BYLAWS OF THE MEDICAL STAFF OF PLATTE VALLEY MEDICAL CENTER
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DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

a. The Hospital means Platte Valley Medical Center in Brighton, Colorado;

b. The "Medical Staff" or "Staff" shall mean the Practitioners who are appointed to the Hospital's Medical Staff and/or granted clinical privileges to attend patients in the Hospital;

c. "Medical Executive Committee" or "MEC" means the Executive Committee of the Hospital's Medical Staff;

d. "Board" means the Board of Directors of the Hospital;

e. "Chief Executive Officer" or "CEO" means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital or his respective designee;

f. "Chief of Staff" means the chief officer of the Medical Staff or his designee or other person acting for the Chief of Staff as provided in these Bylaws;

g. "Practitioner" means, unless otherwise specifically limited, any licensed physician, podiatrist or dentist applying for and exercising clinical privileges in the Hospital;

h. "Physician" means an individual with an M.D. or D.O. degree who is licensed to practice medicine in the State of Colorado;

i. "Allied Health Professional or AHP" means an individual, other than a licensed physician, dentist or podiatrist, who may be licensed or certified to exercise independent judgment within the areas of his professional competence and who is qualified to render direct or indirect medical, dental, or surgical care under the supervision of a Practitioner who has been accorded privileges to provide such care in the Hospital. Such AHPs shall include, without limitation, clinical psychologists, nurse anesthetists, nurse midwives, nurse clinicians/practitioners, physician assistants and other doctoral scientists and AHPs the Hospital, in its sole discretion, determines will provide a desired and appropriate service in the Hospital;

j. "Clinical privileges or privileges" means the scope of specific diagnostic, therapeutic, medical, dental, podiatric or surgical services the Practitioner is permitted to provide in the Hospital;
k. "Patient Contact" means the admission and/or primary responsibility for a patient admitted as an inpatient or outpatient, to the Hospital, or the performance of a diagnostic service or clinical procedure on a patient admitted to the Hospital at the request of the Practitioner who admitted or has primary responsibility for the patient. Consultation for the purpose of evaluating or providing an opinion on the patient's condition where a patient visit is conducted and/or a report is dictated by the consulting practitioner and included in the medical record shall also constitute a patient contact. Consultation without a patient visit or a report by the consulting practitioner in the medical record, recommending certain medical care and treatment or a referral for medical care, treatment or testing shall not constitute a patient contact for the purposes of determining qualifications for appointment to a certain Staff category.

l. "Rules and Regulations" means all other bylaws, policies, procedures, rules, regulations, guidelines, manuals and requirements of the Hospital and/or its Medical Staff which apply to applicants and/or members of the Medical Staff.

m. "Special Notice" means notification hand delivered to the physician or to the physician’s office, staff, home or sent by certified or registered mail, return receipt requested;

n. "Patient" means inpatients or outpatients of the Hospital;

o. The use of masculine personal pronouns in these Bylaws is purely for efficiency and economy only and shall refer to both sexes equally; and

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

q. “FPPE” means Focused Professional Practice Evaluation

r. “OPPE” means Ongoing Professional Practice Evaluation

s. “Electronic” ballot means a ballot sent to the eligible staff member via email
ARTICLE 1:
PURPOSE AND USE OF MEDICAL STAFF BYLAWS

1.1. Purpose
The purpose of the medical staff is to organize the activities of physicians who practice at Platte Valley Medical Center. These Medical Staff Bylaws are intended to establish guidelines for evaluation of Practitioners applying for appointment or reappointment to the Hospital's Medical Staff and/or clinical privileges, utilization review and quality assessment, corrective action, hearing and appellate review, and accountability to the Hospital's Board. Commencing on January 1, 2003, and continuing through December 31, 2011, the Medical Staff of Platte Valley Medical Center shall be operated under the provisions of the Intended Practice Plan Policy of Platte Valley Medical Center, which is incorporated by reference herein. That Policy may be extended beyond 2011 by action of the Hospital's Board. Nothing in these Bylaws is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services in the Hospital by Practitioners who have been granted Medical Staff appointment and/or clinical privileges by the Board. Furthermore, these Bylaws are not intended to delineate specific medical practice or standards, but only relate to functions of the Hospital and its Medical Staff.

1.2 Additional Rules
These Medical Staff Bylaws are intended to inform members of the Hospital's Medical Staff of the policies, procedures, rules, regulations, guidelines and requirements which apply to them. There may be additional Rules and Regulations which apply to such Medical Staff appointees and it is each Medical Staff appointee's sole responsibility to obtain, read, understand and abide by these Bylaws and the Rules and Regulations of the Hospital and its Medical Staff.

1.3 Use
These Medical Staff Bylaws and the Rules and Regulations are unilateral expressions of the current requirements of the Hospital relating to applicants and members of the Medical Staff and are subject to change at any time. These Medical Staff Bylaws and the Rules and Regulations do not constitute a contract of any kind whatsoever and any Practitioner who intends that these Bylaws and the Rules and Regulations should constitute a contract must first notify the Hospital and obtain the written consent of the Board. These Bylaws and the Rules and Regulations shall be interpreted, applied and enforced within the sole discretion of the Hospital or those individuals delegated responsibility for interpretation, application or enforcement under these Bylaws or the Rules and Regulations.
ARTICLE 2:
RESPONSIBILITIES

2.1 The responsibilities of the Medical Staff are to:

2.1-1 Make a report to the Board on the quality and efficiency of patient care provided by all Practitioners authorized to practice in the Hospital through the following measures:
- Review and evaluation of the quality of patient care through a quality assessment program;
- Provide structure and mechanisms that allow ongoing monitoring of patient care practices;
- Provide a credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised with the verified credentials and current demonstrated performance of the applicant or Staff appointee; and
- Support a utilization review program for the allocation of resources of the Hospital and its Medical Staff.

2.1-2 Make reports and/or recommendations, as required by the Board or under these Bylaws, to the Board with respect to appointment, reappointment, Staff category, clinical privileges and Department assignments for applicants to and members of the Hospital's Medical Staff.

2.1-3 Make recommendations to the Board with respect to the professional guidelines for the delivery of health care within the Hospital;

2.1-4 Initiate, investigate and make reports and/or recommendations, as required by the Board or under these Bylaws, regarding corrective action with respect to members of the Hospital's Medical Staff;

2.1-5 Develop, administer, recommend amendments to and enforce these Bylaws Rules and Regulations of the Hospital and/or its Medical Staff;

2.1-6 Assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs;

2.1-7 Exercise the authority delegated by the Board under these Bylaws as necessary to adequately fulfill the foregoing responsibilities; and

2.1-8 Participate in the Organized Health Care Arrangement (“OHCA”) that will be established by Platte Valley Medical Center (“PVMC”) for the purpose of facilitating the sharing of Protected Health Information (as defined in PVMC policies) of patients for purposes of treatment, payment and health care operations within PVMC in accordance with applicable laws and regulations and shall comply with all policies related to the OHCA.
ARTICLE 3:
CATEGORIES OF MEDICAL STAFF AND ALLIED HEALTH PROFESSIONALS

3.1 Categories of the Medical Staff

All appointments shall be made by the Board to the Platte Valley Medical Center Medical Staff to one of the following categories: Active, Associate, Telemedicine, Inactive and Emeritus.

3.2 Active Staff

Members of the active staff are those members committed to the medical staff and the healthcare organization in the fulfillment of its mission. There are two sub-categories within the active medical staff.

1. Active members with clinical privileges currently providing inpatient care as admitting physicians or consultants.

2. Active members without clinical privileges that perform preadmission history and physicals, order outpatient diagnostic tests and services, may visit patients in the hospital and review their medical records however do not write inpatient orders or otherwise provide treatment or care.

3.2-1 Qualifications

Members of this category must be involved in a minimum of 24 patient contacts per appointment period. A patient contact is defined as an inpatient admission; consultation; inpatient or outpatient surgeries; referrals to the ED, or for admission, or diagnostic studies.

3.2-2 Prerogatives:

Members of the active staff may:

1. exercise the privileges granted;
2. vote on all matters presented at the meetings of the Medical staff and of the service and committees to which they are appointed;
3. serve on committees of the Medical Staff; and
4. hold medical staff office and serve as department chair and/or committee chairperson

3.2-3 Responsibilities:

Members of the active staff must fulfill all responsibilities and requirements outlined in the Medical Staff Bylaws/ Rules and Regulations as well as:
1. participate, as requested, in Emergency Department back up call
2. provide for receiving patients from the hospital that do not otherwise have a primary care provider, on a rotational basis;
3. serve on medical staff committees;
4. faithfully perform the duties of any office or position to which they are elected or appointed;
5. participate in performance improvement and monitoring activities as assigned by the department chair or committee chairperson; and
6. pay dues as may be determined by the Medical Staff

3.3 Associate Staff

Members of the associate staff are those members who do not meet the eligibility requirements for the active staff category or choose not to pursue active status however fulfill an essential role in patient care for the medical staff and Hospital.

3.3-1 Qualifications

Members of the associate staff must be currently appointed to the active staff of another hospital, unless this requirement is waived by the Medical Executive Committee (MEC) in consultation with the Administration.

3.3-2 Prerogatives:

1. exercise the privileges granted;
2. attend meetings of the Medical Staff (without vote), applicable department meetings (without vote), and committee meetings (with vote).

3.3-3 Responsibilities:

Members of the associate staff must fulfill all responsibilities and requirements outlined in the Medical Staff Bylaws/ Rules and Regulations as well as:

1. participate, as requested, in Emergency Department back up call
2. provide for receiving patients, when appropriate, from the hospital that do not otherwise have a primary care provider, on a rotational basis;
3. serve on medical staff committees, as requested;
4. participate in performance improvement and monitoring activities as assigned by the department chair or committee chairperson; and
5. pay dues as may be determined by the Medical Staff

3.4 Emeritus Staff

The Emeritus Staff shall consist of Staff appointees who have, as determined by the Hospital in its sole discretion, demonstrated longstanding service to the Hospital or are
recognized for their outstanding reputations or have made noteworthy contributions to the health and medical sciences. Emeritus Staff appointees are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. They may attend Staff and Department meetings and any Staff or Hospital education meetings. Emeritus Staff members shall not be eligible to vote or hold office on the Staff. Emeritus Staff shall not be required to apply for appointment or reappointment to the Medical Staff.

3.5 **Allied Health Professionals**

AHPs shall include those individuals the Board, in its sole discretion, determines will provide a desired and appropriate service in the Hospital. Certain categories of AHPs may be granted privilege to provide specified services independently in the Hospital; however, the daily continuing care of each patient must be by and under the supervision of the attending Practitioner. AHPs are not appointees of the Hospital's Medical Staff and are not entitled to the same rights, privileges and prerogatives of Medical Staff appointees. AHPs are not entitled to the procedural rights and processes specified in these Bylaws and the Rules and Regulations unless otherwise specified by the Board. AHP’s credentialed with independent privileges may have procedural rights specified in the Allied Health Professional Rules and Regulations.

Requests to perform specified patient care services from AHPs are processed in the manner outlined in the Allied Health Practitioner Rules and Regulations. An AHP may, subject to any licensure requirements or other limitations, participate directly in the medical management of patients only under the supervision/sponsorship of a Practitioner who has been accorded privileges to provide such care.

