EXEMPLA GOOD SAMARITAN MEDICAL CENTER, LLC

GENERAL MEDICAL STAFF RULES

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1.1 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for Emeritus Members (see the Credentialing and Privileging Rules regarding Categories of Medical Staff), each Medical Staff Member and each Practitioner exercising temporary Privileges shall continuously meet all of the following responsibilities:

1.1.1 Provide his or her patients with care of the generally recognized professional level of quality and efficiency.

1.1.2 Abide by the Medical Staff Bylaws, Rules and all other lawful standards, policies, and rules of the Medical Staff, the Hospital and the System, including the expectations of Medical Staff Members.

1.1.3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of the Joint Commission and other accrediting entities.

1.1.4 For all practice at Good Samaritan, abide by the Ethical and Religious Directives for Catholic Healthcare Services promulgated by the National Conference of Catholic Bishops.

1.1.5 Discharge responsibilities for the oversight of care, treatment, and services provided by other Practitioners for his or her patients, as appropriate to his or her specialty, and for others as delegated through the Medical Staff Process.

1.1.6 Discharge such Medical Staff, Department, and committee functions for which he or she is responsible by appointment, election, or otherwise.

1.1.7 Prepare and complete in a timely manner the medical and other required records for all patients to whom the Practitioner in any way provides services in the System.

1.1.8 Abide by the ethical principles of his or her profession.

1.1.9 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

1.1.10 Refrain from harassment of or discrimination against any person (including any patient, Hospital employee, Practitioner, AHP, volunteer or visitor) based upon the person’s age, sex, religion, race, creed, color, national origin, health status, disability, ability to pay, sexual orientation, or source of payment.

1.1.11 Delegate responsibility for diagnosis or care of hospitalized patients only to a Practitioner, House Staff member, subject to appropriate supervision, or AHP who is qualified to undertake this responsibility and who is adequately supervised.

1.1.12 Seek consultation whenever warranted by the patient’s condition or when required by the Rules.

1.1.13 Actively participate in and regularly cooperate with the Medical Staff in assisting the System to fulfill its obligations related to patient care, including, but not limited to, safety, continuous quality improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

1.1.14 Communicate with appropriate Department leaders and/or Medical Staff Officers when he or she obtains credible information indicating that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct, provided unsafe patient care, or may have a health concern which poses a risk to patient
safety, quality of care, or safe and effective operation of the Hospital, and the Medical Staff Member will cooperate as reasonably necessary toward the appropriate resolution of any such matter.

1.1.15 Recognize the importance of communicating with appropriate Department leaders and/or Medical Staff Officers when he or she obtains credible information indicating that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

1.1.16 Conduct himself or herself in a professional and cooperative manner while in the Hospital or involved in Medical Staff or Hospital business so as to not adversely affect patient care or Hospital operations.

1.1.17 Work cooperatively with Members, nurses, System administrative staff, and others so as not to adversely affect patient care or System operations.

1.1.18 Participate in emergency service coverage and consultation panels as allowed and as required by the Rules.

1.1.19 Cooperate with the Medical Staff in assisting the System to meet its uncompensated or partially compensated patient care obligations.

1.1.20 Cooperate in peer review and quality improvement processes and refrain from retaliation against any person who participates in these processes.

1.1.21 Inform the Medical Staff of any significant changes in the information required on appointment and reappointment within thirty (30) days of the change.

1.1.22 Continuously meet the qualifications for membership and Privileges granted as set forth in the Credentialing and Privileging Rules (including privileging forms). A Member may be required to demonstrate continuing satisfaction of any of the requirements of the Credentialing and Privileging Rules and the Medical Staff Bylaws upon the reasonable request of the Medical Executive Committee or Credentials Committee.

1.1.23 Abide by the terms of the System's Joint Notice of Privacy Practices and any other applicable provisions of HIPAA, as may be amended from time to time, with respect to Protected Health Information created or received by the System or Medical Staff Members, as part of Medical Staff Member's participation in System's Organized Health Care Arrangement ("OHCA"), and to abide by the policies and procedures relating to the OHCA as may be developed by the System.

1.1.24 Consent to the System’s use of his or her likeness, demographics and practice information for the System’s internal on-line directory and password restricted external directory. Provide appropriate consent to (or opt-out of) the System’s use of such information on its external on-line directory. The Member’s consent shall be effective until he or she revokes such consent in writing.

1.1.25 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients.

1.1.26 Complete continuing medical education ("CME") that is appropriate to the Practitioner's specialty every two years as a requirement for reappointment.

1.1.27 Participate in electronic medical record we based training and instructor lead training. Seek additional training as needed to effectively utilize the electronic medical record.
1.1.28 Utilize the electronic medical record for electronic chart review and for electronically entering progress notes. Note: Hospital staff will not be expected to print any part of the chart for the purpose of chart review.

1.1.29 Actively use the electronic problem list (as soon as available) as a key communication tool for enhanced reporting and performance optimization.

1.1.30 Utilize Computerized Physician Order Entry (CPOE) with electronic medication reconciliation.

1.1.31 Protect the confidentiality and integrity of all patients' individually identifiable health information that is created, received, maintained or transmitted regardless of medium or format.

1.2 MEDICAL SCREENING EXAMINATIONS

The Hospital ensures that medical screening examinations are provided as required by the Emergency Medical Treatment Act, 42 U.S.C. § 1395dd ("EMTALA") and the System EMTALA policies. A "medical screening examination" is the process required to determine, with reasonable clinical confidence, whether the patient has an emergency medical condition as defined under EMTALA and System policies governing EMTALA. A "dedicated emergency department" under EMTALA includes any department or facility that (1) is licensed by the State as an emergency room or emergency department, (2) is held out to the public as a place that provides care for emergency medical conditions on an urgent basis without a scheduled appointment, or (3) during the immediately preceding calendar year, provided at least one-third of all of its outpatient visits for the treatment of emergency medical conditions without a scheduled appointment. For purpose of this Rule 1.2, the Hospital's dedicated emergency departments include the Emergency Department and the Obstetrics Department for pregnant patients.

