# Medical Staff Bylaws
# Part 1: GOVERNANCE

Medical Staff Bylaws Part 1:
Governance

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## SECTION 1. GOVERNANCE

### 1.1 Purpose

The purpose of the medical staff is to organize the activities of physicians and other clinical Practitioners' who practice at Boulder Community Health in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital board of directors.

### 1.2 Authority

Subject to the authority and approval of the board of directors, the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the board of directors.

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## SECTION 2. MEDICAL STAFF MEMBERSHIP

### 2.1 Nature of Medical Staff Membership

Membership on the medical staff of Boulder Community Health is a privilege which shall be extended only to professionally competent physicians (M.D. or D.O.), podiatrists, dentists, and oral surgeons who continuously meet the qualifications, standards and requirements set forth in these bylaws and associated policies of the medical staff and the hospital.

### 2.2 General Requirements, Criteria and Qualifications

Membership on the medical staff and/or clinical privileges shall be granted and continued by the board of directors of the hospital to those physicians, dentists, podiatrists and oral surgeons and other practitioners designated by the board of directors who demonstrate to the satisfaction of the board of directors that they meet the following continuing criteria, qualifications and obligations:

2.2.1 Maintain a current, valid unrestricted license which is not subject to any supervision, probation, monitoring, conditions or limitations, or have other authority to act pursuant to the laws of the state of Colorado, as well as any other licensure, registration, certification or other authorization required by any regulatory authority to permit the practitioner to provide the appropriate health care service at the hospital.

2.2.2 Maintain professional liability insurance providing coverage for the entire time the member has privileges at the hospital with an insurer approved by the hospital in no less than the minimum amount and in such form as may be required from time to time by the board of directors.[1]

2.2.3 Shall practice in the community and within a reasonable distance of the hospital in order to be able to provide timely and appropriate coverage for patients in the hospital.[2]

2.2.4 Has not been excluded from or sanctioned by the Medicare or Medicaid programs or any other governmental program, and is not on the OIG list of excluded providers.

2.2.5 Has never been convicted of a felony or a misdemeanor related to the practitioner's suitability to practice medicine.

2.2.6 Does not have any physicalor mental health status that cannot be reasonably accommodated and would interfere with the fulfillment of the applicant's responsibilities of medical staff membership and the exercise of the specific clinical privileges requested by the applicant.

2.2.7 The applicant has, within the last twelve months, been engaged in active clinical practice or engaged in medical related activities (e.g. residency, fellowship).

2.2.8 Possess a current, valid, unrestricted drug enforcementadministration (DEA) number, if applicable.

2.2.9 The privileges requested by the prospective applicant are consistent with the hospital's mission, ethical standards, and patient care services currently provided or to be provided at the hospital.

2.2.10 The hospital has not contracted on an exclusive basis with an individual or group, with which the prospective applicant is not affiliated, to provide the clinical services sought by the applicant.

2.2.11 If the prospective applicant is an allied health care provider, the prospective applicant is a

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[1] $1,000,000 - $3,000,000

[2] 60 miles

type of allied health professional approved by the board of directors to provide patient care services in the hospital.

2.2.12 The prospective applicant has not been involuntarily terminated from the medical staff of Boulder Community Health or any other hospital, and has not resigned while under investigation, in order to avoid an investigation or disciplinary action, or following an adverse recommendation by a department chair, credentials committee or medical executive committee (MEC), unless the board of directors has consented to the applicant's reapplying for medical staff membership and clinical privileges.

2.2.13 The prospective applicant’s clinical privileges are not currently suspended at any other hospital.

2.2.14 The prospective applicant can document his experience, background, specific training, and demonstrated ability to perform the privileges requested, clinical results, current clinical competence, and physical and mental health status sufficiently to demonstrate that any patient treated by them has in the past and will in the future receive appropriate high quality care.

2.2.15 The prospective applicant can demonstrate a willingness and capability to:

a. Work with other members of the medical staff, health care providers, hospital administration, management and employees, visitors and the community in general in the cooperative, professional manner that is essential to maintain a hospital environment appropriate to quality patient care.

b. Participate in the performance of medical staff obligations and discharge such staff, committee, department and other hospital functions for which he or she is responsible by staff category, assignment, appointment, election, or otherwise.

c. Adhere to generally recognized standards of professional and personal ethics and conduct.

d. Prepare and complete in a timely fashion the medical and other required records for all patients for whom the member provides care in the hospital.

e. Abide by all medical staff and hospital bylaws, rules, regulations, policies and procedures.

f. Satisfy any continuing education requirements established by the medical staff, hospital and any appropriate professional organizations or regulatory and licensing authorities.