3.6 **Inactive Staff**

Appointment to the Inactive Staff shall be accorded Medical Staff appointees who require an extended leave of absence for no more than a two-year period. Physicians that have been appointed as Active or Associate Staff may request inactive status. The Governing Board, in its sole discretion, may determine an appointee to be inactive due to verified inactivity. Appointees to the inactive Staff may not admit or attend patients at the Hospital, shall have no voting privileges and cannot hold office. The appointee may attend Medical Staff meetings and educational programs. At the time of requesting reactivation of their Medical Staff appointment, inactive staff appointees must apply for reappointment. Inactive staff applying for reappointment may be eligible to ask for temporary privileges during the processing of their reappointment application.

3.7 **Telemedicine Staff**

The Telemedicine Staff shall consist of Practitioners who do not meet the requirements for Active, or Associate Staff appointment and who are otherwise qualified for Medical Staff appointment. Telemedicine appointees are those Practitioners who do not provide services on-site. Qualified appointee’s scope of practice will be limited to providing telemedicine reading services for patients whose care is provided at Platte Valley Medical
Center. A Telemedicine Staff appointee is not eligible to serve upon committees of the Medical Staff and may not vote or hold office. Telemedicine Staff appointees must discharge the responsibilities outlined in these Bylaws and other responsibilities the Hospital or its Medical Staff request.

ARTICLE 4:
MEDICAL STAFF APPOINTMENT

4.1 General Qualification

Appointment to the Medical Staff is a privilege which shall be extended in the discretion of the Hospital only to Practitioners who continuously meet the qualifications and requirements set forth in these Bylaws and the Rules and Regulations and who are invited to apply for membership on the Medical Staff after submission of an Intended Practice Plan.

Appointment to the Staff shall confer on the appointee only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No Practitioner shall admit or provide services to patients in the Hospital unless he is an appointee to the Staff or has been granted clinical privileges in accordance with the procedures set forth in these Bylaws.

No Practitioner shall be denied appointment or clinical privileges on the basis of sex, race, creed, color, national origin or handicap.

No Practitioner shall be automatically entitled to appointment on the Medical Staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or any other state, an appointee of any professional organization, certified by any clinical board, or because he had, or presently has, Staff appointment or privileges at the Hospital, at another health care facility or in another practice setting.

4.1-1 Ethical Requirements

By accepting an appointment to the Medical Staff, a Practitioner agrees to abide by the applicable Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association and the Code of Ethics of the American Dental Association or the American Podiatric Association, as applicable, and the Hospital and Medical Staff Bylaws and the Rules and Regulations.

4.1-2 Qualifications for Appointment

Every Practitioner who seeks or obtains Medical Staff appointment must, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and of the Board the following qualifications:

a. A currently valid license in good standing issued by the State of Colorado to practice medicine, dentistry or podiatry or an exemption from such licensure requirements;
b. The applicant must demonstrate that he has successfully graduated from an approved school of medicine, osteopathy, dentistry, or podiatry.

c. A willingness to participate equitably in the discharge of Medical Staff obligations and a capability, based on attitude and evidence of performance, to work with and relate to other Medical Staff appointees, members of other health disciplines, Hospital management and employees, visitors and the community in a cooperative, professional manner;

d. The applicant must provide evidence of physical and mental health that does not impair the fulfillment of his medical staff responsibilities and the specific privileges requested by and granted the applicant.

e. All physicians seeking appointment to the PVMC Medical Staff must be board certified in the specialty in which they have an active practice unless an exception is provided in the Specialty Board Certification Policy. Administrative denial or termination for failure to obtain or maintain board certification is not an adverse action and does not entitle the physician to a fair hearing.

f. Commitment to the Hospital—as determined by the Hospital in its sole discretion, must be dedicated and committed to the viability of the Hospital, the team approach to health care, and working with the Hospital in providing health care services to the community served by the Hospital;

g. The applicant must have a record that is free from current Medicare/Medicaid sanctions and not be on the Office of Inspector General’s list of excluded individuals/entities.

h. The applicant must have a record that is free of felony convictions within the last three years, or occurrences that would raise questions of undesirable conduct that could injure the reputation of the medical staff or hospital.

i. The applicant must possess a current, valid, unrestricted drug enforcement administration number, if applicable.

j. The applicant must demonstrate his or her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested.

k. The applicant must demonstrate current clinical competency within the past 12 months in the area in which clinical privileges are sought.

l. The applicant must provide evidence of professional liability insurance appropriate to all privileges requested and of a type and an amount established by the board in consultation with the MEC.

m. Any practitioner who has been granted privileges and who may have the occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and board.

n. Other Qualifications and Requirements - Each applicant for appointment and reappointment shall be subject to additional qualifications and requirements as determined by the Hospital and its Medical Staff.

4.1-3 Basic Responsibilities of Individual Staff Appointment
Each appointee of the Hospital's Medical Staff shall:

a. Provide his patients with daily continuous care at the generally recognized professional level of quality and efficiency.
b. Provide a dictated or written History and Physical on all admissions and surgical cases which will contain sufficient information to identify the patient, support the diagnosis, and justify the treatment to be done no more than thirty days before or 24 hours after an admission and updated as appropriate.
c. Discharge such Staff, Department, committee and Hospital functions for which he is responsible by appointment, election or otherwise;
d. Prepare and complete in timely fashion, as determined by the Hospital, the medical and other required records for all patients he admits or in any way provides care to in the Hospital as provided in the Rules and Regulations;
e. Abide by the recognized standards of professional ethics;
f. Maintain current evidence of financial responsibility for professional liability in accordance with these Bylaws, unless the Practitioner is an appointee of the Hospital's Affiliate or Emeritus Staff and does not admit patients or hold clinical privileges at the Hospital; and

g. Participate as requested in Emergency Department back up call and other call panels approved by the MEC, as provided in the Rules and Regulations;
h. Provide and update the information requested on the original application and subsequent reapplication for reappointment and privilege request forms and immediately notify the Medical Staff Office of any change in the information provided on the most current application form and to provide all information requested by the Hospital or its Medical Staff.

For purposes of this section "immediately" means within seven (7) days of the change in information, unless otherwise provided in these Bylaws or the Rules and Regulations. Notification of a change in such information and information relating thereto shall be provided in writing to the Medical Staff Office.

i. Participate in peer review and performance improvement activities, as appropriate and when requested.

j. Abide by these Bylaws and the Rules and Regulations

Information that must be provided and updated includes:

1. Voluntary or involuntary relinquishment, limitation, reduction, suspension or revocation of medical staff membership or clinical privileges at any health care facility;
2. Disciplinary actions or other challenges initiated or currently pending by any state licensure or registration board;
3. Voluntary or involuntary relinquishment, denial, limitation, suspension, or revocation of Medical, Dental, or Podiatry license;
4. Voluntary or involuntary relinquishment, denial, revocation, or suspension of DEA certificate;
5. Pending adverse actions with regard to employment, clinical privileges at any health care facility, Medical staff appointment or clinical privileges at any health care facility;
6. Professional liability suits or claims pending or previously settled;
7. Pending civil or criminal actions brought by any hospital, law enforcement agency, or professional group;
8. Any felony convictions.

Failure to provide and update information as required in this Section or in other sections of these Bylaws shall be grounds for termination of Staff appointment and clinical privileges and/or such other corrective action as the Hospital and its Medical Staff deem appropriate; and

k. Perform such other responsibilities as may be requested by the Hospital or its Medical Staff.

4.2 **Term of Appointment**

4.2-1 Initial Appointment -- All initial appointments to the Medical Staff will be for a period of twelve (12) months. An applicant who is deemed to be an initial applicant, as provided in these Bylaws, but who has previously held Staff appointment may, in the discretion of the MEC, be granted appointment for a period of twenty-four (24) months.

4.2-2 Reappointment -- All reappointments to any category of the Medical Staff will be for a period of twenty-four (24) months.

4.3 **Contract Physicians**

4.3-1 Practitioners under contract with the Hospital are required to have appointment on the Medical Staff as may be described in the contract and must meet the qualifications and requirements for Staff appointment as outlined in these Bylaws and the Rules and Regulations.

4.3-2 In the absence of a contract or where the contract is silent on the matter, removal from office or termination of the contract alone will have no effect on appointment status or clinical privileges.

4.4 **Medical Residents or Medical School Students**

Medical residents or medical school students in approved training programs who meet qualifications as required by the MEC or Hospital may provide services in the Hospital while acting under the supervision of an appointee to the Medical Staff. Such resident or
medical student shall be approved to provide such services in the manner described in the Rules and Regulations.
ARTICLE 5: APPLICATION

5.1 Application Policy

All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the medical staff office. On receipt of the request, the medical staff office will provide the applicant with an application package, which will include the medical staff bylaws and medical staff rules and regulations or a reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership, privileges, and performance expectations for individuals granted medical staff membership or privileges.

If an applicant does not meet the board’s membership criteria outlined in the medical staff bylaws, the application will not be processed and he will not be entitled to a fair hearing or any rights and due process provided under the medical staff bylaws.

Other health care professionals, including, but not limited to employees of appointees to the Medical Staff and AHPs who wish to provide specified services to patients of the Hospital on an inpatient or outpatient basis, may be permitted to apply for specified services pursuant to the AHP Rules and Regulations. Hospital employees are not required to apply for and be granted clinical privileges or specified services to provide services to patients of the Hospital.

Exceptions to the policy may be made only by the Board.

5.2 Pre-Application

All invited requests for applications for appointment to the Medical Staff will be forwarded to the Medical Staff Office (MSO). Upon receipt of a request for an application, the MSO will provide the potential applicant with an application request form. The potential applicant must:

5.2-1 Have completed an approved residency program;

5.2-2 Be currently licensed to practice medicine, dentistry or podiatry, as applicable, in the State of Colorado, have an application for licensure pending or demonstrate that he is exempt from Colorado licensure requirements, but Staff appointment is contingent upon obtaining and maintaining licensure or an exemption thereto in Colorado;

5.2-3 Maintain or intend to purchase professional liability insurance in amounts required by the Hospital or state or federal law, whichever is highest, however, Staff appointment is contingent upon obtaining and maintaining the required amount of professional liability insurance; and
5.2-4 Provide such other information and demonstrate such other qualifications as the Hospital or its Medical Staff may request.

Upon receipt of a completed application request form, the MSO will verify its contents and will, if the requirements are met, provide a response to the requesting Practitioner which may or may not include an application. Such response shall be provided after verification and review of the pre-application is complete. In the event the requirements are not met, the potential applicant will be notified and, if requested, may be given an opportunity for an informal discussion with the Chief of Staff and the CEO.

ARTICLE 6:
INITIAL APPOINTMENT

6.1 Representations of Applicant

Application for Staff appointment is to be submitted by the applicant and on such form as mandated by the Colorado State Board of Health and approved by the MEC and the Board. Prior to the application being submitted, the applicant will have access to the Medical Staff Bylaws and the Rules and Regulations. It is the applicant's obligation to obtain, read and understand the Bylaws and the Rules and Regulations of Medical Staff.