1.3 QUALIFIED MEDICAL PERSONNEL

All medical screening examinations shall be performed by "qualified medical personnel" in a manner consistent with System policies. As determined by the Governing Body, "qualified medical personnel" shall include (i) Practitioners acting within the scope of their Privileges, and (ii) persons who are participating in a graduate medical education program affiliated with SCL Health – Front Range ("House Staff"), subject to appropriate Physician supervision in accordance with the Clinical Rules and System policies governing House Staff.

"Qualified medical personnel" shall also include the Practitioners listed below who have been determined to be qualified to initiate and/or perform medical screening examinations (i) within the scope of their training and professional licenses or certifications, (ii) in a manner consistent with System and Hospital policies, and (iii) who are either employed by SCL Health – Front Range and acting within the scope of their job description, and/or are members of the Medical Staff or Allied Health Staff acting within the scope of their Privileges or scope of practice, as applicable; provided, however, that any decision to discharge, admit, or transfer a patient following a medical screening examination by a non-physician shall be made by a Physician with appropriate privileges or a House Staff member subject to appropriate Physician supervision or oversight in accordance with the Clinical Rules and System policies governing House Staff. The specific training and supervision for each category of qualified medical personnel and the required level of supervision, are set forth in the job description for SCL Health – Front Range employees and in the Privileges or scope of practice for non-Practitioners who are members of the Allied Health Staff.

1.3.1 Emergency Department (all medical screening examinations in the Emergency Department shall be supervised by a Physician with appropriate Privileges in accordance with Emergency Department or Hospital policies and procedures):

a. Physician Assistants who are licensed by the State of Colorado and who have completed orientation to the Emergency Department.
b. Nurse Practitioners who are licensed by the State of Colorado and who have completed orientation to the Emergency Department.

1.3.2 Obstetrical patients and newborns in the Hospital, including the Obstetrics Department or the Emergency Department (all medical screening examinations of obstetrical and newborn patients shall be subject to supervision by a Physician with appropriate Privileges):

a. Certified Nurse Midwives who are licensed by the State of Colorado, have completed post graduate education in a program accredited by the Division of Accreditation of the American College of Nurse Midwives, and who are oriented to the labor and delivery unit.

b. Physician Assistants who are certified by the State of Colorado and who are oriented to the labor and delivery unit and supervised by a Physician.

c. Registered Nurses who are licensed by the State of Colorado and who meet the following additional criteria:

- Oriented to the labor and delivery unit,
- Demonstrated competence specific to labor and delivery, and
- Completed an electronic fetal monitoring class during the first two years of employment with SCL Health – Front Range and every two years thereafter.

1.3.3 Psychiatric or chemical dependency patients in the Hospital, including the Psychiatric Department or the Emergency Department (all medical screening examinations of psychiatric or chemical dependency patients shall be subject to supervision by a Physician with appropriate Privileges).

a. Assessment and Referral Team ("ART") Specialists and other mental health personnel who are qualified under Rule 1.3.3(b) below and who have satisfied the following additional minimum criteria:

- Completed orientation to the Emergency Department,
- Trained in Crisis Management Training or received equivalent training within three months of the date of hire, scope of practice or privileging,
- Familiarity with applicable criteria for mental health holds under Colorado's Mental Health law, C.R.S. § 27-10-101, et seq., and Alcohol and Drug Division, C.R.S. § 25-1-201, et seq.; and
- Familiarity with applicable DSM-IV diagnostics.

b. ART Specialists and other qualified mental health personnel may include the following categories of mental health professionals:

- Psychologists who are licensed by the State of Colorado.
- Professional Counselors who are licensed by the State of Colorado.
- Clinical Social Workers who are licensed by the State of Colorado.
- Marriage and Family Therapists who are licensed by the State of Colorado.
- Registered Nurses who are licensed by the State of Colorado.
1.4 CALL PANELS

1.4.1 “Call Panels” are lists of Medical Staff members who are on-call for duty after an individual receives an initial examination in the Emergency Department or other location to provide treatment necessary to stabilize an individual with an emergency medical condition in compliance with the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (“EMTALA”) and the System EMTALA Policy, and to ensure the availability of specialty Practitioners for other patients of the Hospital.

1.4.2 Each member of the Active Medical Staff shall participate in a Call Panel as requested, unless the Medical Executive Committee has determined that the Practitioner’s specialty does not have an obligation to participate in a Call Panel. Service on the Call Panel is an obligation of Medical Staff membership. Any Practitioner who refuses to serve on a Call Panel shall be deemed to have voluntarily resigned his or her Medical Staff membership and Privileges, and shall not be entitled to the hearings and appeals processes set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws. A Department Chair/designee may exclude a Medical Staff member from participation in the Call Panel if the specialty is adequately and fairly covered in a manner consistent with the Hospital’s EMTALA obligations.

Practitioners who are at least 65 years old and who have been members of the Active Medical Staff for ten (10) years or more may make a written request to the Department Chair/designee for exemption from Call Panel participation. Exemption from Call Panel participation shall be granted only if the Department Chair/designee determines, in consultation with the Chief Medical Officer, that exemption will not adversely affect patient care. A decision to deny an exemption from Call Panel participation shall be final and shall not entitle the Practitioner to the hearings and appeals processes set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws.

Practitioners will be permitted to take simultaneous call at multiple hospitals, as well as schedule elective surgeries while on call, provided that the Practitioner has made arrangements for adequate back-up coverage by a qualified back-up Practitioner. The back-up coverage Practitioner must comply with these Rules and must be able to respond within the 30-minute timeframe.