(i) Is board certified by an appropriate national specialty board recognized by the American Board of Medical Specialties (ABMS), the American Board of Oral and Maxillofacial surgery, the American Board of Podiatric Surgery, the American Osteopathic Association, or the American Academy of Urgent Care Medicine (MEC 4/09, 2/12)

(ii) Have successfully completed a residency approved by a specialty/subspecialty board and is eligible to become board certified. All individuals granted initial staff membership pursuant to this provision must maintain current eligibility or attain certification directly following completion of training program within the timeframe specified by the individual’s specialty board.

2.3 **Nondiscrimination**

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of mental or physical disability unrelated to the provision of patient care or required medical

staff responsibilities, national origin, religion, ancestry, gender variance, age, sex, race, creed, sexual orientation, or other basis prohibited by applicable law, to the extent the applicant is otherwise qualified for medical staff membership and the requested clinical privileges.

2.4 **Conditions and Duration of Appointment**

Initial appointments and reappointments to the medical staff shall be made by the board of directors for a period not to exceed 24 months. The board shall act on appointments and reappointments only after there has been a recommendation from the medical executive committee in accordance with the provisions of these bylaws and associated manuals. An applicant is not eligible to apply for appointment to the medical staff if the hospital does not currently have adequate facilities and support services for the appointee or his patients or if the service is currently provided under exclusive contract. The board may decline to accept, or have the medical staff review, requests for appointment for privileges that are not within the scope of services, capacity, capabilities and business plan of the hospital.

2.5 **Staff Dues**

Assessment of staff dues shall be determined by the MEC. Dues shall be payable within 30 days of initial notice for payment. A late fee will be assessed if dues are not received within the first 30 days following notification. Failure to pay dues within the 60 day notice period shall be construed as a voluntary resignation from the medical staff. Exceptions to dues requirements may be made by the medical executive committee.

2.6 **Ethical Requirements**

It is the policy of the hospital that all individuals within hospital facilities be treated courteously, respectfully, and with dignity at all times. To that end, the medical staff requires that medical staff members and allied health professionals associated with the hospital conduct themselves in a professional and cooperative manner within the hospital or any of the hospital's properties, or when otherwise acting on behalf of the hospital, as defined by the medical staff code of professional conduct. The code of professional conduct addresses quality patient care, patient disclosures regarding outcomes (including care, treatment or functionality), respect for persons, and avoidance of conflict of interest, ethical business practices, third party relationships and commitment.

If medical staff members or allied health professionals fail to conduct themselves appropriately or in the required manner, the matter shall be addressed in accordance with the appropriate hospital or medical staff policy.

2.7 **Medical Staff Membership and Clinical Privileges**

Requests for medical staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the board. Membership and/or clinical privileges will be granted and administered as delineated in the credentialing manual.

2.8 **Medical Staff Members Responsibility**

2.8.1 Each staff member must provide appropriate, timely and continuous care of his patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

2.8.2 All staff members granted clinical privileges shall participate in the organized health care arrangement ("OHCA") established by thehospital and the medical staff for the purpose of facilitating the sharing of protected health information (PHI) (as defined in hospital policies) of hospital patients for purposes of treatment, payment and health care operations within the hospital in accordance with applicable laws and regulations and shall comply with all Hospital policies related to the OHCA.

2.8.3 Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as may be required.

2.8.4 Each staff member, consistent with his granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.8.5 Each staff member must submit to any pertinent type of health evaluation as requested by the officers of the medical staff, chief executive officer and/or committee or department chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the medical staff and hospital policies addressing physician health or impairment.

2.8.6 Each staff member must abide by the medical staff bylaws and other rules, regulations, policies, procedures and standards of the medical staff and the hospital.

2.8.7 Each staff member must provide evidence of professional liability coverage of type and in an amount sufficient to cover the clinical privileges granted or in an amount established by the board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member shall notify the CEO or designee immediately of any and all malpractice claims threatened in writing or filed against the medical staff member.

