EXEMPLA LUTHERAN MEDICAL CENTER
GENERAL MEDICAL STAFF RULES

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1.1 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

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

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

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

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

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

1.1.6 Prepare and complete in timely manner the medical and other required records for all patients to whom the Practitioner in any way provides services in the System and maintain confidentiality of patient-identifiable information.

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

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

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

1.1.10 Delegate responsibility for diagnosis or care of hospitalized patients only to a Practitioner, practitioner in training, or AHP who is qualified to undertake this responsibility and who is adequately supervised.

1.1.11 Seek consultation whenever warranted by the patient's condition or when required by the Rules.

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

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

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

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

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

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

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

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

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

1.1.22 Continuously inform the Medical Staff of any significant changes in the information required on appointment and reappointment.

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

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

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

1.1.26 Ensure that patients know the name of the Practitioner(s) who is primarily responsible for the delivery of their care, treatment, and services within 24 hours of admission and the names of other Practitioners who will provide care, treatment, and services.

1.2 MEDICAL SCREENING EXAMINATIONS

All patients who come to the Hospital’s dedicated emergency department(s) requesting emergency services shall receive an appropriate, adequately documented medical screening examination as required by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (“EMTALA”) and in accordance with System policies. For purposes of this Rule 2, the Hospital includes the Emergency Department and the Obstetrics Department for pregnant patients, and any other intake department or contiguous or off-site hospital facility, which is owned by the Hospital and operated under the Hospital's provider number.
A "medical screening examination" is the process required to determine, with reasonable clinical confidence, whether the patient has an emergency medical condition as defined under EMTALA and System policies governing EMTALA. A “dedicated emergency department” under EMTALA includes any department or facility that (1) is licensed by the State as an emergency room or emergency department, (2) is held out to the public as a place that provides care for emergency medical conditions on an urgent basis without a scheduled appointment, or (3) during the immediately preceding calendar year, provided at least one-third of all of its outpatient visits for the treatment of emergency medical conditions without a scheduled appointment.

1.3 QUALIFIED MEDICAL PERSONNEL

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

“Qualified medical personnel” shall also include the non-physicians listed below who have been determined to be qualified to initiate and/or perform medical screening examinations (i) within the scope of their training and professional licenses or certifications, (ii) in a manner consistent with System and Hospital policies, and (iii) who are either employed by Exempla and acting within the scope of their job description, and/or are members of the Medical Staff or Allied Health Staff acting within the scope of their privileges; provided, however, that any decision to discharge, admit, or transfer a patient following a medical screening examination by a non-physician shall be made by a Physician with appropriate privileges or a House Staff member subject to appropriate Physician supervision in accordance with the Clinical Rules and System policies governing House Staff:

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

a. Physician Assistants who are certified by the State of Colorado and who have completed orientation to the Emergency Department.

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

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

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

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

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

   Oriented to the labor and delivery unit,

   Demonstrated competence specific to labor and delivery, and

   Completed an electronic fetal monitoring class during the first two years of employment with Exempla and every two years thereafter.
1.3.3 Psychiatric or chemical dependency patients in the Hospital, including the Psychiatric Department or the Emergency Department (all medical screening examinations of psychiatric or chemical dependency patients shall be subject to supervision by a Physician with appropriate clinical privileges).

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

Completed orientation to the Psychiatric Department,

Trained in Crisis Management Training or received equivalent training within three months of the date of hire, scope of practice or privileging,

Familiarity with applicable criteria for mental health holds under Colorado's Mental Health law, C.R.S. § 27-10-101, et seq., and Alcohol and Drug Division, C.R.S. § 25-1-201, et seq.; and

Familiarity with applicable DSM-IV diagnostics.

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

Psychologists who are licensed by the State of Colorado.

Professional Counselors who are licensed by the State of Colorado.

Clinical Social Workers who are licensed by the State of Colorado.

Marriage and Family Therapists who are licensed by the State of Colorado.

Registered Nurses who are licensed by the State of Colorado.

1.3.4 All other Hospital departments and facilities that meet the definition of a “dedicated emergency department” (all medical screening examinations in the Hospital shall be subject to supervision by a Physician with appropriate privileges):

a. Nurse Practitioners who are licensed by the State of Colorado and who are oriented to the applicable department or facility.

b. Physician Assistants who are licensed by the State of Colorado and who are oriented to the applicable department or facility.

c. Registered Nurses who are licensed by the State of Colorado and who are oriented to the applicable department or facility.