1.4.3 The Department Chairs or their designees shall be responsible for assigning Practitioners to the Call Panels and creating a monthly “on-call” list that (1) ensures that the on-call rotation is adequately and fairly covered, (2) is in accordance with the resources available to the Hospital as mandated by EMTALA, and (3) promotes call responsibilities that are proportional to patient volume, as determined by the Medical Executive Committee, in collaboration with Administration. The purpose of an “on-call” list is to ensure that the Emergency Department and other appropriate departments of the Hospital are prospectively aware of the Practitioners, including specialists and subspecialists, who are available to respond to calls to provide examinations and treatment necessary to stabilize patients with an emergency medical condition and to provide consultation services and other services for patients of the Hospital. To implement this requirement, a monthly “on-call” list shall be prepared in writing and submitted to Medical Staff Services not later than the 15th of each month, at least one and a half months in advance of the month addressed by the on-call list. For example, the on-call list for the month of June shall be submitted by April 15th. The on-call list shall include the following: (i) the individual on-call Practitioner (the "Call Panelist") by his or her name (not solely by practice group name), (ii) each Call Panelist’s phone number(s), and (iii) the period of "on-call" time (the "Coverage Period"). Medical Staff Services shall distribute copies of the on-call list to the Emergency Department and other appropriate locations as requested by Administration. Changes to the on-call list shall be documented in accordance with Rule 1.5.2 below. In addition to the on-call list under this Rule 1.4, a Trauma call list shall be prepared and distributed in accordance with the Trauma Policies, as such are adopted and amended from time to time.

1.4.4 Service on a Call Panel is not a clinical privilege and is not a right of Medical Staff membership. The Hospital may enter into exclusive or semi-exclusive contracts with Practitioners for Call Panel services in its sole discretion. The Department Chair/designee may also deny or terminate a Practitioner’s participation on a Call Panel. The Practitioner who is removed from participation in a Call Panel by the
1.4.5 The denial or termination of a Practitioner's Call Panel participation under Rule 1.4.4 above shall not affect the Practitioner's Medical Staff membership or Privileges, nor shall this decision be used as evidence in any corrective action. However, any relevant facts considered by the President, the Department Chair/designee, or the Medical Executive Committee in reaching their decision may be used for any and all purposes, including any corrective action.

1.5 CONDUCT OF CALL PANELISTS

1.5.1 Each Call Panelist must inform the Hospital how to reach him or her immediately and must be immediately available by telephone during his or her Coverage Period. Call Panelists must remain close enough to the Hospital to be able to arrive within a reasonable time during his or her Coverage Period. If requested by the Emergency Physician or other Practitioner or qualified medical personnel, the Call Panelist must arrive at the Emergency Department or other Hospital department that requested his or her services (such as labor and delivery) within a reasonable time in view of the patient's clinical circumstances, but in no circumstances more than thirty (30) minutes from the time of a request for immediate services for a patient with an emergency medical condition. The Medical Executive Committee may establish a shorter time frame for the Call Panelists' response time for certain specialties in its sole discretion and upon notification to all affected Call Panelists.

1.5.2 A Call Panelist who is unable to provide on-call coverage during his or her scheduled Coverage Period or wants to change his or her Coverage Period is responsible for arranging for coverage by a back-up Practitioner who meets the criteria for Call Panel eligibility (the “Substitute Call Panelist”). The Substitute Call Panelist shall call the Call Center to verbally confirm that he or she will provide call coverage as a substitute for the scheduled Call Panelist. The Call Center shall update the on-call list in writing and notify the Emergency Department of all changes in call coverage. The back-up coverage Practitioner must comply with these Rules and must be able to respond within the 30-minute time frame under Section 1.5.1.

1.5.3 The Call Panelist must respond to calls from the Emergency Department or other dedicated emergency department, and cannot delegate the initial response to a mid-level practitioner (Physician Assistant or Advanced Practice Nurse).

1.5.4 The Call Panelist may direct a qualified mid-level practitioner (supervised Physician Assistant or Advanced Practice Nurse with appropriate Privileges) to present to the Emergency Department or other dedicated emergency department, based on the patient's medical needs, the mid-level practitioner's Privileges, and the capabilities of the Hospital. If the Emergency Department Physician or other treating Practitioner disagrees with the Call Panelist's decision to send a mid-level practitioner and requests the Call Panelist's appearance, the Call Panelist will respond in person as provided in these Rules. Regardless of who responds in person to the dedicated emergency department, the Call Panelist remains responsible for the patient.

1.5.5 Each Call Panelist shall accept the care of all patients who are appropriately referred during his or her Coverage Period and shall provide all services in accordance with the System EMTALA Policy and other appropriate Hospital policies. EMTALA obligations do not apply to inpatients of the Hospital.
1.5.6 A patient can be admitted to the Hospital in the name of the Call Panelist by the Emergency Physician if both parties concur, but if the Emergency Physician so specifies, the Call Panelist must see the patient prior to the admission. The Call Panelist must be notified about each admission prior to the patient leaving the Emergency Department.

1.5.7 A Call Panelist shall cooperate with, and assist the Emergency Department, Emergency Physicians, and all Department Chairs or other Practitioners who may call a Call Panelist for assistance. The Call Panelist shall act in the best interests of patient care and in accordance with this Rule and the System’s philosophy and policies and procedures.

1.5.8 Call Panelists will assume the care of any unassigned patients in the Emergency Department and unassigned patients referred for follow-up care. Once the Call Panelist has assumed care of the patient, that patient’s care shall be the responsibility of the Call Panelist until the patient’s emergency medical condition or other problem that prompted the Call Panelist’s assignment is resolved and the patient has been discharged or appropriately transferred in accordance with System policies or discharged with a plan for appropriate follow-up care. The Call Panelist is solely responsible for billing and collecting any professional fees for services provided as a Call Panelist. The Hospital has no responsibility for this physician/patient relationship and each Call Panelist agrees to release the Hospital from any obligation in this regard.

1.5.9 Disputes between a Call Panelist and the patient or the patient’s family or authorized decision-maker in the Emergency Department shall be referred to the Emergency Physician.