2.8.8 Each staff member agrees to release from any liability, to the fullest extent permitted by federal and state law, all persons for their conduct in connection with investigating and/or evaluating the quality of care provided by the medical staff and his credentials.

2.8.9 All practitioners having privileges to admit patients to the hospital shall complete and document, or arrange for another qualified practitioner to complete and document, a physical examination and medical history no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services (moderate sedation or above). For medical history and physical examinations completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services (moderate sedation or above). In accordance with such requirements and procedures as set forth in Section 13 of these Bylaws. (BOD 8/15) [TJC PC01.02.03 EP4, EP5; MS 01.01.01 EP 16; CMS 482.22(c)(5)(i)]

2.8.10 Each staff member will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer

review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

2.8.11 Each staff member must participate in any type of competency evaluation when determined necessary by the MEC and/or board in order to properly delineate that members' clinical privileges.

2.8.12 Each medical staff leader shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or the hospital.

## 2.9 Medical Staff Member Rights

2.9.1 Each member of the active or employed community based category has the right to an audience with the medical executive committee on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event a member is unable to resolve a matter of concern after working with his respective department chair or other appropriate medical staff leader(s), that member may, upon written notice to the president of the medical staff in advance of a regular meeting, meet with the MEC to discuss the issue.

2.9.2 Each member in the active or employed community based category has the right to initiate a recall election of a medical staff officer and/or department chair by following the procedure outlined in Section 4.7 of these bylaws regarding removal and resignation from office.

2.9.3 Any member in the active or employed community based category may initiate a call for a general staff meeting, to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty-five percent (25%) of the members of the active or employed community based category, the MEC shall schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted at such meeting.

2.9.4 Any member in the active or employed community based category may challenge any rule, regulation, or policy, established by the medical executive committee. In the event a rule, regulation, or policy is felt to be inappropriate, any member may submit a petition signed by twenty-five percent (25%) of the members of the active or employed community based category. Upon presentation of such a petition, the procedure outlined in Section 9.3 of these bylaws will be followed. When such petition has been received by the MEC, it will either: 1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or, 2) schedule a meeting with the petitioners to discuss the issue.

2.9.5 Each staff member in the active or employed community based category may call for a department meeting by presenting a petition signed by twenty-five percent (25%) of the members of the department. Upon presentation of such a petition the department chair will schedule a department meeting.

2.9.6 The above sections 2.9.1 through 2.9.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges or any other matter relating to individual membership or privileges. These matters are addressed in Part 2 of these bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan) which provides recourse into these matters.

2.9.7 Any staff member of the active and employed medical staff categories has a right to a hearing/appeal pursuant to the conditions and procedures described in the Part 2 of these Bylaws.

2.10 **Indemnification**

2.10.1 Members of the medical staff are entitled to the applicable immunity provisions of state and federal laws for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and medical staff.

2.10.2 Subject to applicable law, the hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party of by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no members shall be entitled to such indemnification if the acts giving rise to the liability, constituted willful misconduct, breach of fiduciary duty, self-dealing or bad faith. Such indemnification may be provided through appropriate directors' and officers' insurance obtained and maintained by the hospital.

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## SECTION 3. CATEGORIES OF THE MEDICAL STAFF

3.1 Categories of the medical staff are related to membership on the medical staff and are independent of clinical privileges. There are members with privileges and members without privileges. There are also individuals who may be exercising privileges granted through the medical staff process who are not members.

3.1.1 Members with clinical privileges– physicians, dentists, oral and maxillofacial surgeons and podiatrists who treat patients in the hospital in accordance with clinical privileges granted to them by the Board.

3.1.2 Members without clinical privileges – community-based physicians, dentists, oral and maxillofacial surgeons, and podiatrists who do not treat patients in the hospital (they have other privileged members treat their hospitalized patients) but who wish to retain some relationship to the medical staff of the Hospital.

