensed Individuals During a Disaster.
ARTICLE VIII

CORRECTIVE ACTION

SECTION 1

PROCEDURE

1. Whenever the activities or professional conduct of any Practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or to be disruptive to the operation of the Medical Center, corrective action against such practitioner may be requested by any Officer of the Medical Staff, by the Chairperson of any clinical department, by the Chairperson of any standing committee or sub-committee of the Medical Staff, by the President/Chief Executive Officer or his/her designee, or by the Governing Body. All requests for corrective action shall be in writing, or electronic equivalent, to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitutes the grounds for the request. The Medical Staff will adopt and update as necessary the policies and procedures for impaired/disruptive Medical Staff members.

2. Action by the Office of the Inspector General to exclude the practitioners from federal and federally supported programs shall initiate an automatic investigation for potential corrective action by a committee appointed by the President of the Medical Staff. During the investigation, the Practitioner will be removed from Emergency Department call, be prohibited from providing any services for patients on federally funded programs in the Medical Center and from providing services for the Medical Center. If the investigation results in an action adverse to the Practitioner, he/she may exercise his/her right to a Hearing as provided in Article IX of these Bylaws. If the results of Hearing and Appeal results in suspension of clinical privileges, he/she will be eligible to have privileges reinstated when the exclusion expires or is cleared.

3. Whenever the corrective action could be a reduction or suspension of clinical privileges or a suspension or expulsion from the Medical Staff, the Medical Executive Committee shall forward such request to the Practitioner and to the Chairperson of the Department wherein the Practitioner has such privileges. Upon receipt of such request, the Chairperson of the Department shall immediately appoint an Ad Hoc Committee of at least three (3) persons, not in economic competition with the Practitioner, to investigate the matter.
4. Within fourteen (14) days after the Chairman’s receipt of the request for corrective action, the Ad Hoc Committee shall make a report of the investigation to the Medical Executive Committee. Prior to the making of such report, the Practitioner against whom the corrective action has been requested shall have an opportunity for an interview with the departmental ad hoc investigating committee. At such interview, he/she shall be informed of the charges against him/her, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing and shall be preliminary in nature and none of the procedural rules provided in these bylaws with respect to the hearing shall apply thereto. Minutes of such interview shall be taken by the Committee.

5. Within fourteen (14) days following receipt of the report from the Ad Hoc Committee following the investigation of a request for corrective action involving reduction or suspension of clinical privileges, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, the Practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to it taking action on such request. This appearance shall not constitute a Hearing and shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to Hearing shall apply thereto. The Medical Executive Committee shall make minutes of such appearance.

6. Except for those instances which are governed by Section 2-1 of this Article, an adverse recommendation by the Medical Executive Committee shall entitle the affected Practitioner to the procedural rights in Article IX of these Bylaws.

7. The Chairperson of the Medical Executive Committee (President of the Medical Staff) shall promptly notify the President/Chief Executive Officer in writing, or electronic equivalent, of all request for corrective action received by the Medical Executive Committee and shall continue to keep the President/Chief Executive Officer or his/her designee fully informed of all action taken in connection therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be provided in these Bylaws.

SECTION 2

SUMMARY SUSPENSION

1. The President of the Medical Staff, on recommendation of the Medical Executive Committee, shall have the authority whenever action must be taken immediately in the best interest of patient care in the Medical Center, to precautiously suspend all or any portion of the clinical privileges of a Practitioner, and such suspension shall become effective immediately upon imposition. Such Summary Suspension shall be deemed an interim precautionary step (not reportable to the National Practitioner Data Bank) in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual, and is not a complete professional review action in and of itself a reportable offense. It shall not imply any final finding of the responsibility for the situation that caused the suspension.
A Summary Suspension shall become effective immediately upon imposition, shall immediately be reported in writing, or electronic equivalent, to the Chief Executive Officer and the Medical Executive Committee by the President of the Medical Staff and shall remain in effect, unless, or until modified by the President of the Medical Staff and the Medical Executive Committee.

2. Immediately upon the imposition of a suspension, the Chairperson of the Medical Executive Committee or the responsible Department Chairperson shall have the authority to provide the alternative medical coverage for the patients of the suspended practitioner still in the Medical Center at the time of suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

3. A review of the matter resulting in Summary Suspension shall be completed within a reasonable time period not to exceed thirty (30) days or reasons for the delay shall be transmitted to the Governing Board so that the Board may consider whether the suspension should be lifted or extended. In the event the suspension is not lifted at that time, the Medical Center shall bring action under the provisions of Article IX.

SECTION 3

**AUTOMATIC SUSPENSION**

1. Delinquent Medical Records

Physicians may be suspended for any delinquent records. Delinquent records are defined as those records that are not completed within thirty (30) days after patient discharge. Suspension is defined as a temporary suspension of privileges from the date the suspension list is created. The physician shall not admit new patients to inpatient, observation or same day surgery status under his/her name or any other physician name. The physician shall not schedule surgeries or procedures while he/she is on the suspension list. Previously scheduled surgical or procedures will remain scheduled. Upon completion of all incomplete medical records by the physician, Health Information Services will remove him/her from the suspension list. This immediately reinstates the physician to the medical staff and full admitting or scheduling privileges are granted to the physician. Refer to the Medical Staff Rules and Regulations for specific policies on completion of medical records and suspension.

The Regulatory Compliance Coordinator shall contact the Emergency Room, Admissions Office, Department of Surgery (OR), Same Day Surgery and other Departments contacted at the time of suspension.
2. Mandatory Meetings

Whenever a Practitioner fails to attend a meeting to which he was given notice that attendance was mandatory, and no postponement was granted, automatic suspension will occur. Upon review CEO and VPMA or Chief of Staff may uphold and/or reverse the suspension or institute the corrective action process.

3. State Board Action

Action by the State Board of Medical or Dental Examiners, revoking or suspending a “Practitioners” license, shall automatically revoke or suspend all of his/her Medical Center privileges. When the decision is rendered by an agency, Parkview Medical Center will then uphold the decision of said agency.