6.1-1 The applicant must sign the application and in so doing:
   a. Signifies his willingness to appear for interviews in regard to his application;
   b. Authorizes Hospital representatives to consult with others who have been associated with him and/or who have information bearing on his competence and qualifications;
   c. Consents to Hospital representatives' inspection of all records, criminal history, and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests, of his physical and mental health status and of his professional and ethical qualifications;
   d. Releases from any and all liability Hospital representatives for their acts performed in connection with evaluation of him or his credentials. For purposes of this Article, the term "Hospital representatives" includes the Board, its directors and committees; the CEO, or his designee; employees of the Hospital; the Medical Staff and all Medical Staff appointees; clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his application; and any affiliate or authorized representative of any of the foregoing;
   e. Releases from any and all liability all individuals and organizations who provide information, including otherwise privileged or
confidential information, to Hospital representatives concerning his competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Staff appointment and clinical privileges;

f. Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning him, and releases Hospital representatives from any and all liability for so doing. Authorizes and consents to the Hospital's exchange of information as outlined in the Bylaws and the Rules and Regulations of the Hospital and its Medical Staff;

g. Signifies that he has read and understands the current Bylaws and the Rules and Regulations of the Medical Staff and agrees to abide by their provisions and any amendments thereto, in regard to his application and appointment, if applicable, to the Medical Staff, including the obligation to provide continuous care and supervision to his/her patients, to accept committee assignments, and to accept consultation assignments;

h. Agrees to provide and update the information requested on the original application and subsequent reapplication for reappointment and privilege request forms and immediately notify the Medical Staff Office of any change in the information provided on the most current application form and to provide all information requested by the Hospital or its Medical Staff.

*Failure to provide and update information as required in this Section or other sections of these Bylaws shall be grounds for termination of Staff appointment and clinical privileges and/or such other corrective action as the Hospital and its Medical Staff deem appropriate; and

i. In submitting his application for initial appointment every applicant to the Staff expressly represents and warrants that the information contained therein is true, accurate and complete to the best of his knowledge, information and belief.

The applicant agrees that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute an automatic withdrawal of the application for appointment.

Medical Staff appointment and clinical privileges shall expire on the date such current appointment is due to expire or if such appointment has already expired, the current appointment and clinical privileges shall expire upon notice of the automatic withdrawal of the application.
An automatic withdrawal of the application for appointment does not entitle the affected applicant to any of the procedural rights or processes outlined in these Bylaws or the Rules and Regulations of the Hospital and its Medical Staff.

In the event that an appointment has been granted prior to discovery of such misrepresentation, misstatement or omission, the discovery of such misrepresentation or misstatement may result in corrective action, including, but not limited to, revocation of Medical Staff appointment and clinical privileges.

6.2 Information Collection and Verification

6.2-1 The following documentation is necessary to complete an application. The applicant shall have the sole burden of producing adequate information for an evaluation of his eligibility, competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.

a. A completed and signed application form and request for clinical privileges, as appropriate;
b. A current picture hospital ID card or valid picture ID issued by a US state or federal agency
c. A copy of current Colorado licenses or proof of exemption and a copy of other state licensure and, where applicable, DEA certificate;
d. A copy of current professional liability insurance policy;
e. Copies of diplomas, certificates or letters confirming completion of an approved residency/training program or other educational curriculum;
f. Verification (copy of certificates or copy of letter from appropriate specialty board) of specialty board status.
g. Three (3) letters of recommendation must be sent directly to the MSO from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice who can and will provide reliable information regarding the practitioner’s current medical/clinical knowledge; technical and clinical skills; clinical judgment; interpersonal skills; communication skills; and professionalism.

h. Payment of the non-refundable application fee;
i. Copy of ECFMG certificate (if applicable);
j. Copy of Visa (if applicable);
k. Documentation of CME over past two years;
l. Curriculum Vitae;
m. Verifiable documentation of the applicant’s current clinical practice within the past twelve months;
n. Such other information as may be requested by the Hospital or its Medical Staff or any committee thereof at any time during the application process. If additional information is requested, the application shall be deemed incomplete and further processing will be stayed pending receipt of the requested information.

6.2-2 Upon receipt of a completed application, the MSO will verify its contents and will collect additional information, as follows, from the primary source, whenever feasible. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if the medical staff office has documented its attempts to contact primary source.

a. Information from all prior and current insurance carriers concerning claims, suits and settlements (if any) during the past five (5) years;

b. Secure clinical reference questionnaires and administrative references from all past practice settings for the previous five- (5) years;

c. Verification of licensure status in all current or past states of licensure;

d. Information from the AMA or AOA Physician Profile, Federation of State Medical Boards, and Office of Inspector General or other applicable association or board;

e. Information from the National Practitioners' Data Bank established pursuant to the Health Care Quality Improvement Act of 1986; and

f. Information from a criminal background check;

g. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available;

h. Other information regarding adverse credentialing and privileging decisions;

i. Such additional information as the Hospital or its Medical Staff may request.

6.2-3 If all information required above is not submitted within forty-five (45) days of the submission of the application or if the applicant fails to completely respond to or comply with any request for additional information, assistance or an interview, within thirty (30) days of such a request, the application for clinical privileges which are the subject of the request for additional information, assistance or interview or the entire application, depending upon the nature and extent of the additional information, assistance or interview requested, will be deemed withdrawn and no further processing will take place.

Either the Credentials Committee or the MEC shall determine whether an application will be deemed withdrawn in whole or in part. A Practitioner whose application is deemed withdrawn is not entitled to any of the procedural rights or processes outlined of these Bylaws. Notice of the withdrawal shall be provided to the applicant.
ARTICLE 7:
REAPPOINTMENT

7.1 Information Collection and Verification

7.1-1 From Staff Appointees
At least three (3) months prior to the date of expiration of a Medical Staff appointment, the MSO notifies the appointee of the date of expiration of staff appointment and whether the appointee is invited to apply for reappointment. At least sixty (60) days prior to expiration of Staff appointment, the appointee, furnishes in writing:

a. Complete information to update his file on items listed in his original application and information provided to support his previous application;
b. Evidence of continuing training and education external to the Hospital during the preceding period;
c. Specific request for the clinical privileges sought on reappointment and documentation to support a request for review of new or additional clinical privileges;
d. Requests for changes in Staff category or Department assignments;
e. Two (2) peer references from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice including the practitioners current medical/clinical knowledge; technical and clinical skills; clinical judgment; interpersonal skills; communication skills; and professionalism.
f. A signed Applicant’s Acknowledgment signifying that he has read and understands the current Bylaws and Rules and Regulations of the Medical Staff and agrees to abide by their provisions and any amendments thereto, including the obligation to provide continuous care and supervision to his/her patients, to accept committee assignments, and to accept consultation assignments; and
g. Such additional information as the Hospital or its Medical Staff may request.

7.1-2 From Internal and/or External Sources
Based upon the information provided by the Staff appointee the MSO verifies and gathers information regarding the individual’s professional and collegial activities, performance and conduct in the Hospital and/or other health care facilities Such information includes, without limitation:

a. A summary of clinical activity at this hospital
b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided clinical care since the last reappointment, including patient care, medical/clinical
knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice

c. continuing education activities;
d. attendance at required Medical Staff and Department meetings;
e. service on Medical Staff, Department, and Hospital committees;
f. timely and accurate completion of medical records;
g. compliance with all applicable Bylaws and the Rules and Regulations of the Medical Staff.
h. Significant gaps (greater than 30-days) in employment or practice since the previous appointment or reappointment.
i. Verification of current licensure
j. National Practitioner Data Bank query
k. Malpractice history for the past two years

7.1-3 Criteria for Reappointment
It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital’s standards regarding ongoing quality and the hospital performance improvement program. All reappointment and renewals of clinical privileges are for a period not to exceed 24 months.

By accepting appointment, all appointees authorize and consent to the Hospital's exchange of information as outlined in these Bylaws and the Rules and Regulations of its Medical Staff.

7.1-4 Failure to provide this information at least sixty (60) days prior to the expiration of Staff appointment shall result in the application for reappointment being deemed withdrawn and automatically results in expiration of appointment upon the date current appointment is due to expire.

The Staff appointee then has the burden of producing the required and requested information and resolving any doubts about the data.

Failure to completely respond and comply with a request, within thirty (30) days of same, for additional information, assistance or an interview is deemed a voluntary withdrawal of the application either for the clinical privileges which are the subject of the request for additional information, assistance or the interview or the entire application for reappointment, as determined by the Credentials Committee or MEC, in its discretion, depending upon the nature and extent of the additional information, assistance or interview deemed necessary.

Withdrawal of the application for reappointment shall automatically result in expiration of appointment upon the date current appointment is due to expire.
A Practitioner whose application is deemed withdrawn is not entitled to any of the procedural rights or processes outlined in these Bylaws. Notice of the withdrawal shall be provided to the Staff appointee. A Staff appointee whose application for reappointment is deemed withdrawn may apply for Staff appointment and clinical privileges as an applicant for initial appointment.

7.2 Request for Modification of Appointment Status or Privileges

7.2-1 A Staff appointee, either in connection with reappointment or at any other time, may request modification of his Staff category, Department assignment, or clinical privileges by submitting a written request to the Credentials Committee. A request for modification is processed in the same manner as an application for appointment. Such requests are subject to the invitation requirement of the Hospital’s Intended Practice Plan Policy. All requests for increased privileges must be accompanied by information demonstrating eligibility, education, training, qualifications, experience and current clinical competence in the specific privilege requested. If the increased privileges are granted, the practitioner will be placed on FPPE until successful completion of requirements, as per policy.

ARTICLE 8:
PROCEDURE FOR PROCESSING APPLICATIONS FOR INITIAL APPOINTMENT AND REAPPOINTMENT

8.1 Department Review

8.1-1 Review
When information requested has been obtained and verified, the completed application for initial appointment or reappointment will then be forwarded to the appropriate Department Chair for review and report by that Department. Each Chair of Department in which the applicant requests or has exercised privileges will review, as they deem necessary, the applicant's file as described above and evaluate the applicant's demonstrated professional conduct and his eligibility, education, training, qualifications and experience for appointment or reappointment and for Staff category, Department assignment and clinical privileges.

The Department Chair or his designee may, in their discretion, make telephone calls to solicit additional information from past practice settings. Documentation of this contact, if any, shall be made.

The Department Chair or his designee may also request additional information or assistance from the applicant and/or may request an interview with the applicant. This interview shall be informal and none of the procedural rights or processes outlined in these Bylaws shall apply thereto. The additional information,
additional assistance and/or the interview must be completed within thirty (30) days of the date of the request or the application will be deemed withdrawn, in whole or in part, as provided in 6.2-3 above.

The processing of the initial application shall be stayed during the pendency of a request for additional information, assistance and/or an interview.

8.1-2 Department Recommendation
Once the applicable Department has completed its review of the application, the Department Chair or his designee shall forward the application to the Credentials Committee with a recommendation as to the applicant's eligibility, education, training, qualifications and experience for the Medical Staff appointment and clinical privileges requested.

8.1-3 Deferral
Department Chairs may not defer consideration of an application, except that the Department Chair may seek input and review by another Department in which the applicant has requested clinical privileges. In the event a Department Chair is unable to formulate a recommendation for any reason, the Department Chair must so inform the Credentials Committee.

8.2 Credentials Committee Review

8.2-1 Review
The Credentials Committee will review the applicant's application, the Department recommendation and all relevant information available to it to evaluate the applicant's demonstrated professional conduct and his eligibility, education, training, qualifications and experience for appointment or reappointment and for Staff category, Department assignment and clinical privileges requested.

The Credentials Committee may request additional information and/or assistance from the applicant and may request an interview with the applicant. Documentation of this contact, if any, shall be made. This interview shall be informal and none of the procedural rights or processes outlined in these Bylaws shall apply thereto. The additional information, additional assistance and/or the interview must be completed within thirty (30) days of the date of the request or the application will be deemed withdrawn, in whole or in part, as provided above. The processing of the initial application shall be stayed during the pendency of a request for additional information, assistance and/or an interview.