3.1.3 Individuals without membership but with clinical privileges – individuals who are not eligible for medical staff membership but who treat patients in the hospital. These individuals are advanced practice nurses (such as nurse practitioners, certified nurse midwives, and clinical nurse specialists), physician assistants, telemedicine physicians, locum tenens physicians, psychologists, and consulting physicians. (6/12)

3.2 **Active Category**

3.2.1 Qualifications - Members of this category must show participation on the medical staff by having privileges.

3.2.2 Responsibilities - Members of this category shall:

a. Fulfill or comply with any applicable medical staff or hospital policies or procedures.
b. Contribute to the organizational and administrative affairs of the medical staff.
c. Actively participate as requested or required in activities and functions of the medical staff, quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, service on the emergency department call roster and in the discharge of other staff functions as may be required.

3.2.3 Prerogatives - Members of this category may:

a. Attend meetings of the medical staff and department or section to which he is a member and any medical staff or hospital education programs.
b. Vote on all matters presented at general and special meetings of the medical staff, and of the department, section(s) and committees to which he is appointed.
c. Hold office and sit on, or be the chair of, any department, section or committee, in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

3.3 **Employed Community Based Category**

3.3.1 Qualifications - Members of this category must be employees of the hospital and hold ambulatory privileges.

3.3.2 Responsibilities - Members of this category shall:

a. Fulfill or comply with any applicable medical staff or hospital policies or procedures.
b. Contribute to the organizational and administrative affairs of the medical staff.
c. Actively participate as requested or required in activities and functions of the medical staff, quality/performance improvement and peer review, credentialing, risk

and utilization management, medical records completion, and in the discharge of other staff functions as may be required.

3.3.3 Prerogatives - Members of this category:

a. Attend meetings of the medical staff and department or section to which he is a member and any medical staff or hospital education programs.
b. Vote on all matters presented at general and special meetings of the medical staff, and of the department, section(s) and committees to which he is appointed.
c. Hold office and sit on, or be the chair of, any department, section or committee, in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

## 3.4 Community Based Category

3.4.1 Qualifications - The community category is reserved for members who maintain a clinical practice in the hospital services area and wish to be able to follow the course of their patients when admitted to the hospital.

3.4.2 Responsibilities - Members of this category shall fulfill or comply with any applicable medical staff or hospital policies and procedures.

3.4.3 Prerogatives - Members of this category:

a. May order non-invasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records and write courtesy notes.
b. Are not eligible for clinical privileges and do not manage patient care in the hospital.
c. May not vote on medical staff affairs or hold office unless they meet the participation requirements to vote which is at least fifty percent (50%) attendance at all general medical staff, department, section and committee meetings to which the member is assigned.

## 3.5 Honorary Category

The honorary category is restricted to those individuals recommended by the MEC and approved by the board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the honorary category shall consist of those members who have retired from active hospital practice, are of outstanding reputation and have provided distinguished service to the hospital. They may attend medical staff and clinical service meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

## SECTION 4. OFFICERS OF THE MEDICAL STAFF

4.1 The officers of the medical staff shall be a president, president-elect, and immediate past president and shall be members of the active staff in good standing.

4.2 **Qualifications of Officers/Limitation on Leadership Positions**

4.2.1 Officers must be members of the medical staff in good standing, be actively involved in patient care in the hospital or hospital owned clinics, have previously served in a significant leadership position on a medical staff (e.g. departmentchair, committee chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have participated in medical staff leadership training, and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. Qualifications for the positions of medical staff president and president-elect also include the degree of MD or DO. The medical staff nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers, department chairs, and other MEC members may not simultaneously hold leadership position on another hospital's medical staff or in a facility that competeswith the hospital, as determined by the board. Noncompliance with this requirement will result in the officer being automatically removed from office unless the board determines that allowing the officer to maintain his position is in the best interest of the hospital. The board shall have discretion to determine what constitutes a "leadership position" at another hospital. At a minimum, however, such term shall include the positions of president, president-elect or vice-president and immediate past president of a hospital's medical staff.

4.3 **Election of Officers**

4.3.1 A nominating committee shall be appointed by the Medical Executive Committee and may include members of the Medical Executive Committee or any other medical staff committee. The committee will be comprised of 4-6 members; the President Elect or Past President will preside. The Nominating Committee shall solicit nominations from the medical staff and shall offer at least one nominee for each available position, including Executive Committee at-large positions. Nominations must be announced, and the names of the nominees distributed to all members of the active and employed community based medical staff at least thirty (30) days prior to the election.

