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Examplea Good Samaritan Medical Center-Medical Staff Bylaws
Final Version 15 adopted September 19, 2014
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EXEMPLA GOOD SAMARITAN MEDICAL CENTER, LLC
MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted to provide a framework for the Exempla Good Samaritan Medical Center Medical Staff (i) to discharge its responsibilities in matters involving the oversight of care, treatment and services provided by Practitioners with Privileges and Allied Health Practitioners with Privileges or Scope of Practice, (ii) to provide for uniform quality of patient care, treatment and services, (iii) to govern the orderly resolution of issues, (iv) to provide a framework for the Medical Staff’s self-governance, and (v) to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and Members of the Medical Staff. The Governing Body has the ultimate authority and responsibility for the oversight and delivery of health care rendered by Practitioners and Allied Health Practitioners who are credentialed and granted Privileges through the Medical Staff processes. These Bylaws and the Rules are not intended to and shall not be deemed to be a contract between Hospital or Hospital Medical Staff and individual Practitioners or Allied Health Practitioners.

DEFINITIONS

1. ADVANCED PRACTICE NURSE or APN means a nurse with specialized education and training who applies to and is accepted by the Colorado Board of Nursing for inclusion in the advanced practice registry. For purposes of these Bylaws, Advanced Practice Nurse or APN includes those categories of nurses for whom the Medical Staff has recommended and the Board has approved Privileges, as set forth in Exhibit A to the Allied Health Practitioners Rules, which may include nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives.

2. ALLIED HEALTH PRACTITIONER or AHP means an individual, other than a licensed physician, dentist, clinical psychologist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, psychological or podiatric care under the supervision or direction of a Medical Staff Member or in collaboration with a Medical Staff Member possessing Privileges to provide such care in the Hospital, and who may be eligible to exercise Privileges or Scope of Practice and prerogatives in conformity with the Rules adopted by the Governing Body, these Bylaws, and the Rules. AHPs are not eligible for Medical Staff membership.

3. BYLAWS OR MEDICAL STAFF BYLAWS refers to this document as adopted by the Organized Medical Staff Voting Members and approved by the Governing Body, which defines the rights, responsibilities, and accountabilities of the Medical Staff and various officers, persons, and groups within the structure of the Medical Staff; the self-governance functions of the Medical Staff, and the working relationship with and accountability to the Governing Body.

4. CHIEF EXECUTIVE OFFICER means the person appointed by the Governing Body to serve in an administrative capacity or his or her designee.

5. CHIEF MEDICAL OFFICER means a Practitioner appointed by the Chief Executive Officer to provide administrative support and leadership for the Medical Staff and serve as a liaison between the Medical Staff and the administration or his or her designee.

6. DATE OF RECEIPT means the date any Notice, Special Notice or other communication was delivered personally; or if such Notice, Special Notice or communication was sent by mail, it shall mean 72 hours after the Notice, Special Notice or communication was deposited, postage prepaid, in the United States mail. [See also, the definitions of NOTICE and SPECIAL NOTICE, below.]
7. **DEPARTMENT** means an organized integral unit of the Medical Staff.

8. **DESIGNEE** means:

   For purposes of these Bylaws and the Rules, all references to the Chief Executive Officer, a Hospital Vice President, the Chief Medical Officer, a Medical Staff Officer or leader, a Department Chair or Vice Chair, and a Committee Chair, shall include his or her designee. Without limiting the foregoing:

   a. The Chief Executive Officer’s designees shall include the Chief Medical Officer, the Chief Nursing Officer, and such other persons designated by the Chief Executive Officer.

   b. The Chief Medical Officer’s designees shall include the Chief Nursing Officer, the Chief Medical Officers for the other System hospitals, and such other persons designated by the Chief Medical Officer.

   c. A Vice President’s designee shall include such other Vice Presidents and persons designated by such Vice President

   d. The President’s designees shall include the President-Elect, the Credentials Committee Chair, and such other persons designated by the President.

   e. The President Elect’s designees shall include the Credentials Committee Chair and such other persons designated by the President Elect.

   f. The Department Chair’s designee shall include the Vice Chair, and such other persons designated by the Department Chair.

   g. The Credentials Committee Chair’s designee shall include the Vice Chair, a designated committee member, and such other person designated by the Credentials Committee Chair.

   h. Any other Committee’s Chair shall include the Vice Chair (if any), a committee member, and such other person designated by the Chair.

9. **EX OFFICIO** means service by virtue of office or position held. An Ex Officio appointment is with vote unless specified otherwise.

10. **GOVERNING BODY** means the governing body of Hospital. As appropriate to the context and consistent with Hospital’s governance documents, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

11. **HOSPITAL** means Exempla Good Samaritan Medical Center.

12. **LIMITED LICENSE PRACTITIONERS** means dentists, podiatrists, and clinical psychologists.

13. **MEDICAL EXECUTIVE COMMITTEE** or **EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff.

14. **MEDICAL STAFF** means the organizational component of Hospital that includes all physicians (M.D. or D.O.), dentists, clinical psychologists, and podiatrists who have been granted recognition as Members pursuant to these Bylaws.

15. **MEDICAL STAFF POLICIES** means policies relating to Medical Staff governance. This does not include clinical practice policies, guidelines, and protocols.
16. **MEDICAL STAFF YEAR** means the period from January 1 through December 31.

17. **MEMBER** means any Practitioner who has been appointed to the Medical Staff.

18. **NOTICE** means a written communication delivered personally to the addressee or sent by United States mail, postage prepaid, or by facsimile or by electronic transmission addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the System. (See also, the definitions of **DATE OF RECEIPT** above and **SPECIAL NOTICE** below.)

19. **ORGANIZED MEDICAL STAFF** means the self-governing entity accountable to the Governing Body that operates under these Bylaws, the Rules and Regulations, and the Policies developed and adopted by Organized Medical Staff Voting Members and approved by the Governing Body. The Organized Medical Staff is composed of doctors of medicine and osteopathy, dentists, podiatrists, clinical psychologists and, in accordance with these Medical Staff Bylaws, may include other health care professionals as approved by the Organized Medical Staff and Governing Body.

20. **ORGANIZED MEDICAL STAFF VOTING MEMBERS** means those Practitioners within the Organized Medical Staff who are appointed to the active Medical Staff and have the prerogative to vote on adopting and amending Medical Staff Bylaws, Rules and Regulations, and Policies.

21. **PEER REVIEW OR PROFESSIONAL REVIEW** means the entire process to evaluate the competence, professional conduct or, or the quality and appropriateness of care provided by Practitioners and AHPs, including credentialing, privileging, and actions relating to the Practitioner’s authorization to provide patient care in the Hospital or any System Member.

22. **PHYSICIAN** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

23. **PRACTITIONER** means, unless otherwise expressly limited, any currently licensed Physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist.

24. **PRESIDENT** means the chief officer of the Hospital Medical Staff or his or her designee.

25. **PRESIDENT ELECT** means the successor to the chief officer of the Hospital Medical Staff or his or her designee.

26. **PRIVILEGES** means the permission granted to a Medical Staff Member or AHPs who are physician assistants or advance practice nurses to render specific patient services.

27. **RULES OR MEDICAL STAFF RULES AND REGULATIONS** refer to the General Medical Staff Rules; the Credentialing and Privileging Rules; the Peer Review, Fair Hearing and Appeal Rules; the Clinical Rules; Department Rules; Allied Health Practitioner (“AHP”) Rules; Medical Staff Policies and application forms adopted in accordance with these Bylaws, unless specified otherwise.

28. **SCL FRONT RANGE** means SCL Health – Front Range, Inc. (fka Exempla, Inc.), which is the manager of Exempla Good Samaritan Medical Center, LLC.

29. **SCOPE OF PRACTICE** means the permission granted to an AHP (other than a physician assistant or advanced practice nurse) to engage in a specific practice at the Hospital.

30. **SPECIAL NOTICE** means a Notice delivered personally or sent by certified or registered mail, return receipt requested. (See also, the definitions of **DATE OF RECEIPT** and **NOTICE** above.)

31. **SYSTEM** means SCL Health – Front Range and any affiliated System Member.
SYSTEM MEMBER means a facility or entity or department that is part of the System, including without limitation: SCL Health – Front Range, Inc. (fka Exempla) (“SCL Front Range”); SCL Front Range dba Exempla Lutheran Medical Center; Saint Joseph Hospital, Inc., dba Exempla Saint Joseph Hospital; SCL Front Range dba Exempla Physician Network; Exempla Good Samaritan Medical Center, LLC, and other hospitals, health systems, physician organizations, accountable care organizations, ambulatory surgery centers and other entities owned or operated by, or otherwise affiliated with SCL Front Range that are defined as “Authorized Entities” under Colorado Professional Review Act CRS 12-36.5-101, et seq.
ARTICLE 1 NAME AND PURPOSES

1.1 NAME
The name of this organization shall be the Exempla Good Samaritan Medical Center Medical Staff.

1.2 PURPOSES AND RESPONSIBILITIES
The Medical Staff's (when indicated) and the Organized Medical Staff's purposes and responsibilities are:

1.2.1 To report to and be accountable to the Governing Body for matters within its responsibilities.

1.2.2 To provide oversight of quality and safety of care, treatment, and services provided by Practitioners with Privileges, for patients of the Hospital during the entire length of stay, including through delegation of such oversight responsibilities to certain designated Members of the Medical Staff.