8.2-2 Credential's Committee Recommendation
Once the Credentials Committee has completed its review of the application, the Credentials Committee shall make a recommendation to the MEC at its next regularly scheduled meeting, if possible, as to the applicant's eligibility,
education, training, qualifications and experience for the Medical Staff appointment and clinical privileges requested.

8.2-3 **Deferral**
Action by the Credentials Committee to defer the initial application for further consideration should state a time period in which a subsequent report regarding Staff appointment, category of Staff, Department affiliation, and clinical privileges should be submitted back to the Credentials Committee. However, this time period may be stayed pending receipt, verification and review of additional information, assistance and/or an interview requested from the applicant.

8.3 **MEC Review**

The MEC shall review the Credentials Committee report. The MEC may request additional information, and/or additional assistance from and/or an interview with the applicant. The processing of the initial application shall be stayed during the pendency of the request for additional information, assistance and/or an interview which shall be provided/completed by the applicant within thirty (30) days of the date of the request or the application will be deemed withdrawn in whole or in part, as provided above.

Once the MEC's review of the application and supporting information is complete, the MEC shall forward to the Chief of Staff/CEO for transmittal to the Board, a recommendation as to the granting of Staff appointment, Staff category, Department affiliation and clinical privileges and any special conditions to be attached or considered in the final decision regarding appointment. The MEC may also defer action on the initial application pursuant to Section 8.4 of these Bylaws.

8.4 **Effect of MEC Action**

8.4-1 **Deferral**
Action by the MEC to defer the application for further consideration should state the reasons for such deferral, provide direction for further investigation, state time periods for such further investigation and state the time that a report must be made back to the MEC. The MEC may defer the application for further consideration to the Credentials Committee, Department or ad hoc committee as it deems appropriate. After receipt of the report following deferral, the MEC shall review the matter and either defer the application for further consideration or make its report and recommendation in the matter.

8.4-2 **Favorable Recommendation**
When the recommendation of the MEC is favorable to the applicant, the Chief of Staff shall promptly forward it, together with all supporting documentation, to the Board. Pending final action of the Board, an applicant who is the subject of a favorable recommendation of the MEC shall, upon request, be permitted to exercise Medical Staff appointment and clinical privileges. However, whether an
application is approved or denied, in whole or in part, is ultimately the decision of
the Board and the temporary permission to exercise Medical Staff appointment
and clinical privileges in accordance with the MEC recommendation does not
guarantee appointment and/or clinical privileges.

8.4-3 **Adverse Recommendation**
When the recommendation of the MEC is adverse to the applicant, as outlined in
Article 11 of these Bylaws, the CEO shall so inform the applicant, by Special
Notice, of his procedural rights as provided in Article 11 of these Bylaws. The
MEC's adverse recommendation shall not be forwarded to the Board until the
applicant has either exhausted the procedural rights outlined in Article 11 of these
Bylaws or is deemed to have waived same as provided in Article 11 of these
Bylaws.

8.5 **Board Action**

8.5-1 **On a Favorable Recommendation**
The Board may adopt or reject in whole or in part a favorable recommendation of
the MEC or defer the recommendation back to the Credentials Committee for
further consideration stating the reasons for such deferral and setting a time limit
of 90 days within which a subsequent recommendation should be made. Favorable action by the Board is effective as its final action. If, after receiving a
favorable recommendation from the MEC, the Board's action is adverse to the
applicant, Special Notice will be sent to him and he shall then be entitled to
exercise or waive the procedural rights outlined in Article 11 of these Bylaws.

8.5-2 **After Procedural Rights**
In the case of an adverse MEC recommendation, the Board shall take final action
only after the applicant has exhausted or waived the hearing and appellate review
processes outlined in Article 11 of these Bylaws.

8.6 **Notice of Final Decision**

8.6-1 Notice of the Board's final decision shall be given through the Chief of Staff to
the MEC and to the Chair of each applicable Department. The applicant shall
receive written notice of appointment and Special Notice of any adverse final
decision, as applicable.

8.6-2 **A decision and notice of appointment includes:**
a. The Staff category to which the applicant is appointed;
b. The Department to which he is assigned;
c. The clinical privileges he may exercise;
d. Focused Professional Practice Evaluation requirements; and
e. Any special conditions attached to the appointment.
8.6-3 The new appointee will be notified in writing by the CEO of the action of the Board. The signature of the CEO will indicate approval by the Board appointing the applicant with specified clinical privileges to the indicated category of the Medical Staff.

8.6-4 A complete application/reapplication that has not been deferred for further considerations will be acted upon within a 90 day period.

8.7 Reapplication After Adverse Appointment Action or Corrective Action

An applicant who has received a final adverse decision regarding his application for appointment or reappointment and a Practitioner whose Staff appointment and/or clinical privileges are suspended, limited, revoked or terminated shall not be eligible to reapply for Staff appointment and/or clinical privileges for a period of one (1) year following a final adverse appointment or corrective action decision.

If, after receiving the completed application of an applicant who had a previous application for appointment or reappointment denied, or an applicant whose Medical Staff appointment and/or clinical privileges at the Hospital were suspended, limited, revoked or terminated, in whole or in part, the Chief of Staff, the MEC, the Credentials Committee, and/or any Department committee, in consultation with the CEO or the Board, determines that the applicant has not provided sufficient information that was either not available or not presented at the time he previously applied for Staff appointment or reappointment, as applicable, and/or clinical privileges or was subject to corrective action, as applicable, that addresses the reasons Staff appointment and/or clinical privileges were previously denied, suspended, limited, revoked or terminated, in whole or in part, as applicable, his application can be summarily denied and the applicant is not entitled to the procedural rights and processes outlined in these Bylaws.

Board action is not required for a summary denial of an application as provided in this Section. Any such reapplication that is not summarily denied shall be processed as an initial application, and the applicant shall provide additional information, assistance and/or an interview as the Hospital or its Medical Staff may request. However, it is the applicant's burden to demonstrate that the basis of the earlier adverse action no longer exists.
ARTICLE 9:
CLINICAL PRIVILEGES

9.1 Exercise of Privileges

A Practitioner providing clinical services at the Hospital may exercise only those privileges granted to him by the Board or emergency privileges as described herein.

9.2 Privileges in General

9.2-1 Requests

Each application for appointment or reappointment to the Medical Staff must contain a request for specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modification of privileges in the interim between reappointment evaluations.

9.2-2 Basis for Privileges Determination

Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience and demonstrated competence as specified by the Board.

In the event a request is submitted for which no criteria have been created or for a privilege that is not currently available the request may be tabled for a reasonable period of time during which the Board shall, after consultation with the Credentials Committee or the MEC, formulate the necessary criteria and/or make a decision as to whether the privilege is available at the Hospital.

Once objective criteria have been established the original request shall be processed as described herein.

9.2-2.a Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall be subject to a period of FPPE. The Credentials Committee, after receiving a recommendation from the department chair and with the approval of the MEC, will define circumstances that require the clinical performance of each practitioner to be monitored and evaluated after he is initially granted privileges at the hospital. Such monitoring may use prospective, concurrent, or retrospective proctoring, including but not limited to: chart review; tracking performance indicators; external review; interviews with other healthcare providers involved in the care of the patient. The Credentials Committee will also establish the duration for the FPPE and triggers that indicated the need for performance monitoring.
9.2-2.b. Ongoing Professional Practice Evaluation (OPPE)

The medical staff will also engage in OPPE to identify professional practice trends that effect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow practitioners to maintain existing privileges, revise existing privileges, or revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as a part of the medical staff’s evaluation, measurement, and improvement of practitioner’s current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high-quality patient care are identified during the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual’s current clinical competence, practice behavior, and ability to perform a specific privilege.

9.2-3 The procedure by which requests for clinical privileges are processed and the specific eligibility requirements for certain privileges may be outlined elsewhere in these Bylaws and/or the Rules and Regulations of the Hospital and its Medical Staff.

9.3 Special Conditions for Dental and Podiatric Privileges

Requests for clinical privileges for dentists and podiatrists are processed in the manner outlined herein. Surgical procedures performed by dentists and podiatrists will be under the overall supervision of the Chair of the Department of Surgical Care. All dental and podiatric patients shall receive a basic medical appraisal by a physician licensed to practice medicine in the State of Colorado and credentialed by TJC accredited Colorado Hospital, except that oral surgeons with appropriate training, qualifications and privileges may perform the medical appraisal. A physician appointee to the Medical Staff shall also be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalizations. The responsible physician shall have the responsibility for the overall medical care of the patient and any surgical procedure performed must be with his knowledge and concurrence.

9.4 Temporary Privileges

9.4-1 Conditions

The CEO (or designee) acting on behalf of the board and based on the recommendation of the Chief of Staff (or designee) may grant temporary privileges provided the MSO is able to verify the practitioner’s current licensure and competence. Temporary privileges may be granted only in two circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and board.
9.4-2 Circumstances

Important patient care, treatment, or service need: Temporary privileges may be granted on a case-by-case basis when an important care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time not to exceed 120 calendar days, while the practitioner’s full credentials information is verified and approved. When granting such privileges, the medical staff verifies current licensure, current malpractice insurance and current competence.

Pendency of Application: Temporary privileges may be granted when the new applicant with a complete application for medical staff membership or privileges is waiting for a review and recommendation by the Medical Executive Committee and approval by the Governing Board.

To receive temporary privileges under these circumstances, the applicant must provide evidence of the following, which has been verified by the hospital:

a. Current Licensure
b. Relevant training or experience
c. Current competence
d. Ability to perform the privileges requested
e. Current professional liability insurance in the amount required
f. Other criteria required by the organized medical staff bylaws
g. National Practitioner Data Bank (NPDB) query
h. A complete application
i. No current or previously challenge to licensure or registration
j. No subjection to involuntary termination of medical staff membership at another organization
k. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the CEO upon recommendation of either the applicable clinical department chairman or the Chief of Staff.

9.4-3 Termination of Temporary Privileges

The Chief of Staff or the CEO, after consultation with the appropriate Department Chair, may on the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, and may at any other time, terminate any or all of a Practitioner's temporary privileges, provided that where the life or well being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension as outlined in these Bylaws. In the event of any such
termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Department Chair responsible for supervision. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

9.4-4 Rights of the Practitioner with Temporary Privileges

A Practitioner is not entitled to the procedural rights outlined in these Bylaws because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated, limited or suspended.

9.4-5 Emergency Privileges

In case of an emergency any Medical Staff appointee is authorized to do everything possible to save the patient's life or to save the patient from serious harm, regardless of Department affiliation, Staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

9.4-6 Disaster Privileges

Practitioners who are not members of the Platte Valley Medical Center Medical Staff may be granted temporary emergency privileges at this hospital during an “emergency” (defined as any officially declared emergency, whether it is local, state, or national) when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

Privileges may be granted by the appropriate incident commander (CEO/designee) handling the disaster, and/or the Chief of Staff or designee upon presentation of the valid government-issued photo identification (e.g., driver’s license or passport) and at least one of the following:

a. A current license to practice
b. A valid picture ID issued by a US state, federal, or regulatory agency, or Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
c. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
d. Identification by current hospital or medical staff member with personal knowledge regarding practitioner’s ability to act as a licensed independent practitioner during a disaster

Verification of the above information will be done as soon as possible by the Medical Staff Office and will be completed within 72 hours from the time the volunteer practitioner presents to the organization. A record of this information
will be retained in the Medical Staff Office. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care treatment and services; and an attempt to rectify the situation as soon as possible.

A practitioner’s emergency privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

The practitioner will be paired with a currently credentialed Medical Staff member and should act only under the direct supervision of a Medical Staff member.