4. DEA Action

Action by the DEA reducing, revoking, or suspending a DEA certificate will automatically and correspondingly trigger a review of the Practitioner with a possibility of reduction, revocation, or suspension of his/her privileges of the Medical Center that may be related to the DEA action.
ARTICLE IX

HEARING AND APPELLATE REVIEWS

SECTION 1

RIGHT TO HEARING AND APPELLATE REVIEWS

1. Recommendations or Actions

The following recommendations or actions shall, if deemed adverse pursuant to Section 1B of this Article, entitle the practitioner affected thereby to a hearing:

a. Denial of initial staff appointment
b. Denial of reappointment
c. Suspension of staff membership
d. Revocation of staff membership
e. Denial of requested advancement in staff category
f. Reduction in staff category
g. Limitation of the right to admit patients
h. Denial of requested department/service/section affiliation
i. Denial of requested clinical privileges
j. Suspension of clinical privileges
k. Reduction of clinical privileges
l. Revocation of clinical privileges

Admonitions, reprimands, warnings, whether verbal or written, are not considered to be adverse actions and not reportable to the State of Colorado or the National Practitioner Data Bank and the recipients thereof, while entitled to interviews, are not entitled to Hearings or Appellate Reviews. Suspensions or reduction of privileges for less than thirty (30) days are not reportable to the National Practitioner Data Bank, but do entitle the practitioner to Hearings or Appellate Review except that suspensions pursuant to Section 2 and 3 are entitled to interviews with the Medical Executive Committee pursuant to Article VIII, Section 1. A recommendation or action listed Section 1 (1) of this Article shall be deemed adverse only when it has been:
a. Recommended by the Medical Executive Committee;

b. Taken by the Governing Body contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to hearing existed; or

c. Taken by the Governing Body on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

2. Notice of Adverse Recommendations or Actions

A practitioner, against whom an adverse recommendation or action has been taken pursuant to Section 1(2) of this Article, shall promptly be given special written notice of such action. Such notice shall be delivered in person or by certified mail and shall:

a. Advise the Practitioner of his right to Hearing pursuant to the provisions of the Medical Staff Bylaws and the reasons for the proposed action;

b. Specify the number of days (not more than 30 days) following the date of receipt of notice within which a request for a hearing be submitted. Such request shall be delivered to the Chief Executive Officer of the Medical center in person or by certified mail;

c. State that failure to request a Hearing within a specified time period shall constitute a waiver of rights to a Hearing and to an appellate review on the matter; and

d. State that upon receipt of his/her Hearing request, the Practitioner will be sent another notice that indicates the date, time and place of the Hearing, which cannot be held earlier than thirty (30) days after the second notice. A list of witnesses expected to testify at the Hearing against the Practitioner shall be provided.

3. Waiver by Failure to Request a Hearing

A Practitioner who fails to request a Hearing within the time and in the manner specified in Section 1(1) waives any right to such a Hearing and to any Appellate Review to which he/she might otherwise have been entitled. Such waiver in connection with:

a. An adverse action by the Governing Body shall constitute acceptance of this action, which shall thereupon become effective as the final decision by the Governing Body; or
b. An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Governing Body. The Governing Body shall consider the committee's recommendation at its next regular meeting following the waiver. In its deliberation, the Governing Body shall review all relevant information received from any source. If the Governing Body's action on the matter is in accord with the Medical Executive Committee's recommendation, such action shall constitute a final decision of the Governing Body. The President/Chief Executive Officer shall promptly send the Practitioner special notice informing him/her of each action taken pursuant to this section and shall notify the President of the Medical Staff and the Medical Executive Committee of each action.

SECTION 2

REQUEST FOR HEARING

1. Notice of Time and Place for Hearing Other Than for Precautionary Suspension

Upon receipt of a timely request for hearing, the President/Chief Executive Officer of the Medical center shall deliver such request to the President of the Medical Staff or to the Governing Body depending on whose recommendation or action prompted the request for hearing. At least thirty (30) days prior to the Hearing, the President/Chief Executive Officer shall send the Practitioner special notice of the time, place, and date of the hearing. The beginning Hearing date shall not be less than thirty (30) days or no more than forty-five (45) days from the date of receipt of the request for Hearing, provided, however, that a Hearing for the Practitioner who is under Precautionary Suspension in effect shall be held as soon as the arrangements for it may reasonably be made, but not earlier than thirty (30) days from the date of receipt of the request for Hearing unless agreed to by all parties.

2. Statement of Issues and Events

The notice of Hearing required by these Bylaws shall contain a concise statement of the Practitioner's alleged acts or omissions, a list of specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is subject of the Hearing.
3. Appointment of Hearing Committee/Hearing Officer

a. A Hearing occasioned by an adverse recommendation by the Medical Executive Committee or by the Governing Board pursuant to these Bylaws shall be conducted by a Hearing Officer appointed by the President of the Medical Staff who is not in direct economic competition with the Practitioner or a panel of three physicians not in direct economic competition with the Practitioner involved. One member of the panel so appointed shall be designated as Chairperson by the President of the Medical Staff.

b. Service on Hearing Committee
A Medical Staff or Governing Body member shall be disqualified from serving on a Hearing Committee or serving as a Hearing Officer if he/she has significantly participated in initiating or investigating the underlying matter at issue. A Hearing Officer may be from outside the Medical Center and can be an active or retired physician, attorney or administrative law judge approved by the Medical Executive Committee. Anytime “Hearing Committee” is mentioned herein, the term “Hearing Officer” is automatically included.

SECTION 3

CONDUCT OF HEARING

1. Personal Presence

The personal presence of the Practitioner who requested the Hearing 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 right in the same matter and with the same consequence as provided in Section 1(4).

2. Presiding Officer

In the event that a panel of three physicians is named to hear the matter, the Chairperson of the Hearing Committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and assure that all participants in the Hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the Hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.
3. **Representation**

The Practitioner who requested the Hearing shall be entitled to be accompanied and represented at the Hearing by one person of his/her choice, which may be an attorney. The Medical Executive Committee or the Governing Body, depending on whose recommendation or action prompted the Hearing, shall appoint an individual, which may be an attorney, to represent the facts in support of its adverse recommendation or action and to examine witnesses.