1.5.10 If a Call Panelist is not available due to situations beyond his or her control or otherwise refuses or fails to respond to a call during his or her Coverage Period, the appropriate Department Chair/designee will be called for guidance in contacting another appropriate Practitioner to handle the care of the patient in accordance with the Chain of Command policy. All members of the Medical Staff shall cooperate to the fullest extent in order to provide screening and stabilizing treatment to patients seeking emergency care within the services and facilities available at the Hospital.

1.5.11 If a Call Panelist refuses or fails to respond by telephone or in person in a timely manner as required by this Rule, any person may initiate corrective action as provided in these Rules against the Call Panelist based on a violation of Call Panel obligations (alone or in conjunction with any other lack of qualifications, professional misconduct or substandard care).

1.6 EMPLOYED PRACTITIONERS

1.6.1 General

The Hospital or another SCL Health – Front Range System Member may from time to time, in the exercise of their respective business judgment, employ Practitioners who practice at the Hospital. The Hospital desires to preserve the independent medical judgment of employed Practitioners. The Hospital also desires to provide a process for the resolution of any complaints concerning potential violations of this Rule 1.6 and Colorado law regarding employed Practitioners, and to provide adequate due process for the affected Practitioners.

1.6.2 Preservation of Professional Judgment

The Hospital shall not limit or otherwise exercise control over any employed Practitioner’s independent professional judgment concerning the practice of medicine, dentistry or podiatry, as applicable, or diagnosis or treatment, or require any employed Practitioner to refer exclusively to the Hospital or the Hospital’s other employed Practitioners.
1.6.3 No Discrimination

The Hospital shall not discriminate with regard to any Practitioner’s Medical Staff membership or Privileges on the basis of whether the Practitioner (i) is an employee of the Hospital, (ii) has Privileges with Hospital, or (iii) contracts with the Hospital. Notwithstanding the foregoing, nothing in this Rule 1.6 shall affect the terms of any contract or written employment arrangement with any Practitioner that provides that the Practitioner’s Medical Staff membership or Privileges are incident to or coterminous with the contract or employment arrangement with the Hospital or the Practitioner’s association with a professional services group holding the contract with the Hospital, including any exclusive or semi-exclusive contract.

1.6.4 Fees

The Hospital shall not offer any employed Practitioner a percentage of fees charged to patients by the Hospital or any other financial incentive to artificially increase hospital services provided to patients.

1.6.5 Program

Nothing in this Rule 1.6 shall affect the Hospital’s decisions with respect to the availability of services, technology, equipment, facilities or treatment programs. Furthermore, nothing in this Rule 1.6 shall require the Hospital to make available additional services, technology, equipment, facilities or treatment programs.

1.6.6 Due Process

Any Practitioner who believes he or she has been the subject of a violation of Rules 1.6.2, 1.6.3, 1.6.4 or 1.6.5 has the right to complain to the Hospital and to request a review of the complaint in accordance with this Rule 1.6.6.

a. The affected Practitioner shall provide written notice of his/her complaint to Administration.

b. Administration shall review the issues raised in the Practitioner’s notice, and shall attempt to meet and confer with the affected Practitioner within ten (10) working days of receipt of the Practitioner’s notice.

c. If the issues raised in Practitioner’s notice cannot be resolved in accordance with Rule 1.6.6(b) above, Administration shall provide the Practitioner with written notice of the Hospital’s position concerning the complaint within an additional five (5) working days. Such notice shall include a statement of the Hospital’s position and the general reasons for its position.

d. If the affected Practitioner is not satisfied with the Hospital’s written notice, he or she and the Hospital may thereafter proceed with a hearing in accordance with applicable Human Resources policies. The affected Practitioner shall not be entitled to a hearing and appeal under the Medical Staff Bylaws or the Peer Review, Fair Hearing and Appeals Rules for any alleged violation of this Rule 1.6.
RULE 2 COMMITTEES

2.1 GENERAL

2.1.1 Appointment of Members

a. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the President, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

b. A Medical Staff committee created in these Rules is composed as stated in the description of the committee in the Medical Staff Bylaws, Rules or committee charter, each of which is incorporated into these Rules by this reference. Except as otherwise provided in the Medical Staff Bylaws, Rules, or charter, committees established to perform Medical Staff functions may include any category of Medical Staff Members; Allied Health Practitioners; representatives from Hospital departments such as Administration, Nursing Services, or Health Information Services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff Member who serves on a committee participates with a vote, unless the reference description of committee composition designates the position as non-voting.

c. If a Medical Staff committee is performing Professional Review activities, the majority of the voting members of the committee will be licensed Physicians.

d. If the Medical Staff committee will review the competence of, or the quality and appropriateness of patient care provided by an Advanced Practice Nurse, the committee will either (i) have as a voting member (approved by the President as a standing member or as an ad hoc member of the committee), at least one Advanced Practice Nurse with a similar scope of practice as the person who is the subject of the review, or (ii) engage an independent Advanced Practice Nurse with a similar scope of practice as the person who is the subject of the review, and who was not previously involved in the review, to perform an independent review.

e. If the Medical Staff committee will review the competence of, or the quality or appropriateness of care provided by a Physician Assistant, the Medical Staff President may, in his/her discretion, require the committee to (i) have as a voting member (appointed by the President as a standing or ad hoc member of the committee or (ii) consult with or perform an independent review from a Physician Assistant who was not previously involved in the review.

f. The Chief Executive Officer, or his or her designee, shall appoint any non-Medical Staff Members, non-APN or non-PA members who serve on Medical Staff committees in Ex Officio capacities.

g. The committee chair, after consulting with the President and Chief Executive Officer, may call on outside consultants or special advisors, subject to the Rules and the applicable committee’s charter.

h. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.
2.1.2 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

2.1.3 Ex Officio Members

All Medical Staff Officers, the Chief Executive Officer, the Chief Medical Officer and such Vice Presidents designated by the Chief Executive Officer (or any of their designees) are Ex Officio members of all standing and special committees of the Medical Staff and shall serve without vote, unless otherwise provided otherwise in the provision, charter or resolution creating the committee.