The practitioner’s privileges will be for the period needed during the duration of the disaster only. When the emergency situation no longer exists, these temporary emergency privileges automatically terminate.

ARTICLE 10: CORRECTIVE ACTION POLICY

10.1 Automatic Suspension

10.1-1 Upon the occurrence of any event described in Section 10.1-1 a. through f., below, a Practitioner's Staff appointment and clinical privileges shall be automatically suspended:

a. State License: A Practitioner's Staff appointment and clinical privileges shall be automatically suspended upon the occurrence of one or more of the following events affecting a Practitioner's license to practice medicine in Colorado:
   - Revocation: Whenever a Practitioner's license to practice in this state is revoked, immediate and automatic revocation of Staff appointment and all clinical privileges shall occur.
   - Restriction or Stipulation: Whenever a Practitioner's license is partially limited, restricted or under stipulation in any way, those clinical privileges which he has been granted that are within the scope of the limitation or restriction shall be automatically suspended.
   - Suspension: If a license is suspended, the Practitioner's Staff appointment and clinical privileges shall be automatically suspended effective upon and for at least the term of the
suspension and until such appointment and privileges are reinstated by the Hospital.

- **Probation:** If a Practitioner is placed on probation by his licensing authority, his voting and office holding prerogatives shall be automatically suspended effective upon and for at least the term of the probation and until such voting and office holding prerogatives are reinstated by the Hospital.

  b. **Drug Enforcement (DEA):** If a Practitioner's right to prescribe controlled substances is revoked, restricted, suspended, put under a stipulation or placed on probation by a proper licensing or regulating authority, his privileges to prescribe such substances in the Hospital will also be revoked, restricted, suspended, or placed on stipulation or probation automatically and to the same degree. This will be effective upon and for at least the term of the imposed restriction. Every Practitioner, by accepting Staff appointment, agrees to notify, within twenty-four (24) hours or the next business day, the hospital, through its Medical Staff Office, of any investigation, stipulation or action taken by a proper licensing or regulating authority with regard to the Practitioner's right to prescribe medication.

c. **Medical Records Preparation and Completion:** The rules for medical records preparation and completion are outlined in the Medical Staff Rules and Regulations. Failure to complete the medical record within thirty (30) days after the patient's discharge or completion of outpatient or emergency services shall result in an automatic suspension of admitting privileges.

A Practitioner whose admitting privileges are automatically suspended due to failure to timely complete medical records will be automatically reinstated upon demonstration to the Medical Records Department staff of satisfactory completion of delinquent records.

A physician whose privileges are automatically suspended for failure to complete medical records in a timely manner more than three times in one year will be deemed to have voluntarily resigned their Medical Staff appointment and clinical privileges. Practitioners who are deemed to have voluntarily resigned Staff appointment and clinical privileges are not entitled to the procedural rights and processes outlined in these Bylaws. Practitioners who so resign may immediately submit an application for appointment. Any such application shall be treated and processed as an application for initial appointment. All information relating to the Practitioner's actions and conduct during his previous appointments to the Medical Staff may be considered.

d. **Falsification of Patient Medical Record Defined:** A Practitioner's misstatement, omission, alteration, concealment, or intentional destruction of a patient medical record, as determined by the MEC and/or the Hospital in consultation with the Chief of Staff, which gives the appearance of being done
with the intent of significantly obscuring the data and/or misleading the unsuspecting reader as to the true facts in the case, shall constitute falsification of the medical record. Falsification of a patient medical record shall result in automatic suspension of all or part of the Practitioner's Medical Staff appointment and/or clinical privileges, as determined by the Chief of Staff, the MEC, CEO or the Board.

e. Professional Liability Insurance: For failure to maintain professional liability insurance in such amounts as required by the Hospital or state or federal law, whichever is highest, a Practitioner's Medical Staff appointment and clinical privileges are automatically suspended. Practitioners must notify the Medical Staff Office, within twenty-four (24) hours or the next business day, of any termination, cancellation, reduction or limitation in professional liability insurance coverage.

f. Emergency Back-Up Panel Call: Refusal or failure to sign up for and/or accept assignment to Emergency Back-Up panel as required by a Medical Staff appointee's Department policy may result in automatic suspension of Staff appointment and/or clinical privileges and/or other corrective action as the Hospital or its Medical Staff deems appropriate.

10.1-2 Procedural Rights

A Practitioner whose Medical Staff appointment and/or clinical privileges are automatically diminished, restricted, suspended, revoked or limited pursuant to this Section shall not be entitled to the procedural rights and processes outlined in these Bylaws.

A Practitioner whose Medical Staff appointment and/or clinical privileges or admitting privileges are automatically suspended, as described above, must submit a written request for reinstatement during regular business hours (9:00 am - 5:00 pm Monday through Friday) to the Medical Staff Office with documented proof that the deficiencies leading to the suspension have been corrected.

The Practitioner may be reinstated if the Chief of Staff, in consultation with the CEO, determines the deficiencies or occurrences that resulted in the automatic suspension have been corrected.

If the request for reinstatement is denied, the Practitioner is entitled to the procedural rights and processes outlined in these Bylaws and, not later than the end of the fifth working day after the date reinstatement was denied, the CEO shall give the affected Practitioner Special Notice of the denial of his request for reinstatement.

Failure to request reinstatement and/or to be reinstated within ninety (90) days of the automatic suspension or action shall be deemed a voluntary resignation from
the Medical Staff and the affected Practitioner is not entitled to exercise the procedural rights and processes outlined in these Bylaws.

10.1-3 Notice

A Practitioner who is automatically suspended shall be given notice of such automatic suspension or action from the CEO, by first class or certified mail, postage prepaid or hand delivery, after imposition of such automatic suspension or action. Such Notice shall state the reasons for such automatic suspension or action and refer the Practitioner to the process to be followed to release the automatic suspension or action and his procedural rights, if any.

10.2 Precautionary Suspension

A precautionary suspension of all or a portion of a Practitioner’s clinical privileges or medical staff membership may be imposed whenever it is believed that:

1. an investigation is needed to determine the need for a professional review action, or
2. failure to suspend or restrict may result in an imminent danger to the health of any patient or other individual.

Such suspension may be initiated by any Medical Staff Officer, Department Chair, the MEC or the CEO, in consultation with the Chief of Staff. The MEC and CEO should be immediately notified of such precautionary action, if not already aware. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital. Unless otherwise stated, a precautionary suspension shall become effective immediately, and the CEO shall promptly give Special Notice regarding the suspension. A precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension. Unless otherwise indicated by the terms of the precautionary suspension, the practitioner’s patients then in the Hospital must be assigned to another medical staff member by the appropriate Department Chair or designee, considering, where feasible, the wishes of the patient.

10.2-1 MEC Action

Within fourteen (14) calendar days after the precautionary suspension has been imposed the MEC shall convene to review and consider the current status of any investigation and the suspension. On request and at the discretion of the MEC, the practitioner may be given the opportunity to address the MEC in person or in writing concerning the action, on such terms and conditions as the MEC may impose. The MEC may recommend modification, continuation, or termination of the suspension. If the MEC initiated the precautionary suspension, no additional review is required.
10.2-2 Procedural Rights

If a precautionary suspension continues for longer than 14 days, the Practitioner is entitled to a hearing, if requested as outlined in Article 11 of these Bylaws, even if the investigation and recommendation are not yet concluded.

10.2-3 Other Action

A MEC recommendation to terminate or modify the suspension to a lesser sanction which is not adverse, as outlined in 11.2-2 of these Bylaws, is transmitted immediately, together with all supporting documentation, to the Board. Such recommendation will be implemented immediately and will continue unless the Board rejects the MEC's recommendation.

10.3 Investigation

An investigation may be initiated whenever a Practitioner with Staff appointment and/or clinical privileges engages in, makes or exhibits acts, statements, demeanor or professional conduct either within or outside the Hospital, and it is reasonably perceived that the same is or may become detrimental to the quality of patient care or safety, disruptive to the Hospital's operations, or an impairment to the community's confidence in the Hospital. Nothing in this Article is intended to place requirements upon or affect utilization reviews or other routine reviews regarding quality of care or professional conduct.

10.3-1 Requests and Initiation

An investigation for potential corrective action may be requested by the Chief of Staff or CEO or must be requested in writing, submitted to or created by the MEC and supported by reference to specific activities or conduct which constitute grounds for the request. Any Medical Staff appointee, AHP, Hospital employee or member of the Board may make a request for investigation for potential corrective action. The Chief of Staff shall promptly notify the CEO of all requests for investigation for potential corrective action.

An investigation can only begin if the MEC decides that it is warranted by affirmative vote, or, in the event the board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

10.3-2 Investigation

The MEC may conduct such investigation itself or may assign this task to a Medical Staff officer, Department, or ad hoc committee or other individual. External third parties may be utilized in the investigation process to be part of or conduct the investigation, as determined by the MEC. The investigative process is not a "hearing" as that term is used in these Bylaws. It may involve a consultation with the Practitioner involved and with the individual or group making the request, and with other individuals who may have knowledge of the events involved. If the investigation is conducted by a group or
individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below. The CEO shall notify the affected Practitioner of the initiation of an investigation by the MEC.

10.3-3 MEC Action

As soon as practicable after conclusion of the investigative process, but in any event at its next regularly scheduled meeting after conclusion of the investigation and provision of the report of the investigation, the MEC should act upon the report of such investigation. Its action may include, without limitation, recommending:

1. No corrective action;
2. A warning or a formal letter of admonition or reprimand;
3. Special or intensified review of cases with or without special requirements for concurring consultation or direct supervision and with or without probation;
4. Individual requirements for consultation or supervision, education and/or evaluation;
5. Reduction, suspension, limitation or revocation of Staff category or clinical privileges;
6. Suspension or revocation of Staff appointment; and
7. Such other action the MEC deems appropriate

10.3-4 Deferral

If additional time is needed to complete its deliberations or additional information is needed, the MEC may defer action on the request. The deferral should establish a time period for completion of the additional investigation or deliberations, and a recommendation for any one or more of the actions provided above should be made at least at the next regularly scheduled meeting of the MEC after receiving the report after deferral.

10.3-5 Procedural Rights

Only an adverse recommendation entitles the Practitioner to the procedural rights and processes outlined in these Bylaws.

10.4 Interviews Prior to Investigation and Corrective Action

When considering initiating investigation or corrective action, the MEC or the committee or individual appointed to investigate the matter may, in their discretion, arrange for an interview with the affected Practitioner. At the interview, circumstances prompting the consideration of investigation or corrective action may be discussed and the Practitioner may be asked to present relevant information on his own behalf. A written record should
be maintained reflecting the substance of the interview which shall be treated and maintained as professional review information. This interview is not a procedural right of the Practitioner and, if undertaken, need not be conducted according to the procedural rights or processes outlined in these Bylaws.

ARTICLE 11: HEARING AND APPELLATE REVIEW

11.1 Initiation of Hearing

An applicant, or an individual holding Medical Staff appointment, shall be entitled to a hearing whenever an adverse recommendation affecting him has been made by the MEC regarding those matters enumerated in this Article. The affected individual shall be entitled to a hearing before the Board takes final action, in the event the Board should determine, without a similar recommendation from the MEC, to take action unfavorable to the Practitioner regarding those matters set forth below.