4.3.2 Physicians who meet qualifications for member at large may self-nominate by submitting a letter of interest and a letter of support signed by 10 active or employed community physicians, no more than 5 of whom are partners. Names of any added nominees shall be distributed to all members of the active and employed community based category at least ten (10) days prior to the election.

4.3.3 Only members eligible to vote may cast a vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the members' voting choices. No proxy voting will be permissible. The nominee who

receives the greatest number of votes will be elected. In the event of a tie vote, the medical staff support professional will made arrangements for a repeat vote(s) until one candidate receives a greater number of votes.

4.4 **Term of Office**

The term of office for the president shall be two years. The terms of office for the president-elect and past president shall be one year. Each officer shall serve in office until the end of his term or until a successor is duly elected and qualified. An individual may not be reelected for two successive terms. The president-elect shall automatically succeed the president at the end of his term. The president shall automatically serve as Immediate past president. All terms shall commence on the first day of the medical staff year (January-December) following the election.

4.5 **Vacancies in Office**

The MEC shall fill vacancies of office during the medical staff year, except the office of president. If there is a vacancy in the office of the president, the president-elect shall serve the remainder of the term.

4.6 **Duties of Officers**

4.6.1 President – The president shall represent the interests of the medical staff to the MEC and the board. The president will fulfill the duties specified in Section 6 of these bylaws and in the related job descriptionattached to the medical staff compensation policy.

4.6.2 President-Elect – In the absence of the president, the president-elect shall assume all the duties and have the authority of the president. He shall perform such further duties to assist the president as the president may from time to time request. He shall also be a member of the credentials committee.

4.6.3 Past President – In the absence of the president or president-elect, thepast-president will assume the duties of the president and have the authority of the president. He will be a member of the MEC.

4.7 **Removal from Office**

4.7.1 The board, acting on its own initiative, may remove any officer, only after discussion of the matter at a meeting of the joint conference committee; two-thirds of the medical executive committee shall concur with the board's decision to remove an officer. The affected individual will not be present for such meeting of the joint conference committee or the MEC. The medical staff may remove any officer by petition of twenty-five percent (25%) of the active or employed community based staff members and a subsequent two-thirds (2/3) vote by ballot of the active or community based staff present and voting at aspecial meeting called for such purposes. Grounds for removal of officers include, but are not limited to,

a. Conduct which is detrimental to, or reflects adversely on, the medical staff of the hospital;
b. Failure to perform duties of the office as provided in the bylaws, associated documents or other policies and procedures of the medical staff;
c. Any action or conduct which would form the basis for corrective action pursuant to Part 2 of these bylaws: (investigations, corrective actions, hearing and appeal plan), even if corrective action is not taken. An officer shall be automatically removed from office if the officer ceases to be a member of the medical staff in good

standing.

4.7.2 Resignation – Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

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## SECTION 5. MEDICAL STAFF ORGANIZATION

### 5.1 Organization of the Medical Staff

5.1.1 The medical staff shall be departmentalized. Each department shall report to the MEC. A department shall elect a departmentchair and vice chair.

5.1.2 The departments will be composed of section chiefs and other department representatives, as deemed appropriate. Sections representing particular specialties may be established by the departments as specified in the organization and functionsmanual. Such sections shall be directly responsible to a department. Each department shall have a chair with overall responsibility for the supervision and satisfactory discharge of the functions of the department. If subspecialists choose to form sections, they will select their own section chief. Current departments and sections and their functions are listed in the organization and functions manual.

### 5.2 Qualifications, Selection, Term and Removal of DepartmentChairs, Vice Chairs and Section Chiefs

5.2.1 Department chairs, vice chairs and section chiefs shall serve a term of two (2) years commencing on January 1 and may be elected to serve successive terms if elected. All department chairs, vice chairs and section chiefs must be active or employed community based medical staff members, have relevant clinical privileges, and meet the position requirements as specified in the applicable positiondescription.

5.2.2 Department chairs, vice chairs and section chiefs' shallbe elected at least one month prior to theexpiration of the term of the current chair. Only members of the department eligible to vote may cast a vote. The mechanisms for casting a vote may include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee who receives the greatest number of votes will be elected, subject to ratification by the MEC. In the event of a tie vote, the medical staff support professional will make arrangements for a repeat voteuntil one candidate receives a greater number of votes. It is recommended but not mandatory that department chairs, vice chairs and section chiefs be from different specialties within the department.Department chairs, vice chairs and section chiefs may be removed from office in the same manner as officers of the medical staff (Section 4.7).