1.2.3 To provide a structure for a uniform quality of patient care, treatment and services.

1.2.4 To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Hospital's means and circumstances.

1.2.5 To organize and support professional education and community health education and support services.

1.2.6 To initiate, develop, adopt, amend, and maintain Bylaws, Rules and Regulations, and Policies, which shall be compatible with the Governing Body's Bylaws and hospital policies and compliant with law and Regulation, for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital, subject to approval of the Governing Body.

1.2.7 To recommend to the Governing Body any Bylaws, Rules and Regulations, Policies and amendments thereto.

1.2.8 To provide a means for the Medical Staff, Governing Body and Administration to discuss issues of mutual concern.

1.2.9 To periodically conduct appraisals of Medical Staff Members and AHPs.

1.2.10 To establish standards for Medical Staff membership and examine the credentials of applicants for Medical Staff membership and Privileges and for AHP Privileges or Scope of Practice, as applicable, and to make recommendations to the Governing Body.

1.2.11 To engage in performance improvement activities for the Hospital.

1.2.12 To provide for accountability of the Medical Staff to the Governing Body regarding the quality of care, treatment and services provided to patients of the Hospital.

1.2.13 To provide for self-governance, including selection and removal of Medical Staff Officers.

1.2.14 To comply with these Medical Staff Bylaws, Rules and Regulations, Policies, and clinical policies, protocols, and guidelines (Applies to all Medical Staff).

1.2.15 To enforce these Medical Staff Bylaws, Rules and Regulations, Policies and clinical policies, protocols, and guidelines by recommending action to the Governing Body in certain circumstances and taking action in others pursuant to the Medical Staff Bylaws, Rules and Regulations and Policies.
1.2.16 To provide oversight for analyzing and improving patient safety and patient satisfaction.

1.2.17 To support the mission and vision of the Sisters of Charity of Leavenworth Health System, SCL Health – Front Range and Exempla Good Samaritan Medical Center.

1.3 HEALTH SYSTEM AFFILIATION

One of the purposes of the System is to maintain comparably high professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, corrective action, and procedural rights are hereby authorized, in accordance with the guidelines in these Bylaws.

1.3.1 Peer Review

The Medical Staff may use information from the Credentials Verification Office (CVO) and other System Members to assist it in credentialing and other Peer Review activities. This may include, without limitation, relying on information in other System Members' credentials and peer review files in evaluating applications for appointment and reappointment, and utilizing the other System Members' medical or professional staff support resources to process or assist in processing applications for appointment and reappointment and other Peer Review activities.

1.3.2 Appointment, Reappointment and Corrective Action

The Medical Staff will work cooperatively with any other System Member at which a Medical Staff Member applies for or holds Privileges to develop and impose coordinated, cooperative, or joint appointment, reappointment and corrective action measures as deemed appropriate to the circumstances. This may include, but is not limited to, coordinated appointment and reappointment and giving timely notice of emerging or pending problems, as well as notice of any limitations or corrective actions imposed and/or reciprocal effectiveness of such corrective actions as provided in these Bylaws and the Rules.

1.3.3 Joint Investigations, Hearings and Appeals

The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals with System Members provided the applicable procedures are substantially comparable to those set forth in the Hearing and Appellate Review Procedures established in the Peer Review, Fair Hearing and Appeal Rules and these Bylaws.
ARTICLE 2 MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff and/or Privileges is privileges and not a right, and may be extended to and maintained by only those professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules. A Practitioner, including one who is employed by and/or has a contract with the Hospital to provide medical-administrative services, may admit or provide services to patients in the Hospital only if the Practitioner is a Member of the Medical Staff or has been granted temporary Privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such Privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 General Qualifications

Membership on the Medical Staff and Privileges shall be extended only to Practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. Medical Staff membership (except Emeritus Medical Staff) shall be limited to Practitioners who are currently licensed or qualified to practice medicine, podiatry, clinical psychology, or dentistry in Colorado.

2.2.2 Basic Qualifications

A Practitioner must demonstrate compliance with all the basic standards set forth in this section in order to have an application for Medical Staff membership accepted for review. The Practitioner must:

a. Be licensed to practice medicine, dentistry, podiatry or clinical psychology in Colorado or qualify under Colorado law to practice with an out-of-state license.

b. To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration. Full DEA schedules are preferred. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA.

Exemption from this requirement may be granted if no scheduled drugs are required for the practitioner to exercise their clinical privileges and none will be prescribed. Applicant must so stipulate at time of appointment.

c. Be currently certified by a board recognized by the American Board of Medical Specialties, the American Board of Osteopathic Specialties, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, or a board association, or society, with equivalent requirements approved by the Medical Executive Committee and Governing Body in the specialty that the Practitioner will practice at the Hospital, or obtain such certification within five (5) years from completion of residency/fellowship training. This Section shall not apply to dentists, clinical psychologists, Affiliate staff, or Emeritus staff. A Practitioner will be granted a 60 day grace period to provide evidence of current Board Certification or other required certification providing the Practitioner has completed or submitted all requirements for the certification and is only awaiting confirmation of successfully attaining the certification.

d. Have and maintain professional liability insurance in the amounts required by the Governing Body, as set forth in the Rules that covers all Privileges requested or granted.

e. For Hospital Privileges, be able to provide continuous care to his or her patients. The Practitioner's distance to the Hospital may vary depending upon the Medical Staff category and...
Privileges which are involved and the feasibility of arranging alternative coverage and may be defined in the Rules.

f. Practitioners with or requesting Active or Courtesy status must identify one or more Medical Staff Members with comparable Privileges to provide 24-hour, 7 day a week coverage in their absence.

g. If requesting Privileges in a program or service line operated under an exclusive or semi-exclusive contract, be a member, employee, or subcontractor of the group or person that holds the contract.

h. Not be currently excluded or suspended from participation in any federal health care program, including the Medicare and Medicaid programs.

i. Provide an attestation and/or documentation of annual TB skin test status as may be required in accordance with the Colorado Department of Public Health & Environment surveillance data and the SCL Health – Front Range Tuberculosis Screening, Prevention, and Control Plan Policy.

j. Not have been convicted of any felony.

k. For Active and Courtesy applicants and members (other than Practitioners who limit their practice to telemedicine services and who do not come to the Hospital), provide evidence of seasonal influenza vaccination or receive a vaccine from SCL Health – Front Range for the current flu season, unless a medical exemption is documented and the Practitioner complies with the mask requirement in accordance with the Rules and the System’s Influenza Vaccination Policy, as amended from time to time.

l. Not have been involuntarily dismissed, terminated or summarily suspended from any medical staff or had privileges involuntarily terminated, restricted or summarily suspended by any health facility for reasons of clinical competence or professional conduct, which action was upheld following waiver or exhaustion of any procedural remedies.

m. Provide a valid email address that will be used as a primary method of communication.

n. Agree to abide by the Medical Staff Expectations, which is the Code of Conduct for the Medical Staff.

A Practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership and the application shall not be accepted for review, except that applicants for the Emeritus Medical Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws and the Rules, but may submit comments and a request for reconsideration of the specific standards which adversely affected such Practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.2.4 below. All Members of the Interim Medical Staff shall become Members of the Medical Staff on the effective date of these Bylaws, with all of the prerogatives and Privileges granted by the Governing Body.

2.2.3 Qualifications for Membership

In addition to meeting the basic standards, the Practitioner must:

a. Document his or her (i) adequate experience, education, and training in the requested Privileges; (ii) current professional competence; (iii) good judgment; and (iv) adequate physical and mental health status (subject to any legally-required reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that
patients can reasonably expect to receive the generally recognized high professional level of quality of care for this community; and

b. Be determined (i) to adhere to the lawful ethics of his or her profession; (ii) to be capable of consistently working in a professional and cooperative manner with others in a hospital setting and refraining from harassment of others so as to not adversely affect patient care or Hospital operations; and (iii) to be willing to participate in and properly discharge Medical Staff responsibilities.

2.2.4 Waiver of Qualifications

Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem a Practitioner to have satisfied a qualification for Medical Staff membership or Privileges, after consulting with the Medical Executive Committee, if it determines that the Practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the System. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under the Rules.

2.3 EFFECT OF OTHER AFFILIATIONS

No Practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, staff membership or Privileges at another health care facility including any SCL Health – Front Range facility.

2.4 NONDISCRIMINATION

Medical Staff membership or Privileges shall not be denied or granted on the basis of age, sex, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or the Hospital.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for Emeritus Members (see the Credentialing and Privileging Rule regarding Categories of Medical Staff), each Medical Staff Member and each Practitioner exercising temporary Privileges shall continuously meet all of the responsibilities set forth in the Rules.
ARTICLE 3 CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

Each Medical Staff Member shall be assigned to a Medical Staff category based upon the qualifications defined in the Bylaws and Rules. Medical Staff categories include Active, Courtesy, Affiliate, and Emeritus. The Members of each Medical Staff category shall have the prerogatives (privileges) and carry out the responsibilities (duties) defined in the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any Member who fails to meet the qualifications or fulfill the responsibilities (duties) described in the Bylaws and Rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the Member's Privileges.