4. **Rights of Parties**

During a Hearing, each of the parties shall have the right to:

   a. Call and examine witnesses;
   
   b. Introduce exhibits;
   
   c. Cross-examine any witness or any matter relevant to the issues;
   
   d. Impeach any witness;
   
   e. Rebut any evidence; and
   
   f. Be called and examined as if under cross-examination by the individual presenting the matter.
   
   g. Both parties have the right to provide a written statement at the conclusion of the Hearing.
   
   h. The Hearing Panel’s or Hearing Officer’s decision must be in writing and shall include the Findings of Fact on which this decision was made.
   
   i. Any decision in the matter by the Medical Executive Committee or the Governing Body must be in writing and shall include the basis on which the decision was made.

5. **Procedure and Evidence**

A record of the Hearing shall be made by the use of a court reporter or an electronic recording unit. The Hearing need not be conducted strictly according to rules of law relating to the examination of witness or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The Hearing Committee/Hearing Officer shall also be entitled to consider all other information that can be considered, pursuant to the Medical Staff Bylaws, in reappointment to the Medical Staff and for Clinical Privileges. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the Hearing Record.
6. Official Notice

In reaching a decision, the Hearing Committee may take official notice, either before or after accepted technical or scientific matter relating to the issues under consideration and of any facts that may be Judicially Noticed by the Colorado Courts. Parties present at the Hearing shall be informed of the matters to be noticed and those matters shall be noted in the Hearing record. Any party shall be given opportunity, on a timely request, to request that a matter is Officially Noticed and to refute the Officially Noticed matters by evidence or by written or oral presentation of authority. The matter of such refutation is to be determined by the Hearing Committee/Hearing Officer.

7. Burden of Proof

When a Hearing related to Section 1(1) (a), (h), or (i), the Practitioner who requested the Hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation of the action lacks substantial factual basis or that such basis or conclusions drawn there from are either arbitrary or capricious.

8. Postponement

Request for postponement of a Hearing shall be granted by the Hearing Committee/Hearing Officer only upon a showing of good cause and only if the request therefore is made as soon as is reasonably practical.

9. Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee shall constitute a quorum of that Committee. If a committee member is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

10. Recesses and Adjournment

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and summation if desired and permitted, the Hearing shall be closed. The Hearing Committee/Hearing Officer shall thereupon, at a time convenient to itself/himself/herself, conduct their deliberations outside the presence of the parties. Upon conclusion of their deliberations, the Hearing shall be declared finally adjourned.

11. Hearing Committee Report/Hearing Officer Report

The Hearing Committee/Hearing Officer shall make a written report of its findings and recommendations to the matter and shall forward the same, together with the hearing record and all other documentation by it, him/her, to the Body whose adverse recommendation or action caused the Hearing.
SECTION 4

ACTION OF HEARING COMMITTEE REPORT

1. Consideration of Hearing Committee Report

Within twenty-one (21) days after receipt of the report of the Hearing Committee/Hearing Officer, the Medical Executive Committee or the Governing Body as the case may be shall consider the same and affirm, modify, or reverse the recommendation or action in the matter. It shall transmit the result together with the hearing record, the report of the Hearing Committee and all other documentation considered to the President/Chief Executive Officer.

2. Notice, Effect and Result

a. Notice

The President/Chief Executive Officer shall promptly send a copy of the result to the Practitioner, to the President of the Medical Staff, to the MEC, and to the Governing Body.

b. Effect of Favorable Result

- Adopted by the Governing Body

If the Governing Body’s result, pursuant to Section 4 (1), is favorable to the Practitioner, such result shall become the final decision of the Governing Body.

- Adopted by the Medical Executive Committee

The MEC’s President/Chief Executive Officer shall promptly forward decision together with all documentation, to the Governing Body for its final action.

The Governing Body shall take action thereon by adopting or rejecting the Medical Executive Committee’s result in whole or part, or by referring the matter back to the Medical Executive Committee for further consideration. Any referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Governing Body must be made, and may include a directive that any additional hearing be conducted by the Medical Executive Committee to clarify issues that are in doubt. After receipt of such subsequent recommendation, the Governing Body shall take final action. The President/Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section 4 (2) b. Favorable action shall become the final decision of the Governing Body. If the Governing Body’s action is adverse in any of the respects listed in Section 1(1) of this Article, the notice shall inform the Practitioner of his/her rights to request an appellate review by the Governing Body as provided in Section 5(1) of this Article.
c. Effect of Adverse Result

If the result of the Medical Executive Committee or if the Governing Body continues to be adverse to the Practitioner in any of the respects listed in Section 1(1) of this Article, the notice required by Section 4(2)(a) shall inform the Practitioner of his/her right to request an appellate review by the Governing Body as provided in Section 5(1) of this Article.

SECTION 5

APPEAL TO THE GOVERNING BODY

1. Request for Appellate Review

Practitioner shall have seven (7) days following his/her receipt of notice pursuant to Section 4 (2) b or 4 (2) c to file a written request for an Appellate Review. Such request shall be delivered to the President/Chief Executive Officer either in person or by certified or registered mail and may include, to the extent he/she has not previously been given it, a request for a copy of the report and record of the Hearing Committee and all other exhibits, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse action or result.

2. Waiver by failure to Request Appellate Review

A Practitioner who fails to request an Appellate Review within the time and in the manner specified in Section 5(1) above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 1(5) of this Article.

3. Notice of Time and Place for Appellate Review

Upon receipt of a timely request for Appellate Review, the President/Chief Executive Officer shall deliver such request to the Governing Body. As soon as practical, the Governing Body shall schedule and arrange for an Appellate Review which shall commence no more than twenty-one (21) days from the date of receipt of the Appellate Review request 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, if possible not later than seven (7) days from the date of receipt of the request for review. At least five (5) days prior to Appellate Review, the President/Chief Executive Officer shall send the Practitioner notice of the time, place, and date of review. The time for the Appellate Review may be extended by the Appellate Review Body for good cause if the request therefore is made as soon as is reasonably practical.

4. Appellate Review Body

Appellate Review shall be by the Appeals Committee of the Medical Center.
5. Nature of Proceeding

The proceedings by the Appellate Review Body shall be in the nature of an Appellate Review based upon the record of the Hearing before the Hearing Committee, the Committee’s report, and all subsequent action thereon. The Appellate Review Body shall also consider the written statements, if any, submitted pursuant to Section 5(6) of the Article and such other material as may be presented and accepted under Section 5(8) and 5(9) of this Article.