1.4 CALL PANELS

1.4.1 “Call Panels” are maintained to ensure the availability of on-call Practitioners to provide further medical screening evaluations and medical treatment necessary to stabilize patients with an emergency medical condition and to otherwise fulfill the Hospital’s obligations under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (“EMTALA”) including Follow-Up Care, and to ensure the availability of specialty Practitioners for other patients of the Hospital. For purposes of this Rule 1.4, “Follow-Up Care” includes care for any patient who is “stable for discharge” as defined under EMTALA, but who needs continued care in accordance with the plan of care in the patient’s discharge instructions.

1.4.2 Each member of the Active and Courtesy Medical Staff shall participate in a Call Panel as requested, unless the Medical Executive Committee has determined that the Practitioner’s specialty does not have an
obligation to participate in a Call Panel. Each Member of the Affiliate Medical Staff shall also participate in a Call Panel in the discretion of the Department Chair or his/her designee, but solely for purposes of Follow-Up Care. Service on the Call Panel is an obligation of Medical Staff membership. Any Practitioner who refuses to serve on a Call Panel shall be deemed to have voluntarily resigned his or her Medical Staff membership and clinical privileges, and shall not be entitled to the hearings and appeals processes set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws. A Department Chair or a Section Chief (or a Practitioner under contract with the Hospital) may exclude Courtesy or Affiliate Medical Staff Members from participation in the Call Panel if the specialty is adequately and fairly covered in a manner consistent with the Hospital’s EMTALA obligations.

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

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

1.4.3 The Department Chairs and Section Chiefs (or certain Practitioners under contract with the Hospital) shall be responsible for assigning Practitioners to the Call Panels and creating a “on-call” list that (1) ensures that the on-call rotation is adequately and fairly covered, (2) best meets the needs of the Hospital’s patients who are receiving services mandated by EMTALA, and (3) promotes call responsibilities that are proportional to patient volume, as determined by the Medical Executive Committee, in collaboration with Administration. The purpose of an “on-call” list is to ensure that the Emergency Department and other departments of the Hospital are prospectively aware of the Practitioners, including specialists and subspecialists, who are available to provide examinations and treatment necessary to stabilize patients with an emergency medical condition and to provide consultation services and other services for patients of the Hospital. To implement this requirement, a monthly “on-call” list shall be prepared in writing and submitted to Medical Staff Services. The “on-call” list shall include the following: (i) the individual on-call Practitioner (the “Call Panelist”) by his or her name (not solely by practice group name), (ii) each Call Panelist’s phone number(s), (iii) the period of “on-call” time (the “Coverage Period”), and (iv) when applicable, the period of Follow-Up Care availability for all Medical Staff Members, including Affiliates. Medical Staff Services shall distribute copies of the “on-call” list shall be forwarded to the Emergency Department and other appropriate locations as requested by Administration. Changes to the “on-call” list shall be documented in accordance with Rule 1.5.2 below.

1.4.4 Service on a Call Panel is not a clinical privilege and is not a right of Medical Staff membership. The Hospital may enter into exclusive or semi-exclusive contracts with Practitioners for Call Panel services in its sole discretion. The Department Chair or Section Chief may also deny or terminate a Practitioner’s participation on a Call Panel. The Practitioner will be given a written statement of the reason(s) for the proposed denial or termination of Call Panel participation and an opportunity to appear before the Medical Executive Committee before the action becomes final. This opportunity to appear shall not constitute a hearing and shall not entitle the Practitioner to any of the hearings and appeals rights set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws. The Department Chair’s or Section Chief’s decision will become final if the Practitioner does not request an opportunity to be heard by the Medical Executive Committee within ten (10) business days of the written statement or when approved by the Medical Executive Committee. Notwithstanding the foregoing, the President may suspend a Practitioner’s Call Panel participation at any time until the Practitioner has waived his or her opportunity to be heard or a final decision is reached by the Medical Executive Committee. Participation on a Call Panel may be denied or terminated when the Hospital enters into an exclusive or semi-exclusive contract with Practitioners for Call Panel services. The Practitioner will be given a written statement of the reason(s) for
the denial or termination of Call Panel participation, however, the Practitioner is not entitled to appear before the Medical Executive Committee or any of the hearings and appeals rights set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws.