3.2 CATEGORY RESPONSIBILITIES (DUTIES) AND PREROGATIVES (PRIVILEGES)

3.2.1 Active

Members of the Active Staff are regularly involved in caring for/treating patients or demonstrate by way of other substantial involvement in Medical Staff or Hospital activities a genuine concern and interest in the Hospital. Members in the Active Category have Prerogatives (admit patients consistent with approved privileges, exercise approved privileges, vote on any Medical Staff matters, serve as a Medical Staff Officer, hold office in the Department to which he or she is assigned, serve on Committees and vote on Committee matters, serve as chair of a Committee, attend Medical staff meetings and CME events, provide on-call coverage on behalf of an Active Medical Staff member, and reserve OR time) and Responsibilities (participate equitably in Medical Staff functions, serve on the on-call roster, submit an application for initial and reappointment and request for Privileges, and pay applicable fees, dues and assessments).

3.2.2 Courtesy

Members of the Courtesy Staff occasionally admit/treat patients. Members in the Courtesy Category have Prerogatives (admit patients consistent with approved privileges, exercise approved privileges, serve on Committees and vote on Committee matters, attend Medical staff meetings and CME events, and provide on-call coverage on behalf of an Active Medical Staff member) and Responsibilities (participate equitably in Medical Staff functions, submit an application for initial and reappointment and request for Privileges, and pay applicable fees, dues and assessments).

3.2.3 Affiliate

Members of the Affiliate Staff do not qualify for full Privileges in a specialty but appear likely to provide a distinct service or have requested Affiliate Staff. Members in the Affiliate Category have Prerogatives (write progress notes and assist in surgery consistent with approved privileges, exercise approved limited privileges, serve on Committees and attend Medical staff meetings and CME events) and Responsibilities (submit an application for initial and reappointment and request for limited Privileges and pay applicable fees, dues and assessments).

3.2.4 Emeritus

Members of the Emeritus Staff are retired or not practicing at the Hospital but who were previously members of the Medical Staff or the Hospital or the System and who wish to remain in contact with the Medical Staff and the Hospital. Members in the Emeritus Category have Prerogatives (serve on Committees and attend Medical Staff meetings and CME events).

3.3 GENERAL EXCEPTIONS FOR LIMITED LICENSE PRACTITIONERS

Regardless of the category of membership in the Medical Staff, Limited License Practitioners shall exercise Privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and Rules.
ARTICLE 4 APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Appointment is the process of considering each completed application for initial Medical Staff membership or designation as an AHP through the Medical Staff process. Reappointment is the process of reconsidering each completed reappointment application for Medical Staff membership or designation as an AHP through the Medical Staff process.

The Medical Staff, through the Department Chair, Credentials Committee and Medical Executive Committee, shall consider each application for appointment and reappointment through the basic steps of the process described in this Article and the associated details (procedures and standards) set forth in these Medical Staff Bylaw, the Rules and Regulations, and/or Medical Staff Policies. The Department Chair, Credentials Committee and the Medical Executive Committee shall evaluate each applicant before recommending action to the Governing Body. The evaluation shall include a review of the applicant's satisfaction of the qualifications under Article 2 of these Bylaws, his or her education, training, clinical competence, professional conduct and other criteria set forth in these Bylaws, the Rules, and the criteria for the Privileges requested. The Governing Body shall ultimately be responsible for granting membership or designation as an AHP. The Medical Staff shall perform this function also for Practitioners who seek temporary Privileges and for AHPs who seek Privileges or Scope of Practice.

By applying for appointment or reappointment to the Medical Staff or as an AHP (or by accepting Emeritus Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested membership, status, he or she will comply with the responsibilities of Medical Staff membership or designation as an AHP and with the Medical Staff Bylaws and Rules as they exist and as they may be modified from time to time.

4.2 LEAVE OF ABSENCE

Members and AHPs must request a leave of absence if they will be absent from patient care responsibilities for more than six (6) months. Members and AHPs may, but are not required, to request a leave of absence for a period of less than six (6) months. A leave of absence must be approved by the Medical Executive Committee, not to exceed twenty four (24) months. The Credentialing and Privileging Rules address the processes for approval of a leave of absence, reinstatement following a leave of absence, and the Member's or AHP's obligation to apply for reappointment if his/her then-current appointment will expire during a leave of absence.

A leave of absence temporarily relieves a Member or AHP of clinical and other responsibilities and suspends prerogatives under the Medical Staff Bylaws and Rules and the AHP Rules, but is not a relinquishment or limitation of Privileges, Scope of Practice or membership. During the period of the leave of absence, the Member or AHP shall not exercise Privileges or Scope of Practice at the Hospital, as applicable, and membership rights and responsibilities are inactive, but the obligation to pay dues, if any, shall continue unless waived by the Credentials Committee.

If a Member or AHP is absent from patient care responsibilities for more than six (6) months and fails to request a leave of absence, or takes a leave of absence that exceeds the maximum twenty four (24) months, the Member or AHP shall be deemed to have voluntarily relinquished appointment, Privileges or Scope of Practice, as applicable, effective at the end of the approved leave period, and is not entitled to a hearing or appeal. Additionally, if a Member or AHP fails to request reinstatement in a timely manner prior to expiration of his or her approved leave period, the Member or AHP shall be deemed to have voluntarily relinquished appointment, Privileges or Scope of Practice, as applicable, effective at the end of the approved leave period, and is not entitled to a hearing or appeal.
ARTICLE 5 CREDENTIALING AND PRIVILEGING

5.1 GENERAL

Credentialing is the Peer Review process of obtaining and verifying the contents of a completed initial application for Medical Staff Membership or designation as an AHP through Medical Staff process. Re-credentialing is the process of obtaining and verifying the contents of a completed reappointment application for Medical Staff Membership or designation through the Medical Staff process as an AHP. Contents such as education which were verified initially and are static will not be re-verified.

Privileging is the Peer Review process of evaluating and assessing the initial request for Privileges or the request for modification of Privileges for Medical Staff Members and Privileges or Scope of Practice for designated AHP through the Medical Staff process. Re-privileging is the process of re-evaluating and re-assessing the request for Privileges for Medical Staff Members and Privileges or Scope of Practice as a designated AHP through the Medical Staff process at reappointment.

The Medical Staff, through the Department Chair, Credentials Committee and Medical Executive Committee, shall consider the verified contents of the completed application for appointment and reappointment and the request for Privileges or Scope of Practice through the basic steps of the processes described in this Article and the associated details (procedures and standards) set forth in these Medical Staff Bylaws, the Rules and Regulations, and/or Medical Staff Policies. The Department Chair, Credentials Committee, and the Medical Executive Committee shall evaluate the verified contents of the completed application to the Governing Body. The evaluation shall include a review of the applicant’s education, training, clinical competence, professional conduct and other criteria for Medical Staff Membership or designation as an AHP and the Privileges or Scope of Practice requested. The Governing Body shall ultimately be responsible for granting Medical Staff Membership, designation as an AHP and Privileges or Scope of Practice as they exist and as they may be modified from time to time.

5.2 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws or the Rules, every Practitioner or AHP providing direct clinical services at the Hospital shall be entitled to exercise only those Privileges or Scope of Practice specifically granted to him or her. Privileges and Scope of Practice shall be reviewed for initial granting, renewal and revising subject to the standards, and using the procedures set forth in the Credentialing and Privileging Rules.

5.3 TEMPORARY PRIVILEGES

Temporary Privileges may be granted only in those situations provided in the Rules, after the Practitioner or AHP has satisfied the requirements set forth in the Credentialing and Privileging Rules.

5.4 EMERGENCY PRIVILEGES

In the event of an emergency for an individual patient, any Member of the Medical Staff or AHP granted Privileges or Scope of Practice shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Member or AHP shall promptly yield such care to a qualified Member when one becomes available.

5.5 DISASTER PRIVILEGES

In a state of emergency, to fulfill the requirements of the Hospital’s Disaster Plan, Practitioners and AHPs may be privileged on an emergency basis in accordance with the disaster privileging processes set forth in the Credentialing and Privileging Rules.
Privileges for medical history and physical examination include the following requirements:

a. A medical history and physical examination will be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other licensed individual in accordance with state law, the Medical Staff Bylaws and Rules, hospital policy.

b. When the medical history and examination is completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient’s condition, is completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other licensed individual in accordance with state law, the Medical Staff Bylaws and Rules, and hospital policy.
ARTICLE 6 ALLIED HEALTH PRACTITIONERS

6.1 QUALIFICATIONS OF ALLIED HEALTH PRACTITIONERS

Allied Health Practitioners ("AHPs") are not eligible for Medical Staff membership. They may be granted Privileges or Scope of Practice if they hold a license, certificate, or other credentials in a category of AHPs that the Governing Body (after securing Medical Executive Committee comments) has identified as eligible to apply for Privileges or Scope of Practice, and only if the AHPs have demonstrated professional competence and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws, Rules and Privileges or Scope of Practice criteria.