6. Written Statements

The Practitioner seeking the Review may 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 Appellate Review Body through the President/Chief Executive Officer at least seven (7) days prior to scheduled date of the Appellate Review, except if the Appellate Review Body waives such time limit. A written Statement in reply may be submitted, by the Medical Executive Committee, or the Governing Body and, if submitted, the President/Chief Executive Officer shall provide a copy thereof to the Practitioner at least two (2) days prior to the scheduled date for the Appellate Review.

7. Presiding Officer

The Chairperson of the Appellate Review Body shall be Presiding Officer. He/She shall determine the order of the procedure during the review, make all required rulings and maintain decorum.

8. Oral Statement

The Appellate Review Body, in its sole discretion, may allow the parties and their representatives to personally appear and make an oral statement in favor of their positions. Any party or representative so appearing shall be required to answer questions put by him/her by any member of the Appellate Review Body.

9. 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, may be introduced at the Appellate Review only with permission of the Appellate Review Body following explanation by the Party requesting the consideration of such matters or evidence as to the extraordinary reasons it was not presented earlier and comments by the opposing Party, if any.
10. Powers

The Appellate Review Body shall have all powers granted to the Hearing Committee/Hearing Officer and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

11. Presence of Members and Vote

A majority of the Appellate Review Body shall constitute a quorum. If a member of the Review Body is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberation of the decision.

12. Recesses and Adjournment

The Appellate Review Body may recess the review proceedings and reconvene the same 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 statements, if allowed, the appellate review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberation and the appellate shall be declared finally adjourned.

13. Action Taken

The Appellate Review Body may recommend to the Governing Body affirm, modifies, or reverses the result. The Governing Body pursuant to Section 4 (1) or 4 (2) b or, in its discretion, may refer the matter back to the Hearing Committee/Hearing Officer for further review and further recommendations to be returned to it within a reasonable time and in accordance with its instructions. Within fourteen (14) days after receipt of such recommendations after referral, the Appellate Review Body shall make its recommendations to the Governing Body as provided in this Section 5(13).

14. Conclusion

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived. If the final decision is to recommend termination of Medical Staff membership, the Practitioner will be notified by certified letter.
SECTION 6

FINAL DECISION BY GOVERNING BODY

1. Governing Body’s Action

At its next regular meeting after the conclusion of the Appellate Review, unless otherwise postponed for good cause, the Governing Body shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner by certified mail or hand delivered to the President of the Medical Staff, and to the Medical Executive Committee.

SECTION 7

HEARING SPECIFICATIONS

1. Attorneys

If the affected Practitioner desires to be represented by an attorney, whether or not a physician at any hearing or at any Appellate Review appearance, his/her initial request for the Hearing must state his/her wish to be so represented at either or both such proceedings in the event they are held. If, and only if, the Practitioner gives notice at the time that he/she shall be represented by an attorney, shall the Medical Executive Committee or the Governing Body be allowed representation by an attorney. The foregoing shall not be deemed to deprive the Practitioner, the Medical Executive Committee, or the Governing Body of the right to legal counsel in connection with the preparation for Hearing or an Appellate Review or to give advice to the representatives of the Practitioner, Medical Executive Committee, Hearing Panel or the Governing Body at the Hearing.

2. Number of Hearings and Reviews

Notwithstanding any other provisions of the Medical Staff Bylaws or of this Article, no Practitioner shall be entitled, as a right to more than one evidentiary hearing and one Appellate Review with respect to the adverse recommendation or action.

3. Releases

By requesting a Hearing or Appellate Review under this Article, a Practitioner agrees to be bound by the provisions of Article XV in the Medical Staff Bylaws relating to immunity from liability in all matters relating thereto.
4. Waiver

If at any time after receipt of special notice of an adverse recommendation, action, or result a Practitioner fails to make a required request or appearance or otherwise fails to comply with this Article or to proceed with this matter, he/she shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Article with respect to the matter involved.
ARTICLE X

OFFICERS

SECTION 1

OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff Shall be a President/Chief of Staff, Vice President, and Secretary.

SECTION 2

QUALIFICATIONS OF OFFICERS

Officers must be members of the Active Medical Staff at the time of nomination and election, and must remain in good standing during their term of office. Failure to maintain such status shall result in automatic removal from office.

SECTION 3

ELECTION OF OFFICERS

1. Officers shall be elected every two years at the meeting of the Medical Staff, which is to be held in the fall. Only members of the Active Medical Staff shall be eligible to vote.

2. The nominating committee shall consist of at least three (3) members of the Active Medical Staff. The Chief of Staff shall designate the composition of the nominating committee.

3. Nominations may be made from the floor at the time of the annual meeting. In a situation where there are three (3) or more candidates and no candidate received a majority, successive balloting, with the name of the candidate receiving the fewest votes omitted from each successive ballot until the successful candidate receives a majority vote of those voting, will be carried out as a method of selection.

SECTION 4

TERM LIMITS

No More than three (3) consecutive terms may be served.
SECTION 5

VACANCIES IN OFFICE

Vacancies during the Medical Staff year, except for Presidency, shall be filled by appointment by the Medical Executive Committee. If there is a vacancy in the office of the President, the Vice President shall serve out the remaining term.

SECTION 6

REMOVAL OF OFFICERS

1. An officer or member of the Medical Executive Committee can be removed from office only by a two-thirds majority affirmative vote of a Quorum of the Medical Executive Committee of the Medical Staff after having given at least a seven (7) day written notice together with the grounds for removal signed by a simple majority of the entire membership of the MEC. A Quorum shall consist of a majority of members of the Medical Executive Committee.

2. If a vote of removal of an officer occurs, then a special meeting of the Active Medical Staff will be held for the purpose of discussing and acting on the recommendation of the Medical Executive Committee.

3. Grounds for removal shall be in writing and include, but are not limited to mental and/or physical impairment, change in staff status from Active Medical Staff to another category, loss of licensure or inability and/or willingness to perform the duties and responsibilities of the office.