1.4.5 The denial or termination of a Practitioner’s Call Panel participation under Rule 1.4.4 above shall not affect the Practitioner’s Medical Staff membership or clinical privileges, nor shall this decision be used as evidence in any corrective action. However, any relevant facts considered by the President, the Department Chair, Section Chief or the Medical Executive Committee in reaching their decision may be used for any and all purposes, including any corrective action.

1.5 CONDUCT OF CALL PANELISTS

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

1.5.2 A Call Panelist who is unable to provide on-call coverage during his or her scheduled Coverage Period or wants to change his or her Coverage Period is responsible for arranging for coverage by a Practitioner who meets the criteria for Call Panel eligibility (the “Substitute Call Panelist”). The Substitute Call Panelist shall inform the Emergency Department or Medical Staff Services (during weekdays and non-holiday business hours) of the name of the Practitioner who will provide back-up coverage so that the “on-call” list can be updated. At the discretion of the Emergency Department Physician, Practitioners are permitted to send certain mid-level practitioners (i.e., advance practice nurses and physician assistants with appropriate Privileges) to respond to a call. If in the opinion of the Emergency Department Physician the situation necessitates that the physician respond rather than send a mid-level practitioner, the physician on call will be obligated to respond.

1.5.3 During each Coverage Period, including the provision of Follow-Up Care, each Call Panelist shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient’s race, creed, sex, age, national origin, ethnicity, citizenship, religion, pre-existing medical condition (except to the extent it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay. Each Call Panelist shall provide all services, including Follow-Up Care, in accordance with System policies on EMTALA and other appropriate Hospital policies. EMTALA obligations do not apply to inpatients of the Hospital.

1.5.4 A patient can be admitted to the Hospital in the name of the Call Panelist with appropriate Privileges by the Emergency Physician if both parties concur, but if the Emergency Physician so specifies, the Call Panelist must see the patient prior to the admission. The Call Panelist must be notified about each admission prior to the patient leaving the Emergency Department.

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

1.5.6 Call Panelists will assume the care of any unassigned patients in the Emergency Department and unassigned patients referred for Follow-Up Care. Once the Call Panelist has assumed care of the patient, that patient’s care shall be the responsibility of the Call Panelist until the patient's emergency medical
condition or other problem that prompted the Call Panelist’s assignment is resolved and the patient has been discharged or appropriately transferred in accordance with System policies or discharged with a plan for appropriate Follow-Up Care. The Call Panelist is solely responsible for billing and collecting any professional fees for services provided as a Call Panelist. The Call Panelist may not withhold Care based upon the patient’s ability to pay. The Hospital has no responsibility for this physician/patient relationship and each Call Panelist agrees to release the Hospital from any obligation in this regard.

1.5.7 Any dispute between a Call Panelist and the patient or the patient’s family or authorized decision-maker, including any dispute regarding Follow-Up Care in the Emergency Department shall be referred to the Emergency Physician. No Call Panelist shall presume that his or her services have been refused unless the patient or his or her authorized decision-maker has been fully informed of the benefits of the treatment offered and the risk of refusing such treatment, including Follow-Up Care, and has given an informed refusal of treatment in writing. The Emergency Physician shall be informed of any such refusal of treatment.

1.5.8 If a Call Panelist refuses or fails to respond to a call during his or her Coverage Period, the appropriate Department Chair or Section Chief will be called for guidance in contacting another appropriate Practitioner to handle the care of the patient in accordance with the Chain of Command policy. All members of the Medical Staff shall cooperate to the fullest extent in order to provide screening and stabilizing treatment to patients seeking emergency care within the services and facilities available at the Hospital.