5.2.3 If the Department chairs, vice chairs and section chiefs are removed through this process, a new election will beheld according to established Department procedures.

### 5.3 Assignment to Departments

The MEC will, after consideration of the recommendations of the department chair of the appropriate department, recommend department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary department. Clinical privileges are independent of department assignment.

## SECTION 6. MEDICAL EXECUTIVE COMMITTEE (MEC)

6.1 **Delegated Authority**

The organized medical staff delegates authority in accordance with law and regulations to the medical executive committee to carry out medical staff responsibilities. The medical executive committee has the primary authority for activities related to self governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process.

6.2 **Committee Membership**

6.2.1 Composition - The MEC shall be a standing committee consisting of the following voting members: the officers of the medical staff, the chairs of the credentials and professional practice review committees, department chairs, two (2) at large members from hospital based specialties (anesthesia, cardiology, emergency medicine, radiology, pathology, and hospitalists) as well as two members of the medical staff elected at large. The critical care and trauma medical directors will also be a part of the MEC. A majority of the members of the MEC must be actively practicing physicians. The chief executive officer and vice presidents as designated by the CEO will be ex officio members without vote. The president of the medical staff will serve as chairperson of the committee. Support staff will attend the meeting without membership on the committee.

6.2.2 Term and Election of At-Large Members - At-large members shall be elected at least one month prior to the expiration of the term of the current at large members. Only members eligible to vote may cast a vote. The mechanisms for casting a vote may include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the members' voting choices. No proxy voting will be permissible. The nominee who receives the greatest number of votes will be elected. In the event of a tie vote, the medical staff support professional will make arrangements for repeat vote(s) until one candidate receives a greater number of votes. At-large members are elected for a two (2) year term, with the option of serving an additional one (1) year term. (9/2013)

6.2.3 Removal of Committee Members - Any committee member, including members of the MEC, may be removed by the individual or entity which elected or appointed the committee member. At large members of the MEC may be removed from the executive committee in the same manner as officers of the medical staff (Section 4.7).

6.3 **Duties.** The duties of the MEC, as delegated by the medical staff, shall be to:

a. Serve as the final decision-making body of the medical staff, in accordance with the medical staff bylaws and provide oversight for all medical staff functions;
b. Coordinate the implementation of policies adopted by the board;
c. Submit recommendations to the board concerning all matters relating to the appointment, reappointment, staff category, department assignments, clinical privileges, and corrective action;
d. Report to the board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;
e. The MEC, on behalf of the organized medical staff and based upon recommendation of the medical director(s) for radiology/nuclear medicine, annually approves the qualifications of the radiology staff who use equipment and

administer procedures as well as approves the specifications for the qualifications, training, functions and responsibilities of the nuclear medicine staff. (BOD 8/15; Ref TJC MS 03.01.01 EP 16, 17)

f. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;
g. Make recommendations to the board on medical administrative and hospital management matters;
h. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
i. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
j. Review and act on reports from medical staff committees, departments, and other assigned activity groups;
k. Formulate and recommend to the board medical staff rules, policies and procedures;
l. Request evaluations of practitioners privileged through the medical staff process when there is questions about an applicant or member's ability to perform privileges requested or currently granted;
m. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
n. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;
o. Oversee that portion of the corporate compliance plan that pertains to the medical staff;
p. Make recommendations to the board regarding contracted clinical services provided at the hospital.
q. Hold medical staff leaders, committees, and departments accountable for fulfilling their duties and responsibilities; and
r. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws.
s. In addition to the above duties, the MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.

6.4 **Meetings**

6.4.1 The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Records of its proceedings and actions shall be maintained.

6.4.2 In the event an issue is brought before the MEC for which there is insufficient specialty representation present, the MEC will seek input from one or more physicians who practice in that specialty. The specialty-specific representatives may attend the MEC meetings as non-voting ad hoc members until the issue for which their input has been sought is resolved.