SECTION 7

DUTIES OF OFFICERS

1. President

The President of the Medical Staff shall:

a. Be certified by an appropriate specialty board or the Medical Staff has affirmatively determined, through the privilege delineation process and experience, that the President of the Medical Staff possesses comparable competence;
The President of the Medical Staff shall have experience and knowledge of:

1. Medical Staff Credentialing;
2. Medical Staff Bylaws and Rules and Regulations;
3. External mandatory regulations;
4. PM/PI;
5. Peer Review;
6. Colorado and Federal law pertaining to the Medical Staff function; and
7. Hospital finances and the processes for which the Medical Staff is responsible.

It is preferred that the President of the Medical Staff has served as Vice President and/or has significant experience on the Medical Executive Committee, Credentials Committee, the Quality Utilization Committee, and as Department Chairperson.

b. Call and preside at all meetings of the General Medical Staff;

c. Act in coordination and cooperation with the President/Chief Executive Officer in all matters of mutual concern within the Medical Center;

d. Serve as Chairperson of the Medical Executive Committee;

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

f. Be a member of the Medical Center Board of Directors;

g. 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 where corrective action has been requested against a Practitioner;

h. Appoint committee members to all standing, special, and multi-disciplinary Medical staff committees, as necessary;

i. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the President/Chief Executive Officer or his/her designee. The President of the Medical Staff shall have the ability to appoint the chairman of the Medical Staff committees except as specified elsewhere in the Bylaws;

j. Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff’s delegated responsibility to provide medical care;

k. Cooperate with the President/Chief Executive Officer or his/her designee in enforcing automatic suspension; and

l. Be the spokesperson for the Medical Staff in its external public relations.
2. Vice President

In the absence of the President, the Vice President shall assume all duties and have the authority of the President. He/She shall be a member of the Medical Executive Committee. He/She shall automatically succeed the President when the latter fails to serve for any reason. The Vice President of the Medical Staff will serve as voting member of the credentials committee.

3. Secretary

The Secretary shall be responsible for keeping accurate and complete minutes of all meetings of the General Medical Staff, call Medical Staff meetings on order of the President, attend to all correspondence, serve as a member of the Medical Executive Committee, and perform such duties as ordinarily pertain to his/her office.
ARTICLE XI

DEPARTMENTS

SECTION 1

ORGANIZATION OF DEPARTMENTS

1. There shall be the following Departments:
   a. Anesthesiology
   b. Dentistry
   c. Emergency Medicine
   d. Family Practice
   e. Medicine
   f. Obstetrics/Gynecology
   g. Pathology
   h. Pediatrics
   i. Psychiatry
   j. Radiology
   k. Surgery

2. Each Department shall be organized as a separate part of the Medical staff and shall have a Chairperson to be responsible for the overall supervision of the clinical work within his/her department. At the last meeting of each Department, prior to the end of the current Medical Staff Chairperson’s term, and before the general semi-annual meeting of the Medical Staff, members of each department shall elect a Chairperson and, if applicable, a Co-Chairperson for the Medical Staff term.
3. Optional Sections

a. Any group of physicians within a Department may organize themselves into a section of the Department. Any section, if organized, will not be required to hold any number of regularly scheduled meetings nor will attendance be required unless the section chairperson, with the approval of the Department Qualifications Committee, calls a special meeting to discuss a particular issue. Such special meetings must be preceded by at least two weeks prior notification for all those expected to attend.

b. Sections may perform any of the following activities:

1. Continuing Education
2. Grand Rounds
3. Discussion of Policy
4. Discussion of Equipment Needs
5. Development of recommendations for Department Chairperson or Medical Executive Committee
6. Participation in the development of criteria for clinical privileges (when requested by the Department Chair)
7. Discuss a specific issue at the special request of a Department Chairperson or the Medical Executive Committee.

c. Except in extraordinary circumstances, no minutes or reports will be required reflecting the activities of actions. Only when sections of making formal recommendations to a Department will a report be required from the Department Chairperson documenting the section specific position.

d. Section meetings will ordinarily not be staffed by representatives of the Medical Staff Office. Meals will not be provided unless the purpose of the meeting is to act as an agent of the Department.

SECTION 2

QUALIFICATIONS AND TENURE OF THE DEPARTMENT CHAIRPERSON

1. Each Chairperson of the Medical Staff Department/Service shall be certified by an American Board of Medical Specialties unless the Medical Staff has determined, through the privilege delineation process, that the Chairperson possesses comparable competence. An appropriate Specialty Board is one:

   a. Which certifies in a specialty that is relevant to the service provided in the department/service; and
b. Whose certification can serve as a reliable benchmark. The certification process should include the examination of the credentials (including supervised training and experience in an appropriate education program) and knowledge of the applicant at the time of certification and the issuance of the certification based on the adequacy of those credentials and knowledge.

c. The Medical Center and its Medical Staff determine whether the specialty is relevant to the services provided by the department/service. This determination is to be documented.

2. Each Chairperson shall be a member of the Active Medical Staff, qualified by training, experience and demonstrated ability for the position.

3. Each Chairperson shall serve for a two (2) year term and may be reappointed.

4. Removal of a Chairperson during his/her terms of Office may be done by a two-thirds majority affirmative vote of the Regular Medical Staff members of the Department after a seven (7) day written notice of such intention, including the grounds that have been sent to the Chairperson by a simple majority of the Active Medical Staff members of the Department.

SECTION 3

FUNCTIONS OF THE DEPARTMENT CHAIRPERSON

Each Chairperson shall:

1. Be accountable for all professional and administrative activities within his/her Department;

2. Be a member of the Medical Executive Committee, giving guidance on the overall medical policies and procedures and those that guide and support the provision of care, treatment and services of the Medical Center and making specific recommendations and suggestions including recommending space and other resources needed by the department, off-site sources regarding his/her own Department in order to assure quality patient care and recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;

3. Maintain continuing review of the professional performance of all Practitioners with clinical privileges in his/her Department and report thereof to the Medical Executive Committee;

4. Be responsible for enforcement of the Medical Center Bylaws and Rules and Regulations within his/her Department;
5. Be responsible for implementation within his/her Department, actions taken by the Medical Executive Committee;

6. Submit to the Medical Executive Committee his/her Department’s written recommendations for the criteria for clinical privileges that are relevant to the care provided in the department and recommendations concerning the staff classification, the reappointment, and the delineation of privileges for all Practitioners including non-licensed independent practitioners in his/her Department;

7. Be responsible for the orientation, teaching, education and research programs in his/her Department;

8. Participate in every phase of administration of his/her Department 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 integration of the department or service into the primary functions of the organization;

9. Coordination and integration of interdepartmental and intradepartmental services;

10. Assist in the preparation of annual reports, including budgetary planning pertaining to his/her department, as may be required by the Medical Executive Committee, the President/Chief Executive Officer or his/her designee, or the Governing Body;

11. Be responsible for the review and documentation of risk management, PM/PI, and utilization review activities including, but not limited to, morbidity, mortality, complicated cases, as well as medical record documentation and clinical pertinence; and

12. Integrate the Medical Staff Departments and members into the primary function of the organization through quality improvement teams.