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

1.5.10 As an alternative to proceeding in accordance with Rule 1.5.9 above, if a Call Panelist refuses or fails to respond by telephone or in person in a timely manner as required by this Rule, the Practitioner may be subject to the following process:

a. For the first offense, the Practitioner shall be provided with a letter of warning from the Department Chair, Section Chief, or any member of the Medical Executive Committee. A copy of this letter of warning shall be forwarded to Medical Staff Services for inclusion in the Practitioner’s credentialing file. The Practitioner shall be given the opportunity to respond in writing to the letter of warning and shall be given the opportunity to the meet with Department Chair, Section Chief, or the member of the Medical Executive Committee who initiated the letter of warning. This opportunity to meet shall not constitute a hearing and shall not entitle the Practitioner to any of the hearings and appeals rights set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws.

b. For a second offense in any twelve month period, the Practitioner shall be provided with a letter of warning from the Medical Executive Committee. This second letter of warning shall specify that one additional failure to respond in the same twelve month period shall be deemed an automatic resignation of Medical Staff membership and clinical Privileges. A copy of this letter of warning shall be forwarded to Medical Staff Services for inclusion in the Practitioner's credentialing file. The Practitioner shall be given the opportunity to respond in writing to the letter of warning and shall be given the opportunity to the meet with the Medical Executive Committee. This opportunity to appear shall not constitute a hearing and shall not entitle the Practitioner to any of the hearings and appeals rights set forth in the Peer Review, Fair Hearing and Appeal Rules and the Medical Staff Bylaws.

c. For a third offense in any twelve month period, the Practitioner shall be deemed to have voluntarily resigned his or her Medical Staff membership and all clinical Privileges, and shall be sent a Notice that his or her Medical Staff membership and all clinical Privileges shall terminate immediately, unless he or she requests an opportunity to appear before the Medical Executive
Committee. This opportunity to appear shall not constitute a hearing and shall not entitle the Practitioner to any of the hearings and appeals rights set forth in the Medical Staff Rules. The decision of the Medical Executive Committee shall be final.

1.5.11 All transfers shall be carried out in accordance with the system policy on transfers. In summary, it requires:

a. The Emergency Department Physician, the patient’s Attending Practitioner, or a call Panelist must personally examine the patient prior to transfer and find that the patient is stable. Patients who are not stable may be transferred only if the practitioner finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient, or his or her authorized decision-maker, requests transfer, after the Practitioner has explained the medical risks and benefits of transfer.

b. In addition: (1) the receiving facility must consent to the transfer and confirm it has the staff and facilities needed to provide the care the patient needs, (2) staff and equipment necessary for a safe transfer must be arranged, (3) copies of pertinent medical records must be provided, including a copy of the consent for transfer, and (4) the appropriate transfer summary form must be completed and copy sent with the patient.

1.6 EMPLOYED PRACTITIONERS

1.6.1 General

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

1.6.2 Preservation of Professional Judgment

The Hospital shall not limit or otherwise exercise control over any employed Practitioner’s independent professional judgment concerning the practice of medicine, dentistry or podiatry, as applicable, or diagnosis or treatment, or require any employed Practitioner to refer exclusively to the Hospital or the Hospital’s other employed Practitioners.

1.6.3 No Discrimination

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

1.6.4 Fees

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

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

1.6.6 Due Process

Any Practitioner who believes he or she has been the subject of a violation of this Rule 1.6 has the right to complain to the Hospital and to request a review of the complaint in accordance with this Rule 1.6.6.

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

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

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

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

2.1 GENERAL

2.1.1 Appointment of Members

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

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

c. The Chief Executive Officer, or his or her designee, shall appoint any non-Medical Staff Members who serve in non-Ex Officio capacities; provided, however, that Medical Staff committees conducting peer review activities shall include at least 50% Physicians.

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

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

2.1.2 Representation on Hospital Committees and Participation in Hospital Deliberations

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

2.1.3 Ex Officio Members

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

2.1.4 Action Through Subcommittees

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

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

2.1.6 Vacancies

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

2.1.7 Conduct and Records of Meetings

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

2.1.8 Attendance of Nonmembers

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

2.1.9 Accountability

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

2.2 Cancer Committee

2.2.1 Composition

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

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

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

2.2.2 Duties

a. Responsible and accountable for all cancer program activities and assure the Hospital is meeting cancer program accreditation standards. To include, goal setting, planning, initiating, implementing, evaluating and improving all cancer-related activities in the facility.
b. When appropriate, the Cancer Committee may delegate this responsibility to a subcommittee or other department. The subcommittees and assessment of activities is documented in Cancer Committee minutes, i.e.: Breast Program Leadership.

2.2.3 Meetings

The Committee shall meet as often as necessary, but no less than quarterly.