2.1.4 Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to or other than members of the standing committee to the subcommittee after consulting with the President regarding Medical Staff Members, and the Chief Executive Officer regarding Hospital staff.

2.1.5 Terms and Removal of Chair and Committee Members

Unless otherwise specified, each chair and committee member shall be appointed by the President for a term of two (2) years, subject to unlimited renewal, and shall serve until the end of this term and until his or her successor is appointed, unless he or she shall sooner resign, die, become disabled (such that he or she cannot fulfill the duties even with any reasonable accommodations required by law) or be removed from the committee. Any chair or committee member who is appointed by the President may be removed by a majority vote of the Medical Executive Committee. The removal of any chair or committee member who is automatically assigned to a committee because he or she is a Medical Staff Officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

2.1.6 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

2.1.7 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 10 of the Medical Staff Bylaws.

2.1.8 Attendance of Nonmembers

Any Medical Staff Member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that Practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request if the Member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited Member shall abide by all Medical Staff Bylaws and Rules applicable to that committee.

2.1.9 Accountability

All committees shall be accountable to the Governing Body, reporting through the Medical Executive Committee, unless otherwise provided in these Rules or other applicable policies or charters.
2.2 CANCER COMMITTEE

2.2.1 Composition

The Cancer Committee shall include at least one physician from the required specialties: Medical Oncology, Radiation Oncology, Surgery, Diagnostic Radiology, and Pathology. The Cancer Liaison Physician shall be a member of the Cancer Committee and may fulfill the role of one of the required specialties.

The Cancer Committee shall include at least one non-physician member from: the cancer program administration, oncology nursing, social services or case management, certified tumor registrar, and quality improvement.

Additional members may include: Hospice, palliative care, clinical research, nutrition, pharmacy, pastoral care, mental health, American Cancer Society, and public members of the community served.

2.2.2 Duties

a. Responsible and accountable for all cancer program activities and assure the Hospital is meeting cancer program accreditation standards.

b. Designates one coordinator for each of the four areas of Cancer Committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach. The Cancer Liaison Physician shall fulfill the role of the community outreach coordinator.

c. Develop and evaluate annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors on an annual basis.

d. Establish subcommittees or workgroups as needed to fulfill cancer program goals.

e. Establish the cancer conference format and annually ensure/monitor: cancer conference frequency, multidisciplinary attendance, required number of cases are discussed, at least 75 percent of the cases are presented prospectively.

f. Establish and implement a plan to evaluate the quality of cancer registry data and activity on an annual basis.

g. Complete site-specific analysis that includes comparison and outcome data and disseminates the results to the Medical Staff.

h. Reviews 10 percent of the analytic caseload to ensure the AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on at least 90 percent of eligibility analytic cases.

i. Review 10 percent of the analytic caseload to ensure the 90 percent of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.

j. Provide a formal mechanism to educate patients about cancer-related clinical trials and review the percentage of cases accrued to the clinical trials annually.

k. Monitor community outreach activities annually.

l. Offer one cancer-related educational activity each year.
m. Complete and document required studies that measure quality and outcomes.

n. Implement two improvements that directly affect patient care.

o. Promote a coordinated, multidisciplinary approach to patient management.

p. Ensure that an active supportive care system is in place for patients, families, and staff.

q. Promote clinical research.

r. Encourage data usage and regular reporting.

s. Uphold medical ethical standards.

t. Maintain and improve relationships with external organizations involved in cancer control and services.

2.2.3 Meetings and Reporting

The Committee shall meet as often as necessary, but no less than quarterly. It shall report to the Performance Excellence Committee.

2.3 CONFERENCE COMMITTEE

2.3.1 Composition

The Conference Committee shall include the following voting members: The Presidents and Credentials Committee Chairs of each System Member Hospital, as ex officio members with a vote, or their respective designees, and one (1) appointed member of the Governing Board or his/her designee. The Conference Committee shall include the Chief Medical Officers of each System Member Hospital, as ex officio members without a vote, or their respective designees.

2.3.2 Quorum

The presence of either the President or Credentials Committee Chair (or their respective designee) from each System Member Hospital, and the member of the Governing Board or his/her designee shall constitute a quorum for any meeting of the Conference Committee.

2.3.3 Meetings

a. A meeting of the Conference Committee may be called by any of its members if two or more Credentials Committees or Medical Executive Committees have made, or are likely to make, inconsistent appointment or reappointment recommendations or other inconsistent professional review recommendations or actions regarding a Shared Practitioner.

b. The Conference Committee shall meet on an ad hoc basis, within ten (10) calendar days of a request for a meeting.

2.3.4 Duties

a. The purpose of the Conference Committee is to promote consistent appointment and reappointment recommendations and other professional review recommendations or actions by the Credentials Committees and Medical Executive Committees regarding a Shared Practitioner, in furtherance of quality of care in the System Members.
b. The Conference Committee will (i) review the professional review information available regarding the subject Shared Practitioner, (ii) consider the views of each System Member's Credentials Committee or Medical Executive Committee, as applicable, and (iii) make a recommendation back to the Credentials Committees or Medical Executive Committees, as applicable, to resolve the inconsistency after considering the available facts, what action is warranted by the facts known and in furtherance of quality of care within the System Members.

c. The Conference Committee does not have authority to take final professional review action or to make a recommendation directly to the Governing Board regarding a Shared Practitioner.

2.4 CONTINUING MEDICAL EDUCATION COMMITTEE

2.4.1 Composition

The Continuing Medical Education Committee (CME) shall consist of at least three (3) Active Medical Staff Members and the Chief Medical Officer.