11.2 The Hearing

11.2-1 Notice of Adverse Action/Recommendation

a. When a recommendation is made or action taken which, according to these Bylaws entitles an individual to a hearing, the affected individual shall promptly be given Special Notice by the CEO. This notice shall contain:
   1. A statement of the nature of and reasons for the adverse action or recommendation;
   2. notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of his receipt of the notice and that any request for a hearing must be in writing and submitted to the CEO;
   3. notice that failure to submit a written request for a hearing to the CEO within the specified time period shall constitute a waiver of the right to a hearing and appeal in the matter and any other rights to which he may otherwise have been entitled under these Bylaws;
   4. a summary of the rights at the hearing as outlined in Section 11.3-4 of these Bylaws; and
   5. a statement that after receipt of a timely request for a hearing, the individual will be notified of the date, time and place of the hearing after the hearing is set.

b. Such individual shall have thirty (30) days following the date of the receipt of the notice within which to request a hearing by the Hearing Panel hereinafter referred to. Said request shall be made by written notice to the CEO. In the event the affected individual does not request a hearing in writing within the time and in the manner here in above set forth, he shall be deemed to have
waived his right to such hearing and to appellate review and to have accepted the action involved and such action shall thereupon become effective immediately upon final Board action.

11.2-2 Grounds for Hearing

No recommendation or action of MEC or Board other than those hereinafter enumerated shall constitute grounds for a hearing:

a. Denial of initial Medical Staff appointment;
b. Denial of requested advancement in Medical Staff category;
c. Denial of Medical Staff reappointment;
d. Revocation of Medical Staff appointment;
e. Denial of requested initial clinical privileges;
f. Denial of requested increased clinical privileges;
g. Decrease of clinical privileges;
h. Suspension, other than automatic suspension, of clinical privileges for a period of longer than 14 calendar days
i. Imposition of a requirement for retraining or additional training that causes the individual to cease his practice at the Hospital during the period of retraining;
j. Denial of a request for reinstatement as authorized in these Bylaws; and
k. Imposition of a requirement for longer than 14 calendar days that the Practitioner must obtain approval from a proctor before administering medical care.

11.2-3 Non-Adverse Actions

Neither voluntary resignation of Staff appointment or clinical privileges and/or the withdrawal of an application for appointment or reappointment, and/or all of any requested clinical privileges as provided for elsewhere in these Bylaws, nor the imposition of any general consultation requirement, nor the imposition of a requirement for retraining, additional training or continuing education, except as described above, nor requirements for special or intensified review, nor automatic suspension, no matter whether imposed by the MEC or the Board, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

A determination by the Board not to extend an invitation for appointment, reappointment or modification of appointment under the provisions of the Intended Practice Plan Policy shall not constitute an adverse action and shall not entitle the physician who is the subject of that determination to any hearing, appellate review, or other rights under these bylaws. The decision not to extend such an invitation shall not be a matter of peer review, but rather shall be a business, administrative decision, which shall not be reportable to the National Practitioner Data Bank or any license agency.
The impact of contractual arrangements, such as exclusive contracts for certain physician services, or other business or administrative decisions shall not give rise to any hearing, appellate review or other rights under these bylaws, and shall not be reportable to the National Practitioner Data Bank or any license agency.

11.2-4 Notice of Hearing and Statement of Reason

The CEO shall schedule the hearing and shall give Special Notice of its time, place and date, in writing, to the affected Practitioner. The notice shall also include a list of witnesses, if known, who will give testimony or evidence in support of the MEC or the Board, as applicable, at the hearing. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties. This notice shall contain a statement of the specific reasons for the recommendation and/or action, as well as the list of patient records supporting the recommendation and/or action. This statement, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant as determined by the Presiding Officer to the continued appointment or clinical privileges of the individual requesting the hearing.

11.2-5 List of Witnesses

A written list of the names and addresses of the individuals so far as is then reasonably known, who may give testimony or evidence in support of the MEC or the Board at the hearing, shall be given with the notice of hearing. The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, within ten (10) days prior to the hearing or in the discretion of the hearing officer or Presiding Officer, be supplemented or amended at any time, provided that notice of the change is given to the other party. Rebuttal witnesses may be called by the parties in the discretion of the Presiding Officer, even if no prior notice has been provided.

11.2-6 Hearing Panel or Officer

a. When a hearing is requested, the Chief of Staff in consultation with the CEO shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The Hearing Panel shall be composed of at least one PVMC Medical Staff appointee and the others may be from other hospitals who practice the same profession (physicians, dentists, podiatrists, as applicable) and who did not actively participate in the consideration of the matter involved at any previous level or of physicians not connected with the Hospital or a combination of such persons. The Hearing Panel shall not include any individual who is in
direct economic competition with the affected person, as determined by the Hospital, or any such individual who is professionally associated with or related to the affected individual. However, at least one (1) member of the Hearing Panel shall be an individual with expertise in the same general clinical area as the affected Practitioner. Such appointment shall include designation of the Presiding Officer. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

b. As an alternative to the Hearing Panel described above, the Chief of Staff, after consulting with the CEO, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The physician requesting a hearing may express a preference for a Hearing Panel or Hearing Officer and any such preference will be considered, but will not be determinative. The Hearing Officer shall preferably be an attorney at law or some other individual capable of conducting the hearing. The Hearing Officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

c. The Hearing Panel has the authority to establish the rules and requirements of the Hearing, in addition to the processes outlined in this Article and to decide prehearing objections and requests.

11.2-7 Pre-Hearing Discovery and Conference

a. Beyond the information provided pursuant to Sections 11.2-1 (a)(1) and 11.2-4, there is no right to discovery in connection with the hearing.

b. The presiding Officer may require the parties and their representatives to participate in a pre-hearing conference for purposes of resolving procedural questions in advance of the hearing.

11.2-8 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at the pre-hearing conference or the hearing shall be deemed to constitute a waiver of the hearing and appellate review rights outlined in this Article and voluntary acceptance of the recommendations and/or actions pending, which shall then become final and effective immediately.
11.2-9 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone but shall be permitted only by the Hearing Panel, its Presiding Officer or the entity which appointed the Hearing Panel on a showing of good cause.

11.2-10 Deliberations and Recommendation of the Hearing Panel

After the close of the hearing and receipt of all information requested by the Hearing Panel, the Hearing Panel shall conduct its deliberations outside the presence of any other person, except its legal counsel, and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons supporting the recommendation made and shall deliver such report to the CEO.

11.2-11 Notice and Disposition of Hearing Panel Report

Within seven (7) days of time after receipt of the Hearing Panel report and recommendation, the CEO shall notify the individual who requested the hearing of the findings and recommendations of the Hearing Panel by Special Notice. If the hearing has been conducted by reason of an adverse recommendation by the MEC, a copy of the report of the Hearing Panel shall be delivered by the CEO to the MEC for informational purposes. The hearing record, all documentation considered by the Hearing Panel and the report and recommendation of the Hearing Panel shall be maintained by the CEO.

11.2-12 Effect of Hearing Panel Report and Recommendations

a. Unfavorable Findings and Recommendations of the Hearing Panel: If the recommendations of the Hearing Panel are unfavorable to the individual who requested the hearing, the notice sent by the CEO to the individual pursuant to this Article shall advise him of his right to an appeal, the time period and requirements for submitting a request for an appeal, state that failure to request an appeal within the specified time period shall constitute a waiver of the right to appellate review, and all other rights to which he may have otherwise been entitled under these Bylaws and the Rules and Regulations of the Hospital and its Medical Staff, and state that after receipt of a timely request for an appeal, the individual will be notified of the date, time and place of the appeal.

b. Favorable Findings and Recommendations of the Hearing Panel: If the Hearing Panel's recommendations are favorable to the individual who requested the hearing, the CEO shall promptly forward the Hearing Panel report and recommendations, together with all supporting documentation, to the Board for final action. The Board
shall take action thereon by adopting or rejecting the Hearing Panel's recommendations in whole or in part, or by referring the matter back to the Hearing Panel for further consideration.

Any such referral back to the Hearing Panel shall state the reasons therefore, set a time limit within which a subsequent recommendation should be made to the Board, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt.

As soon as practicable after receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO shall promptly send the individual who requested the hearing Special Notice informing him of the action taken by the Board.

Favorable action by the Board shall be effective as the final action, and the matter shall be considered finally closed unless either party requests clarification of the Board's decision or requests reconsideration based upon new evidence that was not available at the time of the Board's recommendation. The Board shall decide in its sole discretion whether to grant or deny any request for clarification or reconsideration in light of new evidence offered.

Any request for reconsideration based upon new evidence must be made within ten (10) working days of the receipt of notice of the Board action. The standard and process for reconsideration of new evidence shall be as outlined in Section 11.4-4.b.

11.3 **Hearing Procedure**

11.3-1 **Representation**

The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney or other representative of his choice. He shall inform the CEO in writing of the name of his attorney or representative at least ten (10) days prior to the date of the hearing. The MEC or Board whose actions and/or recommendations gave rise to the hearing may also be represented by an attorney or other representative of its choice, as determined in consultation with the CEO. The Hearing Panel may also be represented by an attorney.

11.3-2 **Presiding Officer**

a. The CEO may appoint an attorney at law as Presiding Officer of the Hearing Panel. Such Presiding Officer may be legal counsel to the Hospital. He must not act as prosecuting officer, or as an advocate for either side at the hearing. He may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall
not be entitled to vote on its recommendations. He may thereafter continue to advise the Board on the matter.

b. The Presiding Officer of the Hearing Panel, if not an attorney as outlined above, shall be entitled to one vote.

c. The Presiding Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. The Presiding Officer shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he may seek advice from legal counsel selected by the Hospital. In all instances the Presiding Officer shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the Presiding Officer is acting at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Board.

11.3-3 Record of Hearing

A record of the hearing shall be made by use of a court reporter or an electronic recording unit, as determined by the CEO. The cost of such court reporter or electronic recording unit shall be borne by the Hospital, but copies of the transcript shall be provided to the Practitioner requesting the hearing at Practitioner’s expense upon written request. Nevertheless, this does not authorize the Practitioner to use or disclose any portion of the record in a manner that would violate confidentiality, privileges, or other protections of state or federal law.

11.3-4 Rights of Both Sides

At a hearing, both sides shall have the following rights: to be represented by an attorney or other individual of the party's choice, to call, examine and cross-examine witnesses, to present evidence determined to be relevant by the Presiding Officer regardless of its admissibility in a court of Law, to impeach any witness, to rebut any evidence, to submit written statements at the close of the Hearing, which shall be part of the Hearing Record and to have a record made of the proceedings by electronic means or court reporter, as determined by the Hospital, and to have a copy of the Hearing Record after request and payment of reasonable charges associated with the preparation of the Hearing Record. If the person requesting the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination. If the affected Practitioner fails to appear after being notified he is required to appear for examination, he shall be
deemed to have waived his right to a hearing and appellate review in the same manner and with the same consequences as outlined in Section 11.2-8.

11.3-5 Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any evidence deemed relevant in the discretion of the Hearing Panel shall be admitted, regardless of the admissibility of such evidence in a court of law. The Hearing Panel may question the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

11.3-6 Official Notice

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time may be granted upon request, to present written rebuttal of any evidence admitted on official notice.

11.3-7 Burden of Proof

At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

a. The Board or the MEC, depending on whose recommendation or action prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in support of his challenge to the recommendation or action.

b. After all the evidence has been submitted by both sides, the Hearing Panel may affirm the recommendation of the MEC or the Board unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or was not supported by credible evidence. As a general matter it is the Practitioner’s burden to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges and fully complies with all medical staff and hospital policies. The Hearing panel may modify the recommendation of the MEC or Board but may not expand any proposed unfavorable recommendation or decision.
11.3-8 **Presence of Hearing Panel Members and Vote**

A majority of the Hearing Panel must be present throughout the hearing and deliberations. If a Hearing Panel member is absent from any part of the proceedings he shall not be permitted to participate in the deliberations or the decision.