2.3 CONTINUING MEDICAL EDUCATION COMMITTEE

2.3.1 Composition

The Continuing Medical Education Committee shall consist of at least 3 Active Staff Medical Staff Members.

2.3.2 Duties

The Continuing Medical Education Committee shall:

a. Maintain accreditation to award American Medical Association Physician Recognition Award Category 1 Continuing Medical Education credits (AMA PRA Category 1 CME Credit™) for the Hospital and outreach educational activities as reviewed and approved by the committee.

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

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

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

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

2.3.3 Meetings

The Continuing Medical Education Committee shall meet at least quarterly.

2.4 CREDENTIALS COMMITTEE

2.4.1 Composition

The Credentials Committee shall be composed of at least 7 members.

2.4.2 Duties

a. The Credentials Committee shall evaluate or coordinate the evaluation of the qualifications of all applicants for Medical Staff appointment, reappointment, or changes in Medical Staff categories or Privileges. The Committee shall develop recommendations based on its and the Department and/or Section’s evaluations of each applicant.
b. The Credentials Committee may also initiate, review and report on matters involving the clinical, ethical or professional performance of any member in connection with an application for appointment, reappointment or for Privileges. The Committee may act on its own initiation or upon the referral of a matter by any Medical Staff Officer, Department or Section leader, or Committee, provided that a formal corrective action investigation may only be initiated by the Medical Executive Committee or its designee.

2.4.3 Meetings

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

2.5 DEPARTMENT COMMITTEES

2.5.1 Composition

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

2.5.2 Duties

The Department Committees shall assist the Department Chair to carry out the responsibilities assigned to the Department Chair, including the duties to review applicants for appointment, reappointment, and Privileges and to fulfill the responsibility for peer review. The Department Committees shall also fulfill the quality improvement functions assigned to them, including review of Department Members' cases.

2.5.3 Meetings

Each Department Committee shall meet as often as necessary.

2.6 ETHICS COMMITTEE

2.6.1 Composition

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

2.6.2 Duties

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

a. Providing assistance and resources for Medical Staff members, Hospital staff, patients and patients' families for decisions, which have ethical implications. The Ethics Committee shall not, however, be a decision-maker in any case.

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

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

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

2.6.3 Meetings
The Ethics Committee shall meet as often as necessary, but at least quarterly. The committee shall appoint members who shall be available to Medical Staff members to consult on an as needed basis.

2.7 JOINT LEADERSHIP COMMITTEE

2.7.1 Composition

The Joint Leadership Committee shall be comprised of the Exempla Lutheran Medical Center Medical Staff President and President-Elect, and a Member selected by the Exempla Lutheran Medical Center President, and such persons designated in the Medical Staff Rules of the Exempla Saint Joseph Hospital and Exempla Good Samaritan Medical Center. The Chief Executive Officer of the System and the Hospitals (if applicable), the Chief Medical Officer, the Vice Presidents with Medical Staff responsibilities, and the Chief Nursing Officers or any of their designees shall serve as ex officio members without vote. Sub-committees or task forces that include other Members and System representatives may be formed to study various issues and make recommendations either to the Joint Leadership Committee or to the Medical Executive Committees of the Hospitals in the System.

2.7.2 Duties

The Joint Leadership Committee shall review issues affecting the clinical operations of the System; the healthcare needs of patients and the community; and recommend strategic plans, policies, and actions to the Medical Executive Committees of the Hospitals in the System and to the Governing Board. The Committee also can review issues and concerns relating to the operations of either Hospital or facility members. The Committee shall be available to study issues referred by the Governing Board and Chief Executive Officer.

2.7.3 Meetings

The Joint Leadership Committee shall meet as needed.

2.8 INFECTION CONTROL COMMITTEE

2.8.1 Composition

a. The Infection Control Committee shall be composed of at least 3 Members, including at least 1 Physician whose primary specialty is infectious disease. In addition, a nurse whose responsibilities primarily involve infectious disease and a Pharmacy representative shall be voting members. The Occupational Health Nurse, a patient care administrator, and a peri-operative services representative shall be ex officio non-voting members.

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

2.8.2 Duties

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

2.8.3 Meetings and Reporting

The Infection Control Committee shall meet as necessary.
2.9  **Institutional Review Board**

2.9.1  Composition

The Board of Directors of Exempla Healthcare, (hereafter referred to as the Exempla Board) shall appoint the Chair and members of the Institutional Review Board (IRB). The terms of office shall be defined in the Institutional Review Board Policies and Standard Operating Procedures and Charter as such are amended from time to time.