6.2 CATEGORIES

The Governing Body shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise Privileges or Scope of Practice in the Hospital. Such AHPs shall be subject to the supervision requirements developed in each Department and approved by the Credentials Committee, Medical Executive Committee and the Governing Body.

6.3 PRIVILEGES OR SCOPE OF PRACTICE, RESPONSIBILITIES, PREROGATIVES, AND PROCEDURAL RIGHTS

The Privileges or Scope of Practice, responsibilities, and prerogatives of AHPs shall be established and reviewed as provided in the AHP Rules. AHP procedural rights shall be limited to the right to appear before the Medical Executive Committee and those specified in the AHP Rules.
ARTICLE 7 MEDICAL STAFF OFFICERS AND CHIEF MEDICAL OFFICER

7.1 MEDICAL STAFF OFFICERS - GENERAL PROVISIONS

7.1.1 Identification

The Medical Staff's general officers are a President and President-Elect (the "Medical Staff Officers"). The Medical Staff may elect Medical Staff Officers.

7.1.2 Qualifications

All Medical Staff Officers shall:

a. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

b. Understand and be willing to work towards attaining the Hospital's lawful and reasonable policies and requirements;

c. Have administrative ability as applicable to the respective office;

d. Be able to work with and motivate others to achieve the objectives of the Medical Staff and Hospital;

e. Demonstrate clinical competence in his or her field of practice;

f. Be an Active Medical Staff Member (and remain in good standing as an Active Medical Staff Member while in office); and

g. Not have any significant conflict of interest.

7.1.3 Disclosure of Conflict of Interest

All nominees for election to Medical Staff offices shall disclose in writing to the Medical Executive Committee and the Governing Body those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a Medical Staff Officer who has disclosed a conflict is elected, he or she shall recuse himself or herself from deliberations and votes relating to the subject matter of the conflict.

7.2 METHOD OF SELECTION - OFFICERS

7.2.1 Nomination and Election of Officers

For elections of any Medical Staff Officer, an ad hoc nominating committee shall nominate at least one candidate for each office for which an election is held. The nominating committee shall be composed of the President, 2 Active Members who are appointed by the Medical Executive Committee and 2 Active Members who are appointed by the President. Each candidate must meet the qualifications of office, as described in Section 7.1.2 above, and shall be presented to the Governing Body for approval. A candidate shall be deemed approved unless the Governing Body acts by the time of its next meeting. Governing Body disapproval of any or all candidates must be accompanied by a written statement to the Medical Executive Committee of the specific reasons therefore. The Medical Executive Committee shall then
decide whether to reconvene the nominating committee to nominate a new slate, in which case the process will be repeated, or to approve the slate notwithstanding Governing Body disapproval.

The Medical Staff shall elect the Medical Staff Officers. Following Governing Body action, an electronic or mail ballot shall be sent to the Medical Staff Members eligible to vote. Medical Staff Members may vote for a write-in candidate, provided, however, that if elected, the candidate must meet the qualifications of office, as described in Section 7.1.2 above, and agree in writing to accept the obligations of office. The outcome of the election shall be determined by a plurality of the votes cast by electronic or mail ballots that are returned to Medical Staff Services within 15 days after the ballots were sent to the Medical Staff Members eligible to vote. In case of a tie, the Medical Executive Committee shall appoint the officer.

7.2.2 Term of Office

Medical Staff Officers shall take office on the first business day of the Medical Staff Year. The term of office shall be two (2) years, the expiration of which coincides with the Medical Staff Year, or until the Medical Staff Officer’s successor take office, unless there is an earlier resignation, removal, death, or disability (such that he or she cannot fulfill the duties of office even with any reasonable accommodations that may be required by law). No Medical Staff Officer shall serve consecutive full terms in the same position. Notwithstanding the foregoing, if there is a vacancy in the office of President-Elect, for any reason, to allow for appropriate leadership development and succession, the Medical Executive Committee may extend the then-current President’s term of office for one additional term, which additional term will not exceed two (2) years.

7.2.3 Recall of Officers

A Medical Staff Officer may be recalled from office for any valid cause, including, but not limited to failure to carry out the duties of his or her office, failure to cooperatively and effectively perform the responsibilities of his or her office or to meet the qualifications for office (other than failure to maintain Active Medical Staff membership, which shall result in automatic removal). A recall may be initiated by the Medical Executive Committee or by a petition signed by a least 33-1/3 percent of the Medical Staff Members eligible to vote. A recall of a Medical Staff Officer shall be conducted by an electronic or mail and shall require a 66-2/3 percent vote of the votes cast by electronic or mail ballot that are returned to the Medical Staff Officer within 15 days after the ballots were sent to the Medical Staff Members eligible to vote.

7.2.4 Filling Vacancies

Vacancies created by resignation, removal, death, or disability shall be filled as follows:

a. A vacancy in the office of President shall be filled by the President-Elect for the balance of the unexpired term.

b. A vacancy in the office of President-Elect shall be filled by special election held in general accordance with Section 7.2 for the balance of the unexpired term.

7.3 DUTIES OF OFFICERS

7.3.1 President

The President shall serve as the chief officer of the Medical Staff. The duties of the President shall include, but not be limited to:

a. Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;
b. Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

c. Serving as the chair of the Medical Executive Committee;

d. Serving as an Ex Officio member of all other Medical Staff committees except Hearing Committees;

e. Serving as a resource to Medical Staff Committees and assisting with review and investigation in connection with peer review investigations and quality improvement functions;

f. Appointing, after consulting with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees and designating the chairpersons of these committees, except when the Bylaws or Rules give another person the authority to make the appointments;

g. Being a spokesperson for the Medical Staff in external professional and public relations;

h. Serving on liaison committees with the Governing Body and Administration, as well as outside licensing or accreditation agencies;

i. Regularly reporting to the Governing Body on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Governing Body;

j. In the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Committee; and

k. Performing such other functions as may be assigned to him or her by these Bylaws, the Rules, the Medical Staff, or the Medical Executive Committee.

7.3.2 President-Elect

The President-Elect shall assume all duties and authority of the President in the absence of the President. The President-Elect shall be a member of the Medical Executive Committee and shall perform such other duties as the President may assign or as may be delegated by the Bylaws or Rules or the Medical Executive Committee.

7.4 CHIEF MEDICAL OFFICER

7.4.1 Appointment

The Chief Medical Officer shall be appointed by the Chief Executive Officer after consulting with the Governing Body and Medical Executive Committee.

7.4.2 Responsibilities

a. The Chief Medical Officer's duties shall be delineated by the Chief Executive Officer in keeping with the general provisions set forth in Section 7.4.2(b) below. The Medical Executive Committee shall approve any Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff.

b. In keeping with the foregoing, the Chief Medical Officer shall:
(1) Serve as administrative liaison among Hospital administration, the Governing Body, outside agencies, and the Medical Staff;

(2) Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Hospital; and

(3) In cooperation and close consultation with the President and the Medical Executive Committee, supervise the day-to-day performance of Medical Staff Services and the Hospital's quality improvement personnel.

7.4.3 Participation in Medical Staff Committees

The Chief Medical Officer shall be an Ex Officio member, without vote, of all Medical Staff committees except any hearing committee and may attend any Department meeting.
ARTICLE 8 COMMITTEES

8.1 GENERAL

8.1.1 Designation

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee, by any standing committee, by the President or by a Department Chair to perform specified tasks. Any committee, whether Medical Staff wide or Department or other clinical unit, or standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws and the Rules is deemed a duly appointed and authorized committee of the Medical Staff. The Governing Body may adopt in the Rules or by policy or resolution a requirement that no more than fifty percent (50%) of the members of the Medical Executive Committee or any other committee shall be from the same medical group or practice.

8.1.2 Appointment of Members and Conduct of Business

The chair and members of all committees shall be appointed as provided in these Bylaws or the Rules. The business of committees shall be conducted as provided in the Rules.