11.3-9 **Adjournment and Conclusion**

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. However, the Hearing Panel may request additional information from the parties. Upon conclusion of its deliberations, which are conducted outside the presence of the parties, and submission of its report and recommendations, the hearing shall be finally adjourned.

11.4 **Appeal**

11.4-1 **Time for Appeal**

Within ten (10) days after the affected individual is notified of an adverse recommendation from the Hearing Panel, or an adverse recommendation from the Board modifying a recommendation of a Hearing Panel which was favorable to the affected individual, he may request an appellate review. The request shall be in writing, and shall be delivered to the CEO, either in person or by certified mail, and shall include a specific statement of the reasons and grounds for appeal and the specific issues he wishes to be considered at the appellate review. If such appellate review is not requested within ten (10) days as provided herein, the affected individual shall be deemed to have accepted the recommendation of the Hearing Panel and the right to appellate review will be deemed waived and the recommendation of the Hearing Panel shall be forwarded to the Board for final action.

11.4-2 **Grounds for Appeal**

The grounds for appeal from an adverse recommendation of the Hearing Panel shall be that:

a. There was substantial failure on the part of the Hearing Panel to substantially comply with the processes outlined in the Hospital or Medical Staff Bylaws in the matter which was the subject of the hearing so as to deny a fair hearing; or

b. The recommendations of the Hearing Panel are not supported by the evidence contained in the Hearing Record.
11.4-3 Time, Place and Notice

Whenever a timely and appropriate request for an appellate review is received, the Chairperson of the Board shall schedule and arrange for an appellate review. The Board shall cause the affected Practitioner to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than ten (10) days from the date of receipt of the request for appellate review, unless the parties otherwise agree in writing. The time for appellate review may be extended by the Chairperson of the Board for good cause.

11.4-4 Nature of Appellate Review

a. The Chairperson of the Board shall appoint an Appeal Committee composed of not less than three persons who are members of the Board. The appeal may also be conducted by independent third parties designated by the Board in its sole discretion. At the time of its appointment, the Appeal Committee shall be given a copy of the Hearing Panel's report and recommendations, as applicable and all supporting documentation.

b. The Appeal Committee may allow new oral or written evidence subject to the same rights of cross-examination or confrontation. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that the oral or written evidence was not available at the hearing and then only at the discretion of the Appeal Committee. If new evidence is allowed, the Appeal Committee shall defer the matter back to the Hearing Panel for consideration of the new evidence. The Hearing Panel shall consider the new evidence under whatever processes it deems appropriate and make a report and recommendation back to the Appeal Committee. If the new report of the Hearing Panel is not adverse to the affected Practitioner, the appeal shall be closed and the report and recommendation of the Hearing Panel shall be transmitted to the Board for final action. If the new report of the Hearing Panel is still adverse, the appellate review shall continue, unless the affected Practitioner withdraws his request for appellate review.

c. Each party shall have the right to present a written statement in support of its position on appeal prior to or at the appellate review, and each party or its representative may appear personally and make oral argument.

d. The standard for review and nature of the appellate review shall be limited to the grounds for appeal outlined above.

11-4.5 Final Decision of the Board

If the Appeal Committee is composed solely of Hospital Board members, the decision of the Appeal Committee shall be final action of the Board and the
recommendation shall not be presented to the Board for action. If the Appeal Committee is composed of third parties who are not members of the Board, the Appeal Committee shall, within thirty (30) days after the appellate review is closed, submit the Appeal Committee's recommendation to the Board. The recommendation of the Appeal Committee shall be considered at the next regular meeting of the Board and the Board shall take final action thereon. The Board may affirm, modify or reverse the recommendation of the Appeal Committee, or in its discretion, refer the matter for further review and recommendation. The affected Practitioner shall be notified of the Board's final action, by Special Notice, through the CEO. The CEO shall also notify the MEC of the final action of the Board.

11.4-6 Further Review

Except where the matter is referred for further action and recommendation in accordance with this section, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further administrative review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. In addition, either party may request clarification of the decision constituting final action or request reconsideration based on new evidence that was not available at the time of the appellate review. However, the Appeal Committee, or the Board, as applicable, depending upon whose action constitutes final action, shall decide in its sole discretion whether to grant or deny any request for clarification or reconsideration in light of new evidence offered. Any request for reconsideration based on new evidence must be made within ten (10) days of the date of receipt of notice of the Appeal Committee's decision in the matter. The standard and process for reconsideration based upon new evidence shall be as outlined above.

11-4.7 Right to One Hearing and Appeal Only

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one hearing and one appellate review on any single matter.
ARTICLE 12:
OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the Chief of Staff, Vice-Chief of Staff and the Immediate Past Chief of Staff, each of whom shall be an appointee to the Active Staff.

12.1 Qualifications of Officers

Officers must be appointees to the Active Medical Staff at the time of nomination and election, and must remain appointees in good standing during their term of office. Officers shall be Board Certified or have comparable competence as determined, through the credentialing process, by the MEC. Failure to maintain such status shall immediately create a vacancy in the office involved. No individual may hold two (2) or more general Medical Staff offices concurrently.

12.2 Election of Officers

12.2-1 Officers, except the immediate Past Chief of Staff, shall be elected by appointees of the Active Medical Staff at the annual Medical Staff meeting held prior to the expiration of the current officers' terms. Voting shall be by written or electronic ballot by eligible members. Simple majority vote of eligible members shall prevail. If only one nominee per office is presented, vote may be made by voice acceptance.

12.2-2 The nominating committee shall be appointed by the MEC and consist of the Member-At Large as Chair and a minimum of three (3) active medical staff appointees.

12.2-3 Nominations may be made from the floor at the time of the annual Medical Staff meeting by appointees to the Medical Staff. All nominees must accept their nomination prior to the vote.

12.3 Term of Office

Each officer shall serve a three (3) year term from their election date unless the officer resigns or is removed from office. Each term shall begin on January 1 and end on December 31.

12.4 Vacancies

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term. Since this would leave a vacancy in the office of the Vice-Chief of Staff, and could conceivably interrupt the conduct of Medical Staff
affairs, an election shall be held for this position if the remaining term is greater than six (6) months.

12.5 Removal from Office

Removal of a Medical Staff officer may be effected by the Board acting upon its own initiative or by a two-thirds (2/3) vote by written or electronic ballot of the appointees to the Medical Staff eligible and qualified to vote for Medical Staff officers, such vote being taken at a special meeting called for that purpose. Permissible basis of removal of a Medical Staff officer include, without limitation, failure to perform the duties of the position held in a timely and appropriate manner. If an officer of the Medical Staff loses his Active Staff status through a suspension lasting longer than thirty (30) days or through final action of the Board, he shall automatically be removed from any offices held without any further action taken by the appointees to the Active Staff of the MEC. If an officer is the subject of an adverse recommendation or action or a suspension lasting less than thirty (30) days, his duties shall be assumed by the next highest-ranking officer pending final action of the Board.

12.6 Duties of Officers

12.6-1 The Chief of Staff shall:
   a. aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff;
   b. communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the CEO and other officers of the Staff;
   c. be responsible for the enforcement of Medical Staff Bylaws and the Rules and Regulations for implementation of sanctions where these are indicated and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
   d. call, preside at and be responsible for the agenda of all general meetings of the Medical Staff; and
   e. serve as chairman of the MEC and as an ex officio member of all other Staff committees.

12.6-2 The Vice-Chief of Staff shall be a member of the MEC and the Credentials Committee. In the absence -- temporary or permanent -- of the Chief of Staff, he shall assume all the duties and have the authority of the Chief of Staff. In the temporary absence of the Chief of either the Medicine or Surgery Department, the Vice-Chief shall assume all duties and responsibilities of said Chief. He shall perform such additional duties as may be assigned to him by the Chief of Staff, the MEC, or the Board.
12.6-3 The Immediate Past Chief of Staff shall perform such additional duties as may be assigned to him by the Chief of Staff, the MEC, or the Board.

12.7 Conflict of Interest

At least annually, each physician serving in an elected or appointed position on the Medical Executive Committee (MEC) of the medical staff shall complete a conflict-of-interest disclosure form identifying any activities, interests, relationships, or financial holdings that create or have the potential to create a conflict of interest for the physician in carrying out the responsibilities of that position.

When an issue comes before the individual physicians as a result of serving in a position in the organized medical staff, such as a department chair or member of a committee, to which an actual or potential conflict of interest may be relevant, the physician shall disclose the conflict of interest prior to participating in consideration of that issue. Such disclosure shall include any conflicts of interest that may have developed since the physician's previous completion of the conflict-of-interest disclosure form.

(Refer to Statement of Conflict of Interest policy)

ARTICLE 13:
MEETINGS OF THE MEDICAL STAFF

13.1 Meetings

13.1-1 Regular Meetings
There shall be at least one regular meeting of the Medical Staff each year. The last regular meeting shall be designated as the annual meeting of the Medical Staff and election of officers shall be accomplished at this meeting. In addition, announcements of committee appointments and annual reports may be presented at the annual meeting.

13.1-2 Special Meetings
a. The Chief of the Medical Staff, the MEC, or not less than one-fourth (1/4) of the appointees to the Active Medical Staff may at any time file a written request with the Chief of Staff that within five (5) days of the filing of such request, a special meeting of the Medical Staff be called. The MEC shall designate the time and place of any such special meeting.

b. Notice stating the place, day and hour of any special meeting of the Medical Staff shall be posted on the Medical Staff bulletin board located in the Medical Staff office and delivered to each appointee to the Active Staff not less than one (1) nor more than four (4) days before the date of such meeting, by or at the direction of the Chief of Staff (or other persons authorized to call the meeting). Notice may also be sent to members of the Associate Staff who have so requested.
The attendance of an appointee to the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 Quorum and Manner of Acting

13.2-1 The presence of thirty percent (30%) of the eligible appointees at any regular or special meeting of the Staff, Department or Committee, as applicable, shall constitute a quorum. The affirmative vote of a majority of those voting at a meeting when a quorum is present shall be the action of the Staff, Department or Committee, as applicable.

13.2-2 A quorum will exist when 50% of the Medical Executive Committee members are present.

13.3 Attendance at Meetings

13.3-1 Attendance at general medical staff meetings is voluntary. Standing Committees of the Medical Staff may establish individual committee attendance requirements.

ARTICLE 14: CLINICAL DEPARTMENTS

14.1 Clinical Departments

14.1-1 The Hospital's Medical Staff shall be organized into the following Clinical Departments:
   a. Medicine, whose appointees shall include, but not be limited to, those appointees whose clinical privileges primarily relate to Family Medicine, Internal Medicine, Pediatrics, Radiology, Emergency, Obstetrics, Nursery and/or their respective subspecialties;

   b. Surgery, whose appointees shall include, but not be limited to, those appointees whose clinical privileges primarily relate to Anesthesiology, General Surgery, Gynecology, Ophthalmology, Orthopedics, Otorhinolaryngology, Pathology, Podiatry, Urology and/or their respective subspecialties;

14.1-2 Each Department wishing to do so may establish, with the MEC's approval, individual clinical sections. Chairs of clinical sections will be elected by a simple majority of the appointees of that section.
14.2 Qualifications/Election of Department Chairs

14.2-1 Officers must be appointees to the Active Medical Staff at the time of nomination and election, and must remain in good standing during their term of office. The Chairman of each department shall be certified by an appropriate specialty board or have comparable competence as determined, through the credentialing process, by the MEC. Failure to maintain such status shall immediately create a vacancy in the office involved.