2.4.2 Duties

The Continuing Medical Education Committee shall:

a. Maintain Colorado Medical Society accreditation to award the American Medical Association Physicians Recognition Award Category 1 CME credits (AMA PRA Category 1 Credit™) for the Hospital as reviewed and approved by the committee.

b. Develop, plan, and participate in programs of continuing medical education which are designed to keep the Medical Staff and regional physicians informed of significant new developments and new skills in medicine, and which are responsive to evaluation findings;

c. Develop, plan, participate in and accredit continuing medical education programs for physicians within the System referral area;

d. Act upon continuing medical education recommendations from the Medical Executive Committee, other committees, and the Department leaders;

e. Track continuing medical education credits earned by Medical Staff Members for programs provided within the System, and provide this information for inclusion in the Members' credentialing files.

2.4.3 Meetings and Reporting

The Continuing Medical Education Committee shall meet at least quarterly. It shall report to the Medical Executive Committee.

2.5 CREDENTIALS COMMITTEE

2.5.1 Composition and Chair

The Credentials Committee shall be composed of at least five (5) members of the Medical Staff and may include one or more Allied Health Professionals, so long as the majority of the voting members of the Credentials Committee are licensed Physicians. Credentials Committee members shall be appointed by and may be removed by the President, subject to consultation with the Medical Executive Committee. The Credentials Committee Chair shall be selected and removed in accordance with Article 8 of the Medical Staff Bylaws. The Committee shall appoint a vice chair to fulfill the duties of the Chair in the absence of
the Chair. The Chair or vice chair shall have the right to discuss and to vote on issues presented to the committee. If the Credentials Committee is reviewing the competence of, or the quality and appropriateness of patient care provided by an Advanced Practice Nurse, the Credentials Committee will either (i) have as a voting member (appointed by the President as a standing member or as an ad hoc member of the Credentials Committee), at least one Advanced Practice Nurse with a similar scope of practice as the person who is the subject of the review, or (ii) engages an independent Advanced Practice Nurse with a similar scope of practice as the person who is the subject of the review, and who was not previously involved in the review, to perform an independent review. If the APN was reviewed by another committee (such as an ad hoc investigation committee) that included an APN as a voting member or that engaged an independent APN with a similar scope of practice as the APN who is the subject of the review, the Credentials Committee may rely on that underlying committee’s expertise in the review of the APN. If the Credentials Committee will review the competence of, or the quality or appropriateness of care provided by a Physician Assistant, the Credentials Committee may, in the discretion of the Medical Staff President, either (i) have as a voting member (appointed by the President as a standing or ad hoc member of the committee) or (ii) consult with or within an independent review from a Physician Assistant who was not previously involved in the review.

2.5.2 Duties

a. The Credentials Committee shall evaluate or coordinate the evaluation of the qualifications of all applicants for Medical Staff appointment, reappointment, or changes in Medical Staff categories or Privileges. The Committee shall develop recommendations based on its and the Department’s evaluation of each applicant.

b. The Credentials Committee may also initiate, review and report on matters involving the clinical, ethical or professional performance of any Member. The Committee may act on its own initiation or upon the referral of a matter by any Medical Staff Officer, Department leader, or Committee, except that the Credentials Committee does not have the authority to authorize a corrective action investigation.

2.5.3 Meetings

The Credentials Committee shall meet as often as necessary, but at least quarterly.

2.6 DEPARTMENT COMMITTEES

2.6.1 Composition

At the discretion of the Department Chair, a Department may form a Department committee consisting of at least three (3) Active Medical Staff Members.

2.6.2 Duties

The Department Committees shall assist the Department Chair to carry out the responsibilities assigned to the Department Chair, including the duties to review applicants for appointment, reappointment, and clinical Privileges. The Department Committees shall also fulfill the performance and quality improvement and peer review functions assigned to them by the Medical Executive Committee.

2.6.3 Meetings

Each Department Committee shall meet as often as necessary and report to their Department.
2.7 **ETHICS COMMITTEE**

2.7.1 Composition

The Ethics Committee shall be composed of at least the following members: three (3) Practitioners, one (1) of whom should be a psychiatrist (if one is available), one (1) Registered Nurse, one (1) clergy, one (1) medical social worker (or a comparable discipline), one (1) member of hospital administration, one (1) non-hospital local community member at large, one (1) patient representative and one (1) ethicist (if one is available). Additional members may be appointed by the President.

2.7.2 Duties

The Ethics Committee shall strive to contribute to the quality of health care provided by the Hospital by:

a. Providing assistance and resources for decisions which have ethical implications. The Ethics Committee shall not, however, be a decision-maker in any case.

b. Educating members within the Hospital concerning ethical issues and dilemmas.

c. Facilitating communication about ethical issues and dilemmas among Hospital staff and Medical Staff members, in general, and among participants involved in ethical dilemmas and decisions, in particular.

d. Retrospectively reviewing cases to evaluate ethical implications, and providing policy and education guidance relating to such matters.

2.7.3 Meetings

The Ethics Committee shall meet as often as necessary. The committee shall appoint members who shall be available to Medical Staff members to consult on an as needed basis.

2.8 **INFECTION PREVENTION COMMITTEE**

2.8.1 Composition

a. The Infection Prevention Committee shall be composed of at least three (3) Members, including at least 1 Physician whose primary specialty is infectious disease. In addition, a nurse whose responsibilities primarily involve infectious disease and a Pharmacy representative shall be voting members.

b. Representatives from Employee Health, nursing administration, the operating room, Central Supply, System administration housekeeping, laundry, dietetic services, and engineering and maintenance shall be available on a permanent or consultative and ad hoc basis, as determined by the President from time to time.

2.8.2 Duties

The Infection Prevention Committee shall develop and monitor the infection control program. The Committee shall review reported data and approve action to reduce risks of acquiring and transmitting infections in patients, healthcare workers, and visitors. At least every two years, the Committee shall review and approve all policies relating to the infection control program. The Chair or his or her designee shall be available for on-the-spot interpretation of applicable Rules and policies.
2.8.3 Meetings and Reporting

The Infection Prevention Committee shall meet as necessary. It shall report to the Performance Excellence Committee.