8.2 MEDICAL EXECUTIVE COMMITTEE

8.2.1 Composition

a. A majority of the voting members of the Medical Executive Committee shall be fully licensed Physicians who are Active Members of the Medical Staff. The Medical Executive Committee shall be composed of the Medical Staff Officers, the Credentials Committee Chair, the Department Chairs, the Medical Staff Peer Review Committee Chair, the Performance Excellence/Patient Safety Committee Chair, (as such committees are established and described in the General Medical Staff Rules from time to time), and the most recent Past President not seated on the Medical Executive Committee by virtue of another office, and may include other Practitioners and any other individuals as determined by the Organized Medical Staff. The Medical Executive Committee may also include one or more Advanced Practice Nurse at-large member(s) (the “appointed APN at-large member(s)” as necessary for professional review of APNs. Any appointed APN at-large member will be appointed for the duration of the meeting only, or in the discretion of the Medical Staff President. The Chief Executive Officer, Chief Medical Officer, the designated nursing executive, and such Vice Presidents designated by the Medical Executive Committee shall serve as Ex Officio members of the Medical Executive Committee without a vote. The Medical Staff President shall chair the Medical Executive Committee. The President-Elect or Past President shall chair the committee if the President is absent. Any member of the Governing Body may attend the meeting, without vote.

b. Medical Staff Officers serving on the Medical Executive Committee shall be selected and may be removed in accordance with Article 7 of these Bylaws.

c. Department Chairs serving on the Medical Executive Committee shall be selected and may be removed in accordance with Article 9 of these Bylaws.

d. The Credentials Committee Chair, Performance Excellence/Patient Safety Committee Chair, and Medical Staff Peer Review Committee Chair serving on the Medical Executive Committee shall meet the qualifications of a Medical Staff Officer in Article 7 and shall be appointed by the President, subject to approval of the Medical Executive Committee, for the 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 (i) resign, (ii) be removed from the
Committee, (iii) die, or (iv) become disabled such that he or she cannot fulfill the duties of office, even with any reasonable accommodation that may be required by law. The term shall begin on the first day of the Medical Staff Year. The Credentials Committee Chair, Performance Excellence/Patient Safety Committee Chair, and Medical Staff Peer Review Committee Chair may be removed by the majority vote of the Medical Executive Committee for any valid cause, including, but not limited to failure to carry out the duties of his or her appointment, the failure to cooperatively and effectively perform the responsibilities of his or her appointment, or the failure to meet the qualifications for office (other than failure to maintain Active Medical Staff membership, which shall result in automatic removal) by a 66 2/3 percent vote of the Medical Executive Committee. Vacancies shall be filled by the Medical Executive Committee.

e. Any appointed APN at-large member(s) shall be appointed and may be removed by the President for any valid cause. Vacancies will be filled by the President.

f. The Performance Excellence/Patient Safety Committee Chair serving on the Medical Executive Committee 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. The chair may be removed for any valid cause, including, but not limited to failure to carry out the duties of his or her appointment, the failure to cooperatively and effectively perform the responsibilities of his or her appointment, or the failure to meet the qualifications for office (other than failure to maintain Active Medical Staff membership, which shall result in automatic removal) by a majority vote of the Medical Executive Committee. Vacancies shall be filled by the President.

g. The Medical Staff Peer Review Committee Chair serving on the Medical Executive Committee shall be appointed by the President for a term of two (2) years, subject to renewal of two consecutive additional two (2) year terms, 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. The chair may be removed for any valid cause, including, but not limited to failure to carry out the duties of his or her appointment, the failure to cooperatively and effectively perform the responsibilities of his or her appointment, or the failure to meet the qualifications for office (other than failure to maintain Active Medical Staff membership, which shall result in automatic removal) by a majority vote of the Medical Executive Committee. Vacancies shall be filled by the President.

h. If Medical Executive Committee is conducting an initial review of the competence of, 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 (1) Advanced Practice Nurse with a similar scope of practice as the APN who is the subject of the review (who may be a qualified APN at-large member, or (ii) engage an independent Advanced Practice Nurse with a similar scope of practice as the APN who is the subject matter 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 Executive 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 Executive Committee shall be Physicians who are Active Members of the Medical Staff.

8.2.2 Duties

The Organized Medical Staff hereby delegates to the Medical Executive Committee the authority to carry out certain Medical Staff responsibilities. The Medical Executive Committee shall carry out its work within
the context of Hospital functions of governance, leadership and performance improvement. The Medical Executive Committee has the primary authority for activities relating to Medical Staff self-governance and performance improvement of Practitioners and AHPs with Privileges or Scopes of Practice. With assistance of the President and Chief Medical Officer, the Medical Executive Committee is delegated to perform the following duties unless the Organized Medical Staff through the Medical Staff Bylaws amendment process revokes or changes the duties delegated to the Medical Executive Committee:

a. Recommend Bylaws and amendments to the Bylaws to the Organized Medical Staff Voting Members for approval. See Article 14.

b. Recommend Rules and Regulations, Medical Staff Policies, and amendments to the Rules and Regulations and Medical Staff Policies including any details associated with the processes contained in the Medical Staff Bylaws.

c. Review all Rules and Regulations, Medical Staff Policies, and amendments to the Rules and Regulations and Medical Staff Policies proposed directly by the Organized Medical Staff. See Article 13.

d. Adopt an urgent Rule or Regulation or amendment to a Rule or Regulation to comply with law or Regulation. See Article 13.

e. Supervise, report to and be accountable to the Governing Body, as appropriate, regarding the performance of all Medical Staff functions, which shall include but are not limited to:

(1) Requiring and acting on regular reports and recommendations from the Medical Staff Officers, Hospital Officers, Department leaders, and committees concerning discharge of assigned functions;

(2) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

(3) Following up to assure implementation of all directives.

f. Coordinate the activities of the committees and Department leaders.

g. Based upon input from the Department leaders and any appropriate committee, make recommendations to the Governing Body regarding all applications for Medical Staff membership or AHP appointment, reappointment, and the delineation of Privileges or Scope of Practice.

h. When indicated, initiate and/or pursue reviews, investigations, disciplinary or corrective actions affecting Medical Staff Members or AHPs.

i. Make recommendations to the Governing Body for the termination of Medical Staff membership for acts, demeanor, or conduct that is reasonably likely to be detrimental to patient safety or quality of care; unethical; contrary to Hospital or Medical Staff Bylaws or Rules; below appropriate professional standards; disruptive; improper use of Hospital resources; or a violation of accreditation standards or laws in accordance with the Peer Review, Fair Hearing and Appeal Rules.

j. With the assistance of the Medical Staff President and Chief Medical Officer, supervise the Medical Staff’s compliance with:

(1) The Medical Staff Bylaws, Rules, and policies;

(2) The System’s and Hospital’s Bylaws, Rules, and policies;
(3) State and federal laws and regulations; and

(4) The Joint Commission accreditation requirements.

k. Oversee the development of Medical Staff Bylaws, Rules and policies, approve (amend or disapprove) all such Bylaws, Rules and policies, and oversee the implementation of all such Bylaws, Rules and policies.

l. Implement, as it relates to the Medical Staff, the approved policies of the Hospital and the System.

m. With the leaders, set objectives for establishing, maintaining and enforcing professional standards within the System, and for the continuing improvement of the quality of care rendered in the System, and assist in developing programs to achieve these objectives.

n. Regularly report to the Governing Body through the President or the Chief Executive Officer on at least the following:

(1) The outcomes of quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards, and

(2) The general status of any Medical Staff or AHP disciplinary or corrective actions in progress.

o. Make recommendations to the Governing Body regarding the structure of the Medical Staff, the process used to review credentials and to delineate individual Privileges or Scope of Practice, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing and appeal procedures. (This responsibility may be satisfied by way of recommending the processes in the Medical Staff Bylaws and Rules addressing these issues.)

p. Review and make recommendations to the Governing Body regarding Practitioners and AHPs requesting Medical Staff Membership or AHP status and Privileges or Scope of Practice at the Hospital in accordance with the processes in the Medical Staff Bylaws and Rules.

q. Request evaluations of Practitioners or AHPs in accordance with the processes in the Rules in instances where there is doubt about an applicant’s ability to perform the Privileges or Scope of Practices requested.

r. Review and make recommendations to the Chief Executive Officer regarding the quality of care by Practitioners under exclusive contract arrangements for professional services at the Hospital.

s. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.

t. Establish the date, place, time, and program of the regular meetings of the Medical Staff.

u. Acts on behalf of the Medical Staff in the intervals between Medical Staff meetings within the scope of its responsibilities as defined by the Medical Staff in these Bylaws.

v. Perform such other duties set forth in these Bylaws and the Rules.
8.2.3 Meetings

The Medical Executive Committee shall generally meet at least monthly during the Medical Staff Year.

8.2.4 Executive Session

To promote confidentiality the Medical Executive Committee may enter into an Executive Session by vote of the Medical Executive Committee or at the request of the Chair of the Medical Executive Committee. Only Medical Staff Members and hospital and system Chief Executive Officers and Chief Medical Officers or their designees may participate in the Executive Session. The participants in the Executive Session must consist of at least three licensed physicians and the majority of the participants must be licensed physicians.
ARTICLE 9 STRUCTURE OF THE MEDICAL STAFF AND DEPARTMENTS

9.1 ORGANIZATION OF DEPARTMENTS

The Medical Staff shall include such Departments listed below. Each Department shall be organized as an integral unit of the Medical Staff and have leaders who are selected and have the authority, duties, and responsibilities specified in the Rules. Departments may be added, deleted, or consolidated by amendment to these Bylaws. Additionally, each Department may appoint a Department committee and each Department may appoint such other standing or ad hoc committees as it deems appropriate to perform its required functions. The composition and responsibilities of each Department shall be specified in the Rules.

9.2 DESIGNATION

The current Departments are designated below. The Medical Executive Committee will periodically restudy the Medical Staff structure and designation of the Departments and may recommend to the Governing Body what action is desirable in creating, eliminating, or combining Departments for better organizational efficiency and improved patient care.