SECTION 4

FUNCTIONS OF DEPARTMENTS

1. Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and the Governing Body, for granting of clinical privileges and for the holding of office in the Department. The Clinical Departments are Departments of Medicine, Emergency Medicine, Family Practice, Surgery, Pediatrics, Obstetrics/Gynecology, Pathology, Radiology, Psychiatry and Dentistry.
2. Each Clinical Department shall define, in writing, or electronic equivalent, categories or types of Clinical Privileges in the Department, which are consistent with the policies of the Medical Staff and of the Governing Body for the granting of Clinical Privileges.

3. The Departments of Anesthesia, Dentistry, Emergency Medicine, Family Practice, Medicine, Pathology, Pediatrics, Obstetrics/Gynecology, Psychiatry, Radiology and Surgery shall meet separately at least quarterly (unless approved by the Medical Executive Committee) to review and analyze on a “Peer Review” basis, the clinical work of the Department. Such review and analysis should include trends, benchmarks, and variation in care, as well as consideration of selected deaths, unimproved patients, patients with infectious complications, errors in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the Medical Center with unsolved clinical problems. Documentation of such review and analysis shall be sent regularly to the Quality and Utilization Review Committee.

4. Any Practitioner whose patient's clinical course has caused a quality of care concern and is scheduled for discussion at a Clinical Department's peer review meeting because of apparent or suspected deviation from standard clinical practice, shall be given fourteen (14) days notice by certified letter of the time and place of the meeting. The notice to the Practitioner shall include a statement that his/her attendance at the meeting at which his/her alleged deviation is to be discussed is optional with the physician. He/She may choose to respond only in writing.

SECTION 5

ASSIGNMENT TO DEPARTMENTS

The Medical Executive Committee shall after consideration of the recommendation of the Clinical Departments as transmitted through the Credentials Committee, recommend initial departmental assignments for all Medical Staff members and AHPs and for all other approved Practitioners with clinical privileges. Each Practitioner shall be assigned to only (1) Clinical Department for purposes of voting in Clinical Department matters, though one may have clinical privileges in more than one (1) clinical department.
ARTICLE XII

COMMITTEES

SECTION 1

STANDING COMMITTEES

There shall be the following standing committees:

1. Executive
2. Credentials
3. Bylaws

SECTION 2

MEDICAL EXECUTIVE COMMITTEE

1. Composition

The Medical Executive Committee shall consist of the officers of the Medical Staff, the Immediate Past President of the Medical Staff, the Chairperson of each Department as voting members, the Chairperson of the Credentials Committee and QUR Committee as non-voting members, and two (2) members at large of the Medical Staff elected by the Medical Staff for two (2) year terms. Ex-officio, non-voting members shall be the President/Chief Executive Officer or his/her designee, the Senior Vice President/COO, the Vice President of Patient Services/Chief Nursing Officer, and the Vice President of Medical Affairs. The chairperson of the Bylaws Committee will attend the meeting as needed as a non-voting member. The President of the Medical Staff shall preside as Chairperson.

2. Meetings

The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.
3. Duties

The duties of the Medical Executive Committee shall be to:

a. Receive and act upon reports and recommendations from the departments, functions, special committees, and officers of the staff concerning PM/PI and the discharge of their delegated medical administrative responsibilities;

b. Report results and recommendations concerning staff functions, including accreditation status, to the Medical Staff and Governing Body;

c. Coordinate the activities and the general policies of the various departments, functions and committees;

d. Monitor the activities of the Department Chairpersons;

e. Recommend to the Governing Body all matters relating to appointments, reappointments, staff category, departmental assignments, clinical privileges, specified services, and correction action. Recommendations are made following consideration of information submitted from Departments and the Credentials Committee;

f. Account to the Governing Body and to the Medical Staff for the overall quality and efficiency of medical care rendered to patients in the medical center;

g. Take all reasonable steps to ensure ethical conduct and competent clinical performance of all Practitioners and to initiate and pursue Corrective Action, when warranted, in accordance with these Bylaws;

h. Make recommendations on medico-administrative and Medical Center management matters;

i. Review, develop and approve Medical Staff and Medical Center policies and rules and regulations relating to medical records practice including, but not limited to, completeness, timeliness, clinical pertinence, confidentiality, and access and recommend methods of enforcement thereof and changes therein;

j. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

k. With stated cause, require a physical and/or mental examination of any applicant for appointment or reappointment to membership on the Medical Staff;

l. Assess and make recommendations for off-site sources for services not provide by the Organization; and
m. Providing ongoing oversight of the department members to assure that they practice within the scope of their privileges as determined from peer review, focused professional practice review, reports from procedure areas and nursing units, transcription and other sources.

4. Removal of members from the MEC (see Article X Section 6 Removal of Officers)

SECTION 3

CREDENTIALS COMMITTEE

1. Composition

The Credentials Committee shall be appointed by the President of the Medical Staff and consist of at least five (5) members. All terms shall be three (3) year staggering terms and members may be reappointed to serve more than one consecutive term. The Chairman of the Credentials Committee shall be appointed by the President of the Medical Staff from the current Credentials Committee and shall serve as an ex-officio non-voting member of the Medical Executive Committee. The Vice President for Medical Affairs (Chief Medical Officer) shall be a voting member of the Committee. The Vice-President of the Medical Staff, CEO, COO, and Medical Center Attorney shall be non-voting members of the Credentials Committee. The Credentials Committee will have input from the specialty of the application/re-applicant via the recommendations from that department’s qualifying committee. The Credentials Committee membership shall consist of at least three different specialties. At least one surgical physician (general surgery, orthopedic surgery, OB/GYN, ENT, cardiovascular, podiatry, dentistry or neuro surgery) and at least one non-surgical physician (internal medicine, family practice, cardiology, emergency medicine, radiology, pathology, anesthesia, psychiatry and pediatrics) will serve on the committee to insure a range of participation.