2.9 **INSTITUTIONAL REVIEW BOARD**

2.9.1 Composition

a. The Board of Directors of SCL Health – Front Range, which serves as Governing Body of the Hospital, shall appoint the members of the Institutional Review Board (IRB) after conferring with the Presidents of the Medical Staffs of Exempla Saint Joseph Hospital, Exempla Lutheran Medical Center and Exempla Good Samaritan Medical Center. The Committee shall function as a joint committee for SCL Health – Front Range and its hospitals. Terms of office will be determined by the Board of Directors.

b. The IRB shall be composed in a manner which meets the requirement of the Department of Health and Human Services (DHHS) and Food and Drug Administration (FDA) regulations for the protection of human subjects. The IRB shall have at least five (5) members, with varying backgrounds, to complete an adequate review of research activities commonly conducted in the institution. If an IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one (1) or more individuals who are primarily concerned with the welfare of these subjects.

c. The IRB may not consist entirely of men or entirely of women, or entirely of members of one (1) profession. It shall include at least one (1) member whose primary concerns are in nonscientific areas (for example: lawyers, ethicists, members of the clergy), and at least one (1) member who is not affiliated with the institution. No member may participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, at its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

2.9.2 Duties

a. The IRB must adopt and follow written procedures for carrying out the duties imposed by the DHHS and FDA regulations, including procedures for:

(1) Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.

(2) Determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review.

(3) Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval was already given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject. Reporting to the IRB shall be at the next appropriate opportunity.

(4) Assuring prompt reporting to the IRB of unanticipated problems involving risks to subjects or others.
(5) For research subject to DHHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.

(6) Assuring timely reporting to the appropriate institutional officials of (i) any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB; and (ii) any suspension or termination of IRB approval. For research subject to the DHHS and FDA regulations, these reports must also be made to DHHS and/or to the FDA, as appropriate.

(7) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth in Paragraph 2.11-2(c) below. In order for the research to be approved it must meet the criteria set forth in federal regulations and it must receive the approval of a majority of those members present at the meeting provided a quorum is present. Research which is approved by the IRB may be subject to further appropriate review by officials of the institution. However, those officials may not approve any research subject to the federal regulations if it has not been approved by the IRB.

b. The Institutional Review Board shall:

(1) Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities.

(2) Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The IRB may require that information, in addition to that specifically mentioned in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.

(3) Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.

(4) Notify the investigator and the institution in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

(5) Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and have authority to observe or have a third party observe the consent process and the research.

(6) Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

c. The IRB shall develop criteria defining when research or experimental procedures that are not subject to the federal Protection of Human Subjects regulations of DHHS and the FDA must
nevertheless be submitted to the IRB for review and then shall provide the review and monitoring for such activities.

2.9.3 Meetings and Reporting

The IRB shall meet as often as needed, but at least quarterly. The IRB shall report to the SCL Health – Front Range Board of Directors. Informational reports will be sent to the Medical Executive Committees for Exempla Saint Joseph Hospital, Exempla Lutheran Medical Center, and Exempla Good Samaritan Medical Center.

2.10 MEDICATION SAFETY COMMITTEE

2.10.1 Composition.

The Medication Safety Committee shall be comprised of not fewer than three (3) Members representing various specialties, plus representatives of Pharmacy and nursing.

2.10.2 Duties.

The Medical Executive Committee has delegated to the Medication Safety Committee the authority to develop, approve, implement, and monitor professional policies regarding (i) evaluation, selection, procurement, and safe use of non-controversial medications comprising the EGSMC Hospital formulary; (ii) preparation and the dispensing of medications; (iii) distribution, administration, safety, and effect (including reactions and interactions) of medication usage; (iv) patient education; (v) staff education; and (vi) other matters pertinent to medication use in EGSMC. For purposes of hospital licensing, the Medication Safety Committee is the Hospital’s designated pharmacy committee.

2.11 MEDICAL STAFF PEER REVIEW COMMITTEE

2.11.1 Composition

The Medical Staff Peer Review Committee ("MSPRC") will be comprised of at least seven (7) representative members (including the Chair) of the Active Medical Staff who are representative of the scope of medical practice in the Hospital. The President of the Medical Staff will appoint members, with approval by the Medical Executive Committee. MSPRC members may be removed by the Medical Executive Committee. Each member will serve such terms in the MSPRC Charter. (See the Medical Staff Peer Review Charter, incorporated by this reference). The Chair of the MSPRC will be appointed by the President in accordance with the Medical Staff Bylaws and the MSPRC Charter. The Chair will be a voting member of the Medical Executive Committee. The Officers of the Medical Staff are ex officio, non-voting members of the MSPRC.

a. A majority of the voting members of the Peer Review Committee will be licensed Physicians. if the Peer Review Committee is conducting an initial review of the competence of, or the quality and appropriateness of patient care provided by an Advanced Practice Nurse, the Committee will either (i) have as a voting member, at least one Advanced Practice Nurse (appointed by the President as standing or ad hoc member), or (ii) engage an independent Advanced Practice Nurse with a similar scope of practice as the person who is the subject of the review, and who was not previously involved in the review, to perform an independent review. If the APN was reviewed by another committee (such as an ad hoc investigation committee) that included an APN as a voting member or that engaged an independent APN with a similar scope of practice as the APN who is the subject of the review, the Medical Staff Peer Review Committee may rely on that underlying committee's expertise in the review of the APN. Notwithstanding the foregoing, the majority of the voting members of the Medical Staff Peer Review Committee shall be Physicians who are Active Members of the Medical Staff.
b. If the Peer Review Committee will review the competence of, or the quality or appropriateness of care provided by a Physician Assistant, in the discretion of the Medical Staff President, the Peer Review Committee may either (i) have as a voting member (appointed by the President as a standing or ad hoc member of the committee, or (ii) consult with or within an independent review from a Physician Assistant who was not previously involved in the review.