9.3 ASSIGNMENT TO DEPARTMENTS

Each Member shall be assigned membership in at least 1 Department, but may also be granted membership and/or Privileges in other Departments.

9.4 FUNCTIONS OF DEPARTMENTS

The Departments shall fulfill the clinical, administrative, safety, quality improvement, risk management, utilization management, and collegial and education functions described in these Bylaws and the Rules. When the Department or any of its committees meet to carry out the duties described in the Rules, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees.

9.5 CURRENT DESIGNATION

The current Departments are:

a. The Department of Anesthesia
b. The Department of Cardiovascular Services
c. The Department of Emergency Medicine
d. The Department of General Surgery and Trauma
e. The Department of Hospital Medicine
f. The Department of Medical Subspecialties
g. The Department of Women and Children
h. The Department of Pathology and Radiology
i. The Department of Surgery Subspecialties
The Department Chair and Vice Chair shall serve two (2) year staggered terms, the expiration of which coincides with the Medical Staff Year. Departments A. through E. will begin serving even year terms and Departments F. through J. will serve odd year terms.

9.6 DEPARTMENT CHAIR AND VICE CHAIR

9.6.1 Qualifications

Each Department Chair and Vice Chair shall:

a. Be willing and able to faithfully discharge the functions of his or her office.

b. Be board certified in his or her appropriate specialty or have affirmatively established comparable competence through the credentialing process.

c. Have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the Members of his or her Department.

d. Have an understanding of the purposes and functions of the Staff organization and a demonstrated willingness to promote compliance with the Medical Staff Bylaws and Rules and to promote patient safety over all other concerns.

e. Have an understanding of and willingness to work with the Hospital towards attaining its lawful and reasonable goals.

f. Have an ability to work with and motivate others to achieve the objectives of the Medical Staff organization in the context of the Hospital's lawful and reasonable objectives.

g. Be (and remain during tenure in office) a Member in good standing.

h. Comply with the Medical Staff Bylaws and Rules in his or her practice at the Hospital.

i. Not have any significant conflict of interest.

9.6.2 Procedures for Electing Department Chairs and Vice Chairs

a. Department Chairs and Vice Chairs may be elected every two years.

b. Active members of the Department may nominate Members to serve as Department Chair or Vice Chair who meet the qualifications specified in Section 9.6.1 and have agreed, either at a Department meeting or in writing prior to the election, to accept the nomination.

c. The voting shall occur as soon as practical. An electronic and/or mail ballot shall be sent to the Members of the Department eligible to vote. The candidate receiving a majority of the votes cast by ballot that respond within 15 days shall win the election. In the case of a tie or if none of the nominees receives a majority of the votes cast, a second vote will be held between the two candidates who received the most votes. If there is still a tie, the President-Elect (for elections in years ending in an odd number) or President (for elections in years ending in an even number) shall appoint the position.

d. All persons elected to Department offices shall upon request, prior to taking office, notify SCL Health -- Front Range in writing those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Department. The President-Elect
Department leaders shall take office on the first business day of the Medical Staff Year, provided that for newly created Departments and for elections to fill vacancies, the Department leaders shall take office immediately upon election. All Department leaders shall serve a two (2) year term (or the balance of a two (2) year term, for newly created Departments and vacancies), the expiration of which coincides with the Medical Staff Year or until their successors take office, unless they sooner (i) resign, (ii) are removed from office in accordance with Section 9.6.4, (iii) die; (iv) become disabled and cannot fulfill the duties of office, even with any reasonable accommodation that may be required by law; or (v) lose their Active Medical Staff membership or Privileges in that Department for any reason, in which case, the Department leader shall be automatically removed. Department leaders are eligible to succeed themselves.

The Medical Staff supports the succession of the Department leadership positions, when appropriate. To that end, the Medical Staff expects that in the ordinary course, at the end of a two year term, the Department Chair will complete his/her service, the Vice Chair will be nominated and elected to serve as Department Chair.

It is recognized that, in certain cases, this ordinary succession of Department leadership positions might not be appropriate. For example, if for any reason the Vice Chair declines the nomination for the Department Chair position, other candidates should be sought among the Members of the Department. If no other qualified Members of the Department are nominated for or are willing to serve as Department Chair, the then-current Department Chair may be nominated for and elected to serve successive two year terms.

A Department leader may be removed for any valid cause, including, but not limited to failure to carry out the duties of his or her office, the failure to cooperatively and effectively perform the responsibilities of his or her office, or the failure to meet the qualifications to serve as a Department leader (other than automatic removal in accordance with Section 9.6.3). Removal of a Department leader may be initiated by 1/3 of the Medical Executive Committee members or by a petition signed by at least 1/4 of the Department’s Active Members. Removal will take effect upon the approval of 2/3 of the Medical Executive Committee Members or 2/3 of the Department’s Active Members. All voting shall be conducted by written secret mail ballot, which shall be sent to those eligible to vote within 45 days after the initiation of removal pursuant to this Section. The ballots must be received no later than 15 days after they are mailed and shall be counted by the Chief Medical Officer and President or their designees. No removal shall be effective unless and until it is ratified by the Medical Executive Committee.

9.6.5 Filling Vacancies

Vacancies created in a Department office shall be filled by election of a Member who meets the qualifications for the position to fill the unexpired term in accordance with Section 9.6.2 above.

9.7 RESPONSIBILITIES OF DEPARTMENT CHAIRS

Each Department Chair shall be responsible for:

a. Clinically related activities of the Department.

b. All administrative activities of the Department (unless otherwise provided for by the Hospital).
c. Continuing surveillance of the professional performance of all individuals in the Department who have delineated Privileges.

d. Working with the Administrative Vice Presidents on matters that affect the Department.

e. Developing and implementing policies and procedures that guide and support the provision of care, treatment and services in the Department.

f. Recommending a sufficient number of qualified and competent persons to provide care/service in the Department.

g. Recommending criteria for Privileges that are relevant to the care provided in the Department.

h. Recommending Privileges to the Medical Staff for each qualified applicant or Member of the Department and each Member desiring to exercise Privileges in the Department.

i. Determining the qualifications and competence of AHPs who provide patient care, treatment and services within the purview of the Department.

j. Making recommendations regarding space and other resources needed by the Department.

k. Assigning and making recommendations to the relevant Hospital authority with respect to off-site sources needed for patient care, treatment and services not provided by the Department or the Hospital.

l. Integrating the Department into the primary functions of the Hospital.

m. Continuous assessment and improvement of the quality of care, treatment and services in the Department.

n. Maintaining quality control programs for the Department, as appropriate.

o. Orientating and promoting continuing education of all persons in the Department.

p. Deciding when to convene Department meetings and chairing those meetings.

q. Serving as Ex Officio member of all committees of his or her Department and attending such committee meetings as deemed necessary.

r. Assuring that records of performance are maintained and updated for all Members of his or her Department.

s. Reporting on activities of the Medical Staff to the Governing Body when called upon to do so by the President or the Chief Executive Officer.

t. Addressing improvement opportunities with individual members of the Department, including such opportunities communicated by the applicable peer review committees.

u. Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Committee or the President.

v. Coordinating and integrating interdepartmental and intra-departmental services.
9.8 DEPARTMENT VICE CHAIRS

Department Vice Chairs shall assist the Department Chair to perform his or her duties. The Vice Chair shall perform the duties of the Department Chair (including but not limited to assuming the Chair’s voting rights on all Medical Staff or Department committees) if the Department Chair is absent or otherwise unavailable.
ARTICLE 10 MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1.1 Medical Staff Meetings

There shall be at least 1 meeting of the Medical Staff during each Medical Staff Year. The date, place, and time of the meeting(s) shall be determined by the President. The President shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership.

10.1.2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the President, Medical Executive Committee, or Governing Body, or upon the written request of 25 percent of the voting Members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the Notice calling the meeting.

10.1.3 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint medical staff meetings with staff members from other System Members, other hospitals, healthcare entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

10.2 DEPARTMENT AND COMMITTEE MEETINGS

10.2.1 Regular Meetings

Departments and committees, by resolution, may provide the time for holding regular meetings and no Notice other than such resolution shall then be required. Each Department shall meet at the request of the Chair as necessary to review and discuss patient care activities and to fulfill other Departmental responsibilities.

10.2.2 Special Meetings

A special meeting of any Department or committee may be called by, or at the request of, the Chair thereof, the Medical Executive Committee, President, or by 33-1/3 percent of the committee's current members, but not fewer than 3 members. No business shall be transacted at any special meeting except that stated in the Notice calling the meeting.