2.9.2  Duties

The duties of the IRB will be those that are defined in the Institutional Review Board Policies and Standard Operating Procedures and Charter as such are amended from time to time.

2.9.3  Meetings and Reporting

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

2.10  **Interdisciplinary Practice Committee**

2.10.1  Composition

The Interdisciplinary Practice Committee (IPC) is an ad hoc subcommittee of the Credentials Committee that shall convene as requested by the Credentials Committee and consists of 3 Medical Staff Members who are selected from or by the Credentials Committee and 3 Allied Health Practitioners (including at least one nurse). The Chair of the Credentials Committee shall chair or appoint the chair of the IPC. In addition, representatives of the categories of AHPs approved for scope of practice in the System should serve as consultants on an as-needed basis and shall participate, when available, in the committee proceedings when a member of the same specialty is applying for scope of practice or being reviewed for corrective action.

2.10.2  Duties

The IPC shall:

a. As requested by the Credentials Committee, develop and review criteria describing the scope of advanced practice for nurses and scope of practice for AHPs; identify the scope of practice that is appropriate for different categories of professionals, develop forms delineating the criteria for granting the scope of practice.

b. If requested, serve as liaison between AHPs and the Medical Staff.

2.10.3  Meetings

The IPC shall meet as often as needed.

2.11  **Pharmacy and Therapeutics (P&T) Committee**

2.11.1  Composition

The P&T Committee shall consist of at least 3 Medical Staff members and the Director of Pharmacy. A representative of System Administration shall serve *ex officio* without vote.

2.11.2  Duties
The P&T Committee shall develop, implement, and monitor professional policies regarding evaluation, selection, and procurement of medications comprising the Hospital formulary; preparation and the dispensing of medications; distribution, administration, safety, and effect (including reactions and interactions) of medication usage; patient education; and other matters pertinent to medication use in the Hospital.

2.11.3 Meetings

The P&T Committee shall meet as often as necessary to fulfill its duties.

2.12 QUALITY IMPROVEMENT COMMITTEE

2.12.1 Composition

The Quality Improvement Committee will include at least three Active Members of the Medical Staff and such other representatives of health care disciplines and administration set forth in the committee’s charter and associated policies (collectively, the ‘charter’) as amended from time to time, which are incorporated herein by reference. The Chair of the Quality Improvement Committee shall be appointed and removed as outlined in the committee’s charter.

2.12.2 Duties

The Quality Improvement Committee shall perform the duties of a medical audit committee, a tissue committee, and such duties as are set forth in its charter. The Performance Excellence Plan shall service as the Hospital’s quality plan and shall be submitted to the Colorado Department of Public Health and Environment, Health Facility Division, for purposes of the Hospital’s Licensing as a general hospital. The Medical Staff Bylaws and Rules are hereby incorporated by reference into the Quality/Performance Excellence Plan for purposes of any credentialing or other peer review on non-Physician practitioners who apply for or are granted Medical Staff Membership, Allied Health Practitioner status, Privileges, or Scope of Practice.

2.12.3 Meetings and Reporting

The Committee shall meet as often as necessary to fulfill its duties. It shall report to the Governing Body and shall report to or collaborate with the Medical Executive Committee as set forth in its charter.

2.13 SECTION COMMITTEES

2.13.1 Composition

At the discretion of the Section Chief, a Section may form a Section Committee consisting of at least 3 Active Staff Members from the Section.

2.13.2 Duties

The Section Committee shall assist the Section Chief to carry out the responsibilities assigned to the Section Chief, including the duties to review applicants for appointment, reappointment, and Privileges and to fulfill the responsibility for peer review. The Department Committees shall also fulfill the quality improvement functions assigned to them including review of Department Members’ cases.

2.13.3 Meetings

Each Section Committee shall meet as often as necessary.
2.14 CRITICAL CARE COMMITTEE

2.14.1 Composition

The Critical Care Committee shall have at least five Members, which may include a cardiologist, pulmonologist, surgeon, family practitioner and general internal medicine specialist. A representative shall serve as ex officio members from each of the following areas: Respiratory Therapy, Pharmacy, and Nursing. The Nurse Managers of Intensive Care Unit, Coronary Care Unit, Intermediate Special Care Unit, and Telemetry Unit may serve as ex officio members.