## SECTION 7. MEDICAL STAFF MEETINGS

7.1 **Meetings of the Medical Staff**

7.1.1 An annual meeting and other general meetings, if any, of the medical staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.

7.1.2 Special meetings of the Medical Staff:

a. The president may call a special meeting of the medical staff at any time. Such request or resolution shall state the purpose of the meeting. The president shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 **Regular Meetings of Medical Staff Committees and Departments**

Committees and departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 **Special Meetings of the Committees and Departments**

A special meeting of any committee, department or section may be called by chair thereof, or by the president of the medical staff.

7.4 **Quorum and Voting**

7.4.1 For any regular or special meeting of the Medical Staff, service, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

a. for meetings of the MEC, Credentials Committee, and the Quality Review Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum;

b. for amendments to these Medical Staff Bylaws, at least 10% of the voting staff shall constitute a quorum

7.4.2 Recommendations and actions of the Medical Staff, services, and committees shall be by consensus if possible. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

7.4.3 As an alternative to a formal meeting, the voting members of the Medical Staff, a service, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the Chief of Staff, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC, the Credentials Committee, and the Quality Review Committee [as noted in (a)], a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

7.4.4 Meetings may be conducted via telephone conference or videoconference.

7.5 **Attendance Requirements**

9.1.1 Members of the medical staff are encouraged to attend meetings (general medical staff, department committees, sections, and assigned committees) of the medical staff.

a. MEC members, credentials committee members, professional practice reviewcommittee members, section chiefs, department chairs, are expected to attend at least seventy-five percent (75%) of the meetings of their respective committee, department or section.

b. Special appearance or conferences: Whenever a staff or department educational program is prompted by findings of quality improvement program activities, the practitioner whose performance prompted the program will be notified of the time, date and place of the program, of the subject matter to be covered, and its special applicability to the practitioner's practice. Except in unusual circumstances, he will be required to be present.

c. Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the president or the applicable department chairperson may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the meeting. This notice shall include the date, time and place, issue involved, and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such conference, after two (2) notices unless excused by the MEC for an adequate reason will result in an automatic suspension of the practitioner's membership and privileges. Such suspension does not give rise to a fair hearing and will be rescinded if and when the practitioner participates in the previously referenced meeting.

d. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or of clinical privileges as outlined in Part 2 of these bylaws (investigations, corrective action, and hearing and appeal plan).

7.6 **Participation By Chief Executive Officer** (**CEO**)

The CEO, or his designee, is an ex-officio member of all medical staff committees to encourage participation of management to assist the medical staff. The committee may go in to executive session, with medical staff members only, as determined by the committee.

7.7 **Parliamentary Procedure**

All committee meetings will be conducted in a manner determined by the chair with the intent of allowing interested parties an opportunity to provide their input and to achieve a fair resolution Robert's Rules of Order, Newly Revised, shall provide general guidance for the conduct of meetings, but adherence to Robert's Rules of Order shall not be required, and technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.
(MEC 6/12)

7.8 **Notice of Meetings**

Written or electronic notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered, or sent to each member of the committee or department not less than three days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 **Action of Committee or Department**

Unless otherwise specified in these bylaws, the recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or department.

7.10 **Rights of Ex Officio Members**

Except, as otherwise provided in these bylaws, persons serving as ex-officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

7.11 **Minutes**

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding chair shall authenticate the minutes and a summary of each meeting shall be reported to the MEC. A record of the minutes of each meeting shall be maintained.

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## SECTION 8. CONFLICTS

8.1 **Conflict Resolution**

8.1.1 In the event the board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to the joint conference committee.

8.1.2 The chair of the board or the president of the medical staff may call for a meeting of the joint conference committee any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

8.1.3 Any conflict between the medical staff and the MEC will be resolved using the mechanisms noted in Sections 2.9.1 through 2.9.4 of Part 1 of these bylaws.