10.2.3 Combined or Joint Department or Committee Meetings

Each Department and committee may participate in combined or joint Department or committee meetings with staff members from other System Members, other hospitals, healthcare entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

10.3 NOTICE OF MEETINGS

Written Notice stating the place, day, and hour of any regular or special Medical Staff meeting or of any regular or special Department or committee meeting not held pursuant to resolution shall be delivered either personally, by
include a statement of the issue involved and that the Practitioner's or AHP's appearance is mandatory. Failure of a Practitioner or AHP to appear at any meeting with respect to which he or she was given Special Notice shall (unless excused by such committee or the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the Practitioner's Privileges or the AHP's Privileges or Scope of Practice until an appearance is made or other action is taken by the Medical Executive Committee. The Practitioner or AHP shall not be entitled to the procedural rights described in these Bylaws and the Rules.
ARTICLE 11 CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 GENERAL

Medical Staff, Department or committee minutes, files and records, including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be privileged and confidential. Such confidentiality shall also extend to information of like kind that may be provided by System Members or third parties. This information shall become a part of the Medical Staff or credentialing files and shall not become part of any particular patient's file or of the general Hospital records. Dissemination of such information and records shall be made only where expressly required or permitted by law, as necessary to carry out Medical Staff functions by Hospital and System Members pursuant to the Rules or officially adopted policies of the Medical Staff, or, where no officially adopted Policy exists, only with the express approval of the Medical Executive Committee or its designee and the Chief Executive Officer or his/her designee.

11.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective credentialing, quality improvement, peer review, and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as Practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of the Medical Staff, Departments or committees, except in conjunction with Medical Staff functions, another System Member, health facility, professional society, affiliated Physician group professional review committee, or licensing authority peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

11.3 IMMUNITY AND RELEASES

11.3.1 Immunity from Liability for Providing Information or Taking Action

As a condition of applying for or maintaining Medical Staff membership, Privileges, or AHP Privileges or Scope of Practice, each Practitioner or AHP acknowledges that each representative of the Medical Staff and System and all third parties shall be immune from liability to an applicant, Member, Practitioner or AHP for damages or other relief by reason of providing information to a representative of the Medical Staff, System, System Member, or any other health-related organization concerning such person who is, or has been, an applicant to or Member of the Medical Staff or AHP or who did, or does, exercise Privileges or Scope of Practice, or provide services at a System Member or by reason of otherwise participating in a Medical Staff or System credentialing, quality improvement, or peer review activities.

11.3.2 Activities and Information Covered

a. Activities

The immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

(1) Applications for appointment, Privileges or Scope of Practice or specified services;

(2) Periodic reappraisals for reappointment, Privileges, or specified services;

(3) Corrective action;
(4) Hearings and appellate reviews;

(5) Quality improvement review, including patient care audit;

(6) Peer review, including Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE);

(7) Utilization reviews;

(8) Morbidity and mortality conferences;

(9) Other System, Hospital, Department or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct; and

(10) The exchange of Peer Review information among System Members and other entities as provided in the Medical Staff Bylaws, Rules and Policies.

b. Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Practitioner’s or AHP’s professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, fair credit reporting act, or other matter that might directly or indirectly affect patient care.

11.4 RELEASES

Each Practitioner and AHP shall, upon request of Hospital, the System or any System Member, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

11.5 CUMULATIVE EFFECT

Provisions in these Bylaws, the Rules and in Medical Staff and AHP application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.
ARTICLE 12 CORRECTIVE ACTION; HEARINGS AND APPEALS

12.1 CORRECTIVE ACTION

Corrective Action, routine reviews, investigations, precautionary suspension, summary suspension, and automatic suspensions, shall be considered and taken or implemented using the procedures detailed in the Credentialing and Privileging Rules and the Peer Review, Fair Hearing and Appeal Rules.

a. Automatic Suspension

A Practitioner’s Medical Staff membership or Privileges may be automatically suspended, limited or terminated for any of the following, further associated details described in the Rules:

i. Licensure actions

ii. DEA certificate actions

iii. Failure to satisfy a Special Appearance requirement

iv. Failure to timely complete medical records

v. Cancellation or limitation of professional liability insurance

vi. Exclusion or failure to comply with governmental or third party payer requirements

vii. Violation of call panel requirements (see General Medical Staff Rules, “Call Panels”)

viii. Failure to verify compliance with privileging criteria

ix. Failure to maintain other qualifications for Medical Staff membership or Privileges, including board certification and back-up coverage

x. For Active and Courtesy Staff members (other than telemedicine Practitioners who do not come to the Hospital) during flu season, failure to comply with the influenza vaccination requirements or if entitled to an exemption for influenza vaccinations, failure to comply with mask requirements in accordance with the System Influenza Vaccination Policy, as amended from time to time.

xi. Failure to pay dues, fees, or assessments as required by the Rules.

xii. Precautionary or summary suspension of Privileges at another System Member.

Practitioners subject to automatic suspension shall be notified of such suspension in accordance with the procedures detailed in the Rules, but shall not be entitled to a hearing or appeal.

b. Precautionary Suspension

A Practitioner’s Medical Staff membership or Privileges may be suspended as a precaution for up to thirty (30) days whenever the failure to take such action may result in imminent damages to the health and/or safety of any individual and/or effective operation of the Hospital including clinical performance issues and disruptive behavior or harassment, as further described in the Rules.
A Practitioner subject to a precautionary suspension is entitled to Special Notice, and may request an interview with the Medical Executive Committee as set forth in the Rules, in accordance with the procedures detailed in the Rules.

c. Allied Health Practitioners Automatic Suspension

An AHP’s status, Privileges or scope of practice may be automatically suspended, limited or terminated Section 12.1(a). An AHP’s status, Privileges or scope of practice may be automatically suspended, limited or terminated if the AHP fails to designate and maintain a qualified supervising physician.

d. Summary Suspension

A Practitioner’s Medical Staff membership or Privileges may be summarily suspended if the failure to take such action may result in imminent danger to the health of any individual, including clinical performance issues and disruptive behavior or harassment, as further described in the Rules.

A Practitioner subject to a summary suspension is entitled to Special Notice and may request an interview with the Medical Executive Committee and/or a hearing and an appeal in accordance with the procedures detailed in the Rules.

e. Allied Health Practitioners Suspension

An AHP’s status, Privileges or scope of practice may be suspended as a precaution or summarily under Sections 12.1(b) and (d); provided that the AHP’s due process rights are set forth below and in the AHP Rules.

12.2 HEARINGS AND APPEALS

Hearings and appeals shall be held when required by the Rules using the procedures set forth in the Peer Review, Fair Hearing and Appeal Rules.

a. Hearing

A Practitioner may request a hearing when an adverse action (as defined in the Rules) is taken or recommended against the Practitioner. The Practitioner is entitled to Special Notice of the adverse action and has thirty (30) days to request a hearing.

The hearing shall be conducted before a Hearing Committee of not less than three (3) Members, in accordance with the Rules.

b. Fair Hearing Committee

When a hearing is requested, the President shall appoint a Hearing Committee which shall be composed of not less than 3 Members who are not in economic competition with the Practitioner, and who have not acted as accuser, investigator, witness, fact finder, initial decision maker, or other active participant in the consideration of the matter leading up to the recommendation or action. The Hearing Committee shall include at least 1 member who is a peer. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the President may appoint Members from other Medical Staff categories or Practitioners who are not Medical Staff Members. Such appointment shall include designation of a chair. The President may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.
c. Appeal

The Practitioner may request an appellate review, which shall be heard by the Governing Body or an Appeal Board designated by the Governing Body.
ARTICLE 13 GENERAL PROVISIONS

13.1 RULES AND REGULATIONS AND POLICIES

13.1.1 Medical Staff Rules and Regulations

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary and shall periodically review, at least every three (3) years, and revise its Rules and Regulations as appropriate to comply with current Medical Staff practice. The Rules and Regulations shall include the General Medical Staff Rules; the Credentialing and Privileging Rules; the Peer Review, Fair Hearing and Appeal Rules; the Allied Health Practitioner Rules; the Clinical Rules; and such other Rules and Regulations as may be adopted in accordance with these Medical Staff Bylaws. Rules and Regulations shall not be inconsistent with the Hospital or System bylaws, rules and regulations or other policies.

13.1.1.1 Proposed Rules and Regulations or amendments to the Rules and Regulations may be originated by the Medical Executive Committee or by a petition signed by twenty-five (25) percent of the Organized Medical Staff Voting Members.

a. When proposed by the Medical Executive Committee, there will be communication of the proposed Rules and Regulations or amendments to the Rules and Regulations to the Medical Staff before a vote is taken by the Medical Executive Committee.

(1) If the Medical Staff does not communicate any comments on the recommended Rules or Regulations or amendments to the Rules or Regulations, the Medical Executive Committee will forward the proposed Rule or Regulation or amendment to a Rule or Regulation to the Governing Body notifying the lack of comments communicated by the Medical Staff and the approval of the Medical Executive Committee.

(2) If the Medical Staff communicates any comments on the recommended Rules or Regulations or amendments to the Rules or Regulations, the Medical Executive Committee will forward the proposed Rule or Regulation or amendment to a Rule or Regulation to the Governing Body noting the comments communicated by the Medical Staff and the approval of the Medical Executive Committee. Conflicts may be addressed through the Conflict Management Process contained in these Bylaws.

b. When proposed by the Organized Medical Staff, there will be communication of the proposed Rule and Regulation or amendment to the Medical Executive Committee.

(1) If the Medical Executive Committee adopts a proposed Rule or Regulation or amendment to the Rules or Regulations, the Medical Executive Committee will forward the proposed Rule or Regulation or amendment to the Governing Body noting the proposal by the Medical Staff and their approval.