2. Meetings

The Credentials Committee shall meet monthly and shall submit to the Medical Executive Committee a written report of its proceedings, recommendations, and actions.

3. Duties

a. Review and evaluate the qualifications, competence, and performance of each applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges; make appropriate recommendations for membership and delineation of clinical privileges and assign practitioners to the various departments, or services as provided in these bylaws.
b. Report to the Medical Executive Committee on each applicant for Medical staff membership and/or clinical privileges. Such reports shall include recommendations with respect to appointments, clinical privileges, or specified services and special considerations.

c. Investigate any alleged breach of ethics that is reported to it and review reports referred by other committees.

SECTION 4

BYLAWS COMMITTEE

1. Composition

The Bylaws Committee shall consist of three (3) members of the Medical Staff appointed by the President of Medical Staff. Ex-officio, non-voting members shall be the President/Chief Executive Officer or his/her designee. The President of the Medical Staff shall appoint the Chairperson. The President of the Medical Staff and/or the Bylaws Committee Chairperson shall appoint additional non-voting members as specialty issues arise.

2. Meetings

The Bylaws Committee shall meet as needed, but at least annually and shall submit a written report to the Medical Executive Committee of its proceedings, recommendations and actions.

3. Duties

The duties involved in maintaining appropriate Bylaws, Rules and Regulations, and other organizational documents pertaining to the Medical Staff are to:

a. Conduct a review as needed, but at least annually, of the Medical Staff Bylaws, Rules and regulations, procedures and form promulgated in connection therewith;

b. Submit recommendations to the Medical Executive Committee and Governing Body for changes in these documents; and

c. Act upon all matters as may be referred by the Governing Body, the President of the Medical Staff, or the President/Chief Executive Officer or his/her designee and will address issues from other committees subject to approval by the Medical Executive Committee.
SECTION 5

SPECIAL COMMITTEES

1. Composition

If a special staff committee is established by the Medical Executive Committee or the President of the Medical Staff to perform one or more of the functions required by these Bylaws (such as Medical Staff and Medical Center office nominations) it shall be composed of appointees of the Active Staff and may include where appropriate, representation from the Medical Center’s administration, nursing service and other Medical Center Departments as are appropriate to the functions to be discharged. Unless otherwise specifically provided, the Medical Staff appointees and Committee Chairperson shall be appointed by the President of the Medical Staff and the administrative staff appointees by the President/Chief Executive Officer or his/her designee. Medical Staff members shall be the only voting members unless otherwise specified by the President of the Medical Staff.

2. Meetings

A special committee established to perform one or more of the Medical Staff functions required by these Bylaws shall meet as often as necessary to discharge its duties.

3. Term, Vacancies and Prior Removal

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

A Medical Staff special committee appointee may be removed by a majority of the Medical Executive Committee after having given seven (7) days written notice together with the grounds therefore to the appointee and signed by a majority of the MEC. An Administrative staff committee appointee may be removed by action of the President/Chief Executive Officer or his/her designee without cause and without notice.
ARTICLE XIII

MEDICAL STAFF MEETINGS

SECTION 1

GENERAL STAFF MEETINGS

1. Annual Medical Staff Meeting

An annual Medical Staff meeting shall be held in the fall of each year. The agenda of such meeting shall include reports of review and evaluation of work done in the clinical departments, the performance of the required medical functions, and any election of officers for the following year.

2. Regular Staff Meeting

A regular meeting of the members of the Medical Staff shall be held in the spring of each year.

3. Quorum

A Quorum for all general meetings of the Medical Staff shall consist of twenty (20) Active Medical Staff members who are eligible to vote.

SECTION 2

SPECIAL MEETINGS

The President of the Medical Staff or the Medical Executive Committee or the Governing Body may call a special meeting of the Medical Staff at any time pursuant to Article XII of these bylaws. The President of the Medical Staff shall call a special meeting within ten (10) days after receipt of written request for same, signed by not less than ¼ of the Active Medical Staff, or the electronic equivalent, and stating the purpose of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.
SECTION 3

NOTICE

Written notice stating the place, day and hour of any meeting of the Medical Staff together with the agenda shall be delivered, either personally or by mail, to each Practitioner, not less than three (3) and not more than thirty (30) days before the date of the meeting. If mailed, the notice of the meeting shall be deemed delivered when addressed to each Medical Staff member at his address as it appears on the records of the Medical Center. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

SECTION 4

QUORUM

A quorum for all meetings other than the general meetings of the Medical Staff shall consist of one-third “1/3” or three (3) of the members whichever is less of the total eligible voting membership. Action is taken by simple majority vote of those eligible members of the Active Medical Staff present at the meeting assuming a quorum is declared.

SECTION 5

ATTENDANCE

All members are required to attend fifty percent (50%) of the general meetings during the provisional year. Members failing to comply with meeting attendance requirements may be held over for an additional provisional year and not advance to voting status.

Members of the Active Medical staff shall be required to attend fifty percent (50%) of the regularly scheduled meetings of the Clinical Department to which they are assigned or fifty percent (50%) of the Committee meetings to which they are assigned and fifty percent (50%) of the regularly scheduled general medical staff meetings in the year prior to any general meeting of the Medical Staff. Failure to do so shall result in a loss of privileges to vote at that general meeting.

Active staff members who have lost their privileges to vote due to failure to comply with the meeting attendance may restore their voting privileges by meeting the basic meeting requirements prior to the next scheduled general meeting of the Medical Staff.
SECTION 6

OTHER REQUIREMENTS

In addition to satisfying the meeting attendance requirements in Section 5, in order to be eligible to vote at the General Medical Staff meetings, Active staff members must be in good standing, with their privileges not currently suspended or inactivated for any reason.
ARTICLE XIV

COMMITTEE AND DEPARTMENT MEETINGS

SECTION 1

REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than by resolution. Departments shall hold regular meetings to review and evaluate the clinical work of Practitioners with privileges in the Departments.