2.14.2 Duties

The Critical Care Committee shall develop, implement, and maintain a plan for continuous delivery of quality care in the System's special care units. This plan shall provide for development, implementation, and oversight of unit-specific policies and procedures, shall address the admission and discharge of patients to the special care units, shall address communications systems as they relate to the special care units, shall assure 24-hour in-hospital or on-call coverage of the units by the directors or their designees, and shall provide for ongoing quality improvement.

2.14.3 Meetings and Reporting

The Critical Care Committee shall meet at least quarterly.

2.15 TRANSFUSION COMMITTEE

2.15.1 Composition

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

2.15.2 Duties

The Transfusion Committee shall:

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

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

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

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

2.15.3 Meetings and Reporting

The Transfusion Committee shall meet as often as necessary to fulfill its duties.

2.16 TRAUMA COMMITTEE

2.16.1 Composition

The Trauma Committee shall be composed of at least 3 Members including at least 1 representative from the Hospital's emergency physicians’ contract group. The composition shall meet the standards for
institutions operating Trauma Services. In addition, the Trauma Nurse Coordinator and a representative of the System administration shall be voting members.

2.16.2 Duties

The Trauma Committee shall review the Trauma plan and ensure compliance with the standards that apply to a Trauma Center. The Committee shall carry out any duties assigned to the Trauma Committee by state or local regulations or policies.

2.16.3 Meetings

The Trauma Committee shall meet at least quarterly.

2.17 Medical Staff Peer Review Committee

2.17.1 Composition

The Medical Staff Peer Review Committee (MSPRC) shall be composed of at least seven Members of the Active Staff. The Medical Staff Officers, the Chief Medical Officer, Chief Nursing Officer, the Director of Quality Development and the Director of Risk Management or their respective designees shall serve as ex officio members, without a vote; provided that the MSPRC shall not address physician peer review matters unless a majority of the MSPRC members present are Physicians. Each member will serve a three-year renewable term. Initial members will have staggered terms of one, two and three years, which will be renewable to a maximum of seven years. Members are eligible for additional terms of service on the MSPRC after a two year absence.

2.17.2 Duties

The MSPRC is designated to be the initial peer review body for such matters addressed in the MSPRC Charter. The MSPRC shall conduct peer review of Medical Staff Members in the areas of clinical quality, Practitioner responsibilities and documentation issues in accordance with the Medical Staff Peer Review Charter and the Medical Staff Peer Review Policy, as such are amended from time to time, and which are incorporated herein by this reference.

2.17.3 Meetings and Reporting

The MSPRC shall meet at least 10 times per year and shall report to the Medical Executive Committee at least quarterly.

2.18 Utilization Management Committee

2.18.1 Composition

The Utilization Management Committee shall be composed of at least the following: two doctors of medicine or osteopathy; the director of Care Management, Utilization Review Nurse, care manager and a nursing representative. The chair of the Utilization Management Committee will be a physician.

2.18.2 Duties

The Utilization Management Committee shall educate members on Recovery Audit Contractor (RAC), facilitate the Utilization Management Plan, review the status of commercial denials, review Medicare/Medicaid cases, and admission status determination and medical necessity for admission and continued stay.
2.18.3 Meeting and Reporting

The Utilization Management Committee will meet monthly and will report to the Medical Executive Committee at least quarterly.
RULE 3 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

3.1 CONTRACTORS WITH NO CLINICAL DUTIES

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

3.2 CONTRACTORS WHO HAVE CLINICAL DUTIES

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

3.2.2. Contracts between Practitioners and the System or the Hospital shall prevail over these Medical Staff Bylaws and the Rules, except that the contracts may not reduce any hearing rights that are legally mandated when an action will be taken that must be reported to the Board of Medical Examiners or the federal National Practitioner Data Bank. Practitioners employed by the System shall be further subject to policies and procedures applicable to employed Practitioners and employees generally.

3.3 SUBCONTRACTORS

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

Medical Executive Committee on

Signed: ____________________________________________
        Medical Staff

Exempla Board of Directors on

Signed: ____________________________________________
        Board of Directors