(2) If the Medical Executive Committee does not adopt the proposed Rule or Regulation or amendment to a Rule or Regulation or Medical Staff Policy, the Medical Executive Committee will forward the proposed Rule or Regulation or amendment to a Rule or Regulation to the Governing Body noting the proposal by the Medical Staff and the disapproval of the Medical Executive Committee. Conflicts may be addressed through the Conflict Management Process contained in these Bylaws.

c. In the event of a documented or need for an urgent Rule or Regulation or amendment to a Rule or Regulation to comply with law or regulation, the Medical Executive Committee may adopt and Governing Body may approve without notification to the Medical Staff a provisional Rule or Regulation or amendment to a Rule or Regulation. After approval, the provisional Rule or
Regulation or amendment thereto will be communicated immediately to the Medical Staff for their retrospective review of and comment.

(1) If there is no conflict communicated to the Medical Executive Committee regarding the provisional Rule or Regulation or amendment thereto, the Rule or Regulation or amendment is adopted.

(2) If there is conflict communicated to the Medical Executive Committee regarding the provisional Rule or Regulation or amendment thereto, the Rule or Regulation or amendment, the process for resolving conflict between the Medical Staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the Governing Body.

d. A Rule and Regulation shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably or automatically within 90 days if no action is taken by the Governing Body.

e. If there is a conflict between the Medical Staff Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

13.1.2 Departmental Rules and Regulations

Each Department may formulate whatever Rules and Regulations are necessary and appropriate for conducting its affairs and discharging its responsibilities. Such Rules and Regulations or amendments thereto, shall not be inconsistent with the Medical Staff, Hospital or System Bylaws, Rules, or other policies. If there is a conflict between the Departmental Rules and Regulations of the Medical Staff Bylaws or the Rules and Regulations and the Departmental Rules, the Medical Staff Bylaws or the Rules and Regulations, as appropriate, shall prevail. The Departmental Rules shall be deemed an integral part of the Medical Staff Bylaws.

13.1.2.1 The proposal and approval processes will follow the processes in Article 13.1.1.a.b.c.and d.

13.1.3 Medical Staff Policies

Medical Staff Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules and Regulations. Such policies or amendments thereto, shall not be inconsistent with the Medical Staff, Hospital or System Bylaws, Rules, and Regulations, or other policies. If there is a conflict between the Medical Staff Bylaws or the Rules and Regulations and the Policies, the Medical Staff Bylaws or the Rules, as appropriate, shall prevail.

13.1.3.1 The proposal and approval process will follow the processes in Article 13.1.1.1.a and b.

13.1.4 Allied Health Practitioner Rules

The Medical Staff shall initiate rules for Allied Health Practitioners ("AHPs") ("AHP Rules") that reflect the more limited Privileges or Scope of Practice of AHPs. The AHP Rules shall be treated in the same manner as Medical Staff Rules for the periodic review and revision, approval, conflicts and integration within the Medical Staff Bylaws in accordance with Section 13.1.1.1 a, b, and c.

13.2 ASSESSMENTS AND APPLICATION FEES

There may be application fees for appointment and reappointment for each category of Medical Staff membership and Allied Health Practitioner. The Medical Executive Committee shall have the power to recommend special assessments for some or all categories of Medical Staff membership or AHP Privileges or Scope of Practice, subject to the Governing Body's approval. Fees and special assessments will be determined by the Medical Executive Committee and are periodically subject to change. The Medical Executive Committee shall determine the manner of
expenditure of the funds that are received and the proceeds of any special assessments provided, however, that such expenditures shall not jeopardize the nonprofit status of the Hospital, the System or any System Member.

13.3 DUES

There may be dues for each category of Medical Staff membership and for Allied Health Practitioner. The Medical Executive Committee shall have the power to recommend dues for some or all categories of Medical Staff membership or for AHP Privileges or Scope of Practice. Dues will be determined by the Medical Executive Committee and are periodically subject to change. The dues will be paid to and maintained by the Medical Staff Dues Fund, Inc. The Medical Executive Committee shall determine the manner of expenditure of the dues that are received provided, however, that such expenditures shall not jeopardize the nonprofit status of the Hospital, System, or any System Member.

13.4 CONFLICT MANAGEMENT PROCESS

Any conflict between the Organized Medical Staff, the Medical Executive Committee, and/or Governing Body will be resolved using the mechanisms noted below:

Each Member of the Organized Medical Staff with voting privileges may challenge any Rule, Regulation or Policy established by the Medical Executive Committee through the following process:

a. Submission of written notification to the President of the Medical Staff of the challenge and the basis for the challenge including any recommended changes to the Rule and Regulation or Policy.

b. At the meeting of the Medical Executive Committee that follows such notification, the Medical Executive Committee shall discuss the challenge and determine if any changes will be made to the Rule, Regulation or Policy.

c. If changes are adopted, they will be communicated to the Medical Staff, at such time Members of the Organized Medical Staff with voting privileges may submit written notification of any further challenge(s) to the Rule, Regulation, or Policy to the President of the Medical Staff.

d. In response to a written challenge to a Rule, Regulation, or Policy, the Medical Executive Committee may, but is not required to, appoint a task force to address concerns raised by the challenge.

e. If a task force is appointed, following the recommendations of such task force, the Medical Executive Committee will take final action on the Rule or Policy.

f. Once the Medical Executive Committee has taken final action in response to the challenge, with or without recommendations from a task force, any Medical Staff Member may submit a petition signed by twenty-five percent (25%) of the Members of the Organized Medical Staff with voting privileges requesting review and possible change of the Rule, Regulation, or Policy. Upon presentation of such petition, the adoption procedure outlined in this Article will be followed.

If the Medical Staff votes to recommend directly to the Governing Body an amendment to the Bylaws, Rules or Regulations, or Policy that is different from what has been recommended by the Medical Executive Committee, the following process shall be followed:

g. The Medical Executive Committee shall have the option of appointing a task force to review the differing recommendations of the Medical Executive Committee and the Medical Staff, and recommend language to the Bylaws, Rules and Regulations, or Policy that is agreeable to both the Medical Staff and the Medical Executive Committee.

h. Whether or not the Medical Executive Committee adopts modified language, the medical Staff shall have the opportunity to recommend directly to the Governing Body alternative language. If the Governing
Body receives differing recommendations for Bylaws, Rules and Regulations, or Policy from the Medical Executive Committee and the Medical Staff; the Governing Body shall have the option of appointing a task force of the Board to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Governing Body appoints such a task force, the Governing Body shall have final authority to resolve the differences between the Organized Medical Staff and the Medical Executive Committee.

i. At any point in the process of addressing a disagreement between the Organized Medical Staff and the Medical Executive Committee regarding the Bylaws, Rules and Regulations, or Policy, the Organized Medical Staff, Medical Executive Committee, or Governing Body shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the Governing Body.
ARTICLE 14 ADOPTION AND AMENDMENT OF BYLAWS

14.1 THE ORGANIZED MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

14.1.1 The Organized Medical Staff shall have the initial responsibility and delegated authority to formulate, amend, adopt, and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body.

14.1.2 Amendments to these Medical Staff Bylaws shall be originated and submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least twenty-five (25) percent of the Organized Medical Staff Voting Members. When proposed by the Medical Executive Committee, there will be communication to the Organized Medical Staff before a vote is taken by the Medical Executive Committee. When proposed by the Organized Medical Staff, there will be communication of the proposed amendment to the Medical Executive Committee before a vote is taken by the Organized Medical Staff Voting Members.

14.2 METHODOLOGY

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

14.2.1 The affirmative vote of two-thirds of the Medical Staff Members who are eligible to vote. Voting on bylaws or amendments shall be by mailed or electronically transmitted. A ballot shall be mailed or electronically transmitted to each Member who is eligible to vote and have a return date that is at least 15 days after the date the ballot was mailed or sent. The ballot shall be accompanied by the proposed Bylaws and/or alterations. Ballots that are not returned are deemed to be a vote to approve the proposed amendment. The ballots shall be counted by the President and Chief Medical Officer or their designee.

14.2.2 The approval of the Governing Body, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the President and the Medical Executive Committee.

Neither the Medical Staff nor the Governing Body may unilaterally amend these Medical Staff Bylaws. However, in recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are reasonably required to comply with applicable law, for continued state licensure, approval by accrediting bodies, or to comply with a court judgment. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

14.3 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross references. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, the substance of such amendments shall be communicated to the Medical Staff and to the Governing Body. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff at a Special Meeting of the Medical Staff in accordance with Section 10.1.2 or the Governing Body within 90 days after adoption by the Medical Executive Committee.
14.4 PERIODIC REVIEW

The Medical Executive Committee shall periodically review the Bylaws, at least every three (3) years. Any amendments shall be subject to Sections 14.1.2 and 14.1.3.
APPROVED BY:

Hospital Medical Executive Committee on **OCTOBER 20, 2014**

Signed: __________________________
Medical Staff President

Governing Body on **10/27**, 2014

Signed: __________________________
SCL Health – Front Range, Inc. Corporate Secretary