14.2-2 The Department Chair shall be elected at the last meeting of that Department of the Medical Staff year for a three (3) year term starting on January 1. Only Active Medical Staff appointees to the Department shall be eligible to vote. Vote may be made by voice acceptance should only one (1) nominee be presented on the slate; otherwise, the election shall be by ballot vote. Nominations shall be made by the MEC or may be made from the floor. All nominees must agree personally to their nomination prior to the vote.

14.2-3 Removal of the Department Chair during his term of office may be initiated by a two-thirds (2/3) majority vote by written ballot of all Active Staff appointees to the Department, but no such removal shall become effective unless and until it has been ratified by the MEC and the Board.

14.3 Department Chair Responsibilities

14.3-1 Each Department Chair is responsible for:
   a. Establishing, together with medical staff and administration, the type and scope of services required to meet the needs of the patients and the hospital;
   b. All clinically related activities of the department;
   c. All administratively related activities of the department, unless otherwise provided for by the hospital;
   d. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
   e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
   f. Recommending clinical privileges for each member of the department;
   g. Assessing the recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;
   h. The integration of the department or service into the primary functions of the organization;
   i. The coordination and integration of the interdepartmental and intradepartmental services;
   j. The development and implementation of policies and procedures that guide and support the provision of services;
k. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment or service;

l. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

m. The continuous assessment and improvement of the quality of care, treatment and services provided;

n. The maintenance of quality control programs, as appropriate;

o. The orientation and continuing education of all persons in the department or service;

p. Recommendations for space and other resources needed by the department or service

ARTICLE 15: COMMITTEES

Members of each committee shall be appointed by the Chief of the Medical Staff, subject to approval by the MEC unless otherwise provided by these Bylaws. The term of appointment is three (3) years. Reappointment to a committee is allowed. Whenever practical and administratively sound, as determined by the MEC and the Hospital, details of committee and subcommittee activities may be delegated to persons not necessarily engaged in the daily practice of medicine or dentistry or podiatry, but nevertheless fully qualified by training and experience to accomplish their assignments. Non-Medical Staff appointees are subject to approval by the MEC in consultation with the CEO.

15.1 Standing Committees

The MEC
Credentials
Medical Staff Quality Committee

Other functions of the Medical Staff such as infection control, critical care, trauma, pharmacy and therapeutics and utilization review will be handled at the Department level or by committees appointed by the MEC and as described in the Rules and Regulations.

15.2 The MEC

The Medical Executive Committee (MEC) includes physicians and may include other licensed independent practitioners. The majority of voting MEC members shall be fully licensed doctors of medicine or osteopathy, actively practicing in the hospital. The MEC represents and acts on behalf of the Medical Staff between Medical Staff meetings. Its members shall include:
a. The Chief of Staff;
b. The Immediate Past Chief;
c. The Vice-Chief of Staff;
d. The Chair of each Clinical Department (Medicine and Surgery)
e. Four (4) At-Large Members elected from the Active Staff by the Medical Staff at its annual meeting; and/or may include other Licensed Independent Practitioners as deemed necessary.
f. Perinatal Clinical Section chairman
g. Credentials Chairman
h. Medical Staff Quality Committee Chairman
i. Medical Director of hospitalist group
j. CEO (ex-officio)

All of the above shall be voting members with the exception of CEO who serves without vote and the Chief of Staff who shall vote only in the event of a tie.

15.2-1 Functions: The MEC shall:

A. Meet at least monthly and as otherwise necessary.

B. Make recommendations, as defined in the medical staff bylaws, directly to the governing board on, at least all of the following:
   1. Medical staff membership;
   2. The organized medical staff’s structure;
   3. The process used to review credentials and delineate privileges;
   4. The delineation of privileges for each practitioner privileged through the medical staff process
   5. Review of and actions on reports of medical staff committees, department, and other assigned activity groups

C. Request evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested.

D. Perform the oversight on behalf of the organized medical staff in the following activities:
   1. Determine through defined mechanisms practitioners practice only within the scope of their privileges
   2. Provides oversight in process of analyzing and improving patient satisfaction
   3. Specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services
   4. Monitors the quality of medical histories and physical examinations and requires that a practitioner who has been granted
privileges by the hospital to do so performs a patient medical history and physical examination and required updates.

5. Choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient’s medical history and physical examination.

6. Defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

7. Defines the scope of the medical history and physical examination when required for non-inpatient services

8. Perform emergency care appraisal and disaster planning

E. Provides leadership in medical care evaluation, performance improvement, and patient safety activities, which includes:
   1. Review findings of the assessment process that is relevant to the individual’s performance through the utilization of OPPE
   2. Recommending FPPE when concerns arise from OPPE based on general competencies defined by the medical staff
   3. Setting expectations and defining individual and aggregate measures to assess current clinical competency, providing feedback to practitioners, and developing plans for improving the quality of clinical care provided
   4. Communication of findings, conclusions, recommendations, and actions to appropriate medical staff members and the board.

F. Provides leadership for measuring, assessing, and improvement of practitioners performance that include, but are not limited to,
   1. Medical assessment and treatment of patients
   2. Use of medications
   3. Use of blood and blood components
   4. Operative and other procedures
   5. Education of patients and families
   6. Accurate, timely, and legible completion of patients’ medical records
   7. Appropriateness of clinical practice patterns
   8. Significant departures of clinical practice patterns
   9. Use of developed criteria for autopsies
   10. Sentinel event data
   11. Patient safety data
   12. Coordination of care, treatment, and service with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
13. Use of information about adverse privileging decisions for any practitioner privileges through the medical staff process

G. The MEC shall arrange for the performance of other medical staff functions such as institutional review of experimental procedures and research protocols, continuing medical education, ethics and ethics review functions, intensive/coronary care oversight and monitoring as well as participation in policy and procedure development in all areas directly impacting upon the provision of medical care provided within the Hospital; and

H. Such other functions as may be requested by the Medical Staff, CEO or the Board.

15.3 Credentials Committee

The Credentials Committee is the body of the Staff responsible for assisting in the evaluation of applicants for initial and/or renewed appointments to Medical Staff appointment. Its voting members shall include the Vice-Chief of the Medical Staff and members from each department appointed by the Chief of Staff, one member from each department appointed by the Department Chair, and sufficient numbers of members at large (to make a total committee of no less than five [5]) appointed by the Chief of Staff.

15.3-1 Functions

a. To review and recommend action on all applications and reapplications for membership on the medical staff assignments of medical staff category
b. To review and recommend action on all requests regarding privileges from eligible practitioners
c. To recommend eligibility criteria that practitioners need to fulfill before the medical staff will consider granting them medical staff membership and privileges
d. To develop, recommend, and consistently implement policies and procedures for all credentialing and privileging activities
e. To review and, when appropriate, take action on reports that are referred to the credentials committee from other medical staff committees or medical staff or hospital leaders
f. Meetings shall be at least monthly. The Committee shall prepare and maintain records of its deliberations, decisions, and actions.
g. Perform such other functions as the Hospital or its Medical Staff may request.

15.4 Medical Staff Quality Committee

The Medical Staff Quality Committee is the body of the Staff responsible for maintaining a process to improve patient care through the monitoring of identified standards of care and to assist in providing education to the Medical Staff. In addition, the committee
provides another process for assessing the competency for privilege delineation of practitioners at Platte Valley Medical Center.

ARTICLE 16:
GENERAL PROVISIONS

16.1 Staff Rules and Regulations

Subject to approval of the Board, the Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these Bylaws. The rules and regulations shall relate to the conduct of Staff activities and provision of patient care services in the Hospital. Such rules and regulations are deemed to be incorporated into these Bylaws by reference, except that they may be amended or repealed at any meeting of the MEC without previous notice, by a majority vote of those present and eligible to vote. Such amendments or repeal shall become effective as approved by the Board. The rules and regulations shall be reviewed on a biannual basis.

16.2 Departmental Rules and Regulations

Subject to the approval of the MEC and the Board, each Department shall formulate its own policies, rules and regulations which shall not be inconsistent with the bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Medical Staff. Said policies, rules and regulations are deemed to be incorporated into these Bylaws by reference, except that they may be amended or repealed by the MEC subject to approval by the Board.

16.3 Transmittal of Reports

Reports, recommendations and other information which these Bylaws require the Medical Staff to transmit to the Board or which require Board action shall be transmitted to the Board through the Chief of Staff.

ARTICLE 17:
ADOPTION AND AMENDMENT OF BYLAWS

17.1 Medical Staff Responsibility

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto, which shall be effective as approved by the Board. The Bylaws shall be reviewed on a biannual basis.

17.2 Methodology

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:
17.2-1  **Medical Staff Action**

The affirmative vote of a majority of the Active Staff members eligible to vote on this matter by written or electronic ballot or by action at a Staff meeting, or as otherwise outlined in these Bylaws, provided that a copy of the proposed Bylaws, and/or amendments are available for Staff review and that at least fourteen (14) days written notice has been given of the intention to take such action; and

17.2-2  **Board Action**

The affirmative vote of a majority of the Board eligible to vote at a Board meeting at which a quorum is present, provided, however, that in the event that the Staff shall fail to exercise its responsibility and authority as required by these Bylaws and after notice from the Board, the Board may take whatever corrective action it deems appropriate.

17.2-3  **Conflict Resolution (Between the Medical Staff and the MEC)**

Any conflict between the Medical Staff and the MEC will be resolved using the mechanisms noted below:

Each staff member in the active category may challenge any rule or policy established by the MEC through the following process:

1. Submission of written notification to the president of the Medical Staff/Chief of Staff of the challenge and the basis for the challenge, including any recommended changes to the rule or policy.

2. At the meeting of the MEC that follows such notification, the MEC shall discuss the challenge and determine if any changes will be made to the rule or policy.

3. If changes are adopted, they will be communicated to the Medical Staff, at such time each Medical Staff member in the active category may submit written notification of any further challenge(s) to the rule or policy to the Chief of Staff.

4. In response to a written challenge to a rule or policy, the MEC may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.

5. If a task force is appointed, following the recommendations of such task force, the MEC will take final action on the rule or policy.

6. Once the MEC 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 active category requesting review and possible change of a rule, regulation, policy or procedure. Upon presentation of such a petition, the adoption procedure outlined in Article 17.2-1 will be followed.
17.2-4 If the Medical Staff votes to recommend directly to the Board an amendment to the bylaws or rules or regulations or a policy that is different from what has been recommended by the MEC, the following conflict resolution process shall be followed:

1. The MEC shall have the option of appointing a task force to review the differing recommendations of the MEC 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 MEC.

2. Whether or not the MEC adopts modified language, the Medical Staff shall still have the opportunity to recommend directly to the Board alternative language. If the board receives differing recommendations for bylaws, rules and regulations, or a policy from the MEC and the Medical Staff, the board shall also 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 Board appoints such a task force, the Board shall have final authority to resolve the differences between the Medical Staff and the MEC.

At any point in the process of addressing a disagreement between the Medical Staff and MEC regarding the bylaws, rules and regulations, or policies, the Medical Staff, MEC, or governing board 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 Board.

ADOPTED by the Medical Staff on May 10, 2012

__________________________
Kirk Quackenbush, MD
Chief of the Medical Staff

APPROVED by the Board on May 23, 2012

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John Hicks, CEO
President of Platte Valley Medical Center