2.11.2 Duties

The MSPRC shall review the quality and appropriateness of care provided by Medical Staff Members and Allied Health Practitioners, as well as compliance with applicable Medical Staff Bylaws, Rules and policies. (See the Medical Staff Peer Review Policy, incorporated by this reference).

2.11.3 Meetings and Reporting

The MSPRC shall meet as often as necessary to fulfill its duties and shall report to the Medical Executive Committee and the Performance Excellence Committee to address System, Hospital and process related topics.

2.12 PERFORMANCE EXCELLENCE/PATIENT SAFETY COMMITTEE

2.12.1 Composition and Chair

The Performance Excellence/Patient Safety Committee will include at least three (3) Active Members of the Medical Staff and such other representatives of health care disciplines and administration set forth in the committee’s charter and associated policies (collectively, the “charter”), as amended from time to time, which is incorporated herein by this reference. The Chair of the Performance Excellence/Patient Safety Committee shall be appointed and removed as set forth in the Medical Staff Bylaws. The Chair shall serve as a member of the Medical Executive Committee.

2.12.2 Duties

The Performance Excellence/Patient Safety Committee shall perform the duties of a medical audit committee, a tissue committee, medical records committee and such duties as are set forth in its charter, which may be amended from time to time. The Performance Excellence Plan shall serve as the Hospital’s quality plan and shall be submitted to the Colorado Department of Public Health and Environment, Health Facilities Division, for purposes of the Hospital’s licensing as a general hospital. The Medical Staff Bylaws and Rules are hereby incorporated by reference into the Performance Excellence/Patient Safety Committee’s charter for purposes of any credentialing or other Peer Review of non-Physician, non-Advanced Practice Nurse and Physician Assistant practitioners who apply for or are granted Medical Staff membership, Allied Health Practitioner status, Privileges or Scope of Practice.

2.12.3 Meetings and Reporting

The Performance Excellence/Patient Safety Committee shall meet as often as necessary to fulfill its duties. It shall report to the Governing Body and shall report to the Medical Executive Committee.

2.13 TRANSFUSION COMMITTEE

2.13.1 Composition

The Transfusion Committee shall consist of the Manager and Medical Director of the Blood Bank, at least two (2) Medical Staff Members, and a representative from nursing.
2.13.2 Duties

The Transfusion Committee shall:

a. Be responsible for monitoring and evaluating the processes related to the use of blood and blood components;

b. Coordinate and critically assess the activities related to the ordering, distributing, handling, dispensing, administering and monitoring blood and blood component effects on patients;

c. Establish a mechanism for systematically measuring and documenting, on an ongoing basis, the processes related to the use of blood and blood components; and

d. Evaluate each actual or suspected transfusion reaction referred to the committee and make a report of its findings for review by other Medical Staff committees as appropriate.

2.13.3 Meetings and Reporting

The Transfusion Committee shall meet as often as necessary to fulfill its duties and shall report to the Trauma Committee and Patient Safety Committee.

2.14 TRAUMA COMMITTEE

2.14.1 Composition and Chair

The Trauma Committee is a multidisciplinary committee and shall consist of the Trauma Service Director, Trauma Nurse Coordinator, representatives of the following medical disciplines: anesthesia, critical care, emergency medicine, orthopedics, neurosurgery, radiology, and trauma surgery; nursing directors or their designees who are responsible for surgery, emergency, ICU, and medical/surgical departments/units; and such other representatives of health care and medical disciplines and administration deemed necessary by the Trauma Committee. The Chair of the Trauma Committee shall be appointed and removed as set forth in the Medical Staff Bylaws.

2.14.2 Duties

The Trauma Committee shall be responsible for the development, implementation, and monitoring of the trauma program. Functions include but are not limited to: quality improvement program; establishing policies and procedures; reviewing process issues, e.g., communications; promoting educational offerings; reviewing systems issues, e.g., response times and notification times; and reviewing and analyzing trauma registry data for program evaluation and utilization; and other such functions deemed necessary by the committee.

2.14.3 Meeting and Reporting

The Trauma Committee shall meet as often as necessary to fulfill its duties. It shall report to the Medical Executive Committee at least two times per year.
RULE 3 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

3.1 CONTRACTORS WITH NO CLINICAL DUTIES

A Practitioner employed by or contracting with the System in a purely administrative capacity with no clinical duties or Privileges is subject to the System’s regular personnel policies and to the terms of his or her contract or other conditions of employment and need not be a Medical Staff Member.

3.2 CONTRACTORS WHO HAVE CLINICAL DUTIES

3.2.1 A Practitioner with whom the System contracts to provide services which involve clinical duties or Privileges must be a Medical Staff Member, achieving his or her status by the procedures described in the Medical Staff Bylaws and Rules. Unless otherwise required by law, those Privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty arrangement will automatically terminate, without the right of access to the review, hearing, and appeal procedures of these Medical Staff Bylaws and Rules, upon termination or expiration of such Practitioner’s contract or agreement with the System or the Hospital.

3.2.2 Contracts between Practitioners and the System or the Hospital shall prevail over these Medical Staff Bylaws and the Rules, except that the contracts may not reduce any hearing rights that are legally mandated when an action will be taken that must be reported to the Colorado Medical Board or the National Practitioner Data Bank.

3.3 SUBCONTRACTORS

Practitioners who are subcontractors of Practitioners with an exclusive or semi-exclusive contract with the System or Hospital shall lose any Privileges granted pursuant to an exclusive or semi-exclusive arrangement (and their Medical Staff membership if all Privileges are automatically terminated) if their relationship with the contracting Practitioner is terminated, or the System or Hospital and the contracting Practitioner’s agreement or exclusive or semi-exclusive relationship is terminated. The System or Hospital may enforce such an automatic termination even if the subcontractor’s agreement fails to recognize this right.