Departmental meetings must place emphasis on morbidity and mortality analysis with detailed consideration of selected deaths, unimproved medical center patients, infections, complications, errors in diagnosis, results of treatment, and analytic reports relative to patient care within the Medical Center.

SECTION 2

SPECIAL MEETINGS

A special meeting of any Committee or Department may be called by, or at the request of, the Chairperson, the President of the Medical Staff, or one-third of the group’s members.

SECTION 3

NOTICE OF MEETINGS

Written or verbal notice stating the place, day, and hour and agenda of any special meeting or any regular meeting shall be given to each member of the Committee or Department not less than one (1) day before the time of such meeting by the person or persons calling the meeting.

SECTION 4

QUORUM

One third (1/3) or three (3), whichever is less, of the voting members of a Committee meeting shall constitute a Quorum at any Committee meeting. One-third or three, whichever is less, of the voting members of a department meeting shall constitute a Quorum at any department meeting.
SECTION 5

MANNER OF ACTION

The action of the majority of the voting members present at a meeting having a Quorum shall be the action of the committee or the department. Action may be taken by a telephone poll of the members where a Quorum has been established.

SECTION 6

MINUTES

Minutes of each regular and special meeting of Committee or Department shall be prepared and shall include a record of attendance of members and the vote taken to each matter. A permanent file of each Committee and Department’s minutes of each meeting shall be maintained. Reports of departmental actions shall be forwarded to the Medical Executive Committee at regular intervals.
ARTICLE XV

IMMUNITY FROM LIABILITY

The following shall express conditions to any Practitioner's application for, or exercise of, Clinical Privileges at the Medical Center.

1. Any act, communication, report recommendation, or disclosure with respect to any such Practitioner, performed or made in good faith without malice and at the request of any authorized representative of this or another health care facility, for the purpose of achieving and maintaining quality patient care at this or any health care facility shall be privileged to the fullest extent permitted by law.

2. Such privileges shall extend to members of the Medical Center's staff and of its Governing Body, its other Practitioners, President/Chief Executive Officer and his/her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which an authorized representative of the Governing Body or the Medical Staff has requested information.

3. There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communications, report, recommendation, or disclosure.

4. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any health care institution's activities related to, but not limited to:
   - Application for appointment or clinical privileges;
   - Periodic reappraisals for reappointment or clinical privileges;
   - Corrective action, including summary suspension;
   - Hearings, interviews, and appellate reviews;
   - Medical care evaluations;
   - Utilization reviews; and
   - Other Medical Center, Departmental Service, or Committee activities related to quality patient care and inter-professional conduct.

5. The acts, communications, reports, recommendations, and disclosures referred to in the Article may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional ability, physical condition, ethics, or any other matter which might directly or indirectly have an effect on patient care.
6. In furtherance of the foregoing, each Practitioner shall, upon request of the Medical Center, execute releases in accordance with the tenor and import of this Article in relation to the individuals and organizations specified in this Article subject to such requirements as good faith, absence of malice, and the exercise of reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

7. The consents, authorizations, releases, rights, privileges and immunities provided in these Bylaws for the protection of the Medical Center's Practitioners, other appropriate Medical Center officials and personnel, and third parties in connection with applications for initial appointment, shall be fully applicable to the activities and procedures covered by this Article.
ARTICLE XVI

RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. The Rules and Regulations shall be subject to the approval of the Governing Body. These shall relate to the proper conduct of the Medical Staff’s organizational activities, as well as embody the level of practice that is to be required for each Practitioner in the Medical Center. Such Rules and Regulations may be amended or repealed at any regular meeting of the MEC at which a Quorum is present and without previous notice, or at any special meeting on notice, by two-thirds (2/3) vote of those present so long as a Quorum is present.

- When Rules and Regulations and policy changes are proposed by the MEC, there will be communication of the proposed amendment to the organized medical staff before a vote is taken by the MEC.
- When Rules and Regulations and policy changes are proposed by the organized medical staff, there will be communication of the proposed amendment to the MEC before a vote is taken by the organized medical staff.
- When amendments are considered by the MEC and Board to be required to meet legal or regulatory compliance, the MEC and Board may adopt such amendments without prior notice to the organized medical staff. After adoption the amendments will be communicated to the organized medical staff for their review.
  - If the organized medical staff approves the provisional amendment, the amendment will stand.
  - If the organized medical staff does not approve the amendment, this will be resolved using the conflict resolution mechanism noted in Rules and Regulations. If a substitute amendment is then proposed, it will follow the usual approval process.

Policies which are administrative policies and procedures, such as corrective action, fair hearing, and appeals, credentialing, privileging and appointment will be submitted for approval to the Medical Staff membership eligible to vote at the General Medical Staff meeting.

Departmental Rules and Regulations shall be adopted as required by each Department and shall be submitted for approval to the Medical Executive Committee. The Department Rules and Regulations shall be subject to approval of the Governing Body.
ARTICLE XVII

AMENDMENTS

Proposed amendments to these bylaws, rules and regulations or policies may be originated by the MEC or by a petition signed by fifty percent (50%) of the voting members of the medical staff, or electronic equivalent. These Bylaws may be amended by a simple majority vote of those members of the Active Medical Staff entitled to vote and present at the general or staff meeting of the Medical Staff, assuming a Quorum is declared. The amendment(s) proposed should be mailed to all members of the Active Medical Staff at least one month prior to the general staff meeting at which they are to be considered. The proposed amendments shall be presented and discussed and voted upon at the meeting. Relevant amendments to any proposed amendment may be adopted at such meeting without further notice. Amendments so adopted by majority vote will become effective upon approval by the Governing Body. These Bylaws cannot be amended unilaterally by either the Medical Staff or the Governing Body.

Bylaws may also be amended from time to time by mail-in ballot to the Active Medical Staff who is eligible to vote. Such amendments may be passed by a simple majority with a minimum of twenty (20) returned ballots. Proposed changes will be reviewed by the Medical Executive Committee prior to mail out ballots and general or special meetings will review proposed changes.

ARTICLE XVIII

ADOPTION

These Bylaws adopted at any general or special meeting of the Regular Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Governing Body of the Medical Center. Adoption by the Governing Body of the Medical Center automatically repeals all previously adopted Bylaws. The medical staff bylaws, rules and regulations and policies and the governing body bylaws and policies will not conflict.