8.2 **Conflicting Language Between Governance Manuals**

8.2.1 In the case of discordance among or between the Bylaws and any of the medical staff governance manuals/hospital policies, the Bylaws will prevail. (3/17)

8.3 **Conflict of Interest**

8.3.1 All practitioners holding membership and/or clinical privileges shall be responsible for disclosing any conflicts of interest and shall recuse him/herself from deliberation and vote on any conflicted issue. Each Department Committee, Section Committee, Standing Committees, or Ad Hoc Committees of the Medical Staff has the authority to determine whether a possible conflict of interest should preclude a member from participating in the deliberation and vote on an issue that may be in conflict

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## SECTION 9. PROCESSING APPLICATIONS FOR MEDICAL STAFF MEMBERSHIP/CLINICAL PRIVILEGES

9.1 Only applicants who meet the minimum eligibility criteria, as set forth in the credentialing manual, shall be provided with an application for medical staff membership and/or clinical privileges. Practitioners who do not meet the minimum eligibility criteria for appointment are not entitled to fair hearing rights. The Medical Staff Department Director shall review all requests for an application and determine whether the criteria for issuing an application have been met.

9.2 Applicants have the burden of producing adequate information to establish their qualifications and competence. Each applicant for appointment, reappointment, clinical privileges, or change in medical staff category or status shall have the burden of producing adequate information and documentation for proper evaluation and verification of the applicant's experience, background, training, demonstrated competence, character, conduct, judgment, attitude, and physical and mental health status, and resolving any questions about those matters or any other matters relating to the character and qualifications of the applicant. Failure to provide all information as requested will result in an incomplete application and will not be accepted for processing.

9.3 **Review of applications for completeness and accuracy.**

9.4.1 The completed application for appointment, reappointment, clinical privileges, or change in medical staff category or status shall be reviewed by the medical staff department for completeness, and the references, licensure, certifications, malpractice insurance, education, training and other information shall be verified with original sources to the extent possible. When all of the information in the application has been verified, the application shall be sent to the chair of each department in which the applicant seeks privileges.

9.4.2 No application for appointment or reappointment shall be accepted for processing and will be deemed incomplete until all information and documents required have been provided and all verifications have been completed. An application for reappointment shall be considered to be incomplete if any applicant for reappointment has not provided requested information or documents, or not responded to requests for comments, concerning peer review or quality improvement matters or any investigation regarding the practitioner's conduct or qualifications for medical staff membership and privileges. The medical staff department also shall verify that the individual requesting privileges is in fact the same individual that is identified in the credentialing documents. If the director of the medical staff department determines that the application contains significant omissions, the application and all fees shall be returned to the applicant with instructions concerning the missing information. If the director of the medical staff department determines that only minor information is missing, the director may retain the application and notify the applicant of the missing information.

9.4.3 No application shall be considered to be complete until it has been reviewed by the department chair, the credentials committee and the medical executive committee, and the credentials or medical executive committee determine that no further documentation or information is required to permit consideration of the application.
Additional information may be requested by any department chair, or by the credentials or medical executive committee. If the applicant fails to submit the requested information within sixty (60) calendar days after being requested to do so, the application shall be deemed to be incomplete and withdrawn, and the application

returned to the applicant, unless the time to obtain the information is extended by the person or committee requesting the information.

9.4.4 On behalf of the hospital, the board takes final action on all completed applications.

9.4 **Expedited Credentialing** – The board of directors has delegated to the Joint Conference Committee (JCC) the authority to render decisions on their behalf for initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges that meet the criteria for expedited privileges.The BOD also delegates to the JCC the ability to approve medical staff forms, policies and/or procedures which have been recommended by the MEC, with prior endorsement by the appropriate medical staff committees, and that are non-controversial or administrative in nature.

9.5 Additional details regarding the credentialing process are set forth in the credentialing manual.

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## SECTION 10. CONFIDENTIALITY, IMMUNITY AND RELEASE OF LIABILITY

10.1. For the purpose of this section, the following definitions shall apply:

10.1.1. The term "INFORMATION" is defined as all acts, communications, interviews, opinions, conclusions, records of proceedings, investigations, hearings, meetings, minutes, other records, reports, memoranda, statements, recommendations, actions, findings, evaluations, data, and other disclosures, whether in writing, recorded, computerized or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality of patient care provided at the hospital.

10.1.2. The term "HEALTH PRACTITIONER" is defined as a practitioner or any other individual who is applying for or has medical staff membership or who is applying for or who has clinical or practice privileges at the hospital.

10.1.3. The term "REPRESENTATIVE" is defined as the hospital, its governing board, any director, a committee or the chief executive officer or attorney of the hospital or other health care institution or their designee; registered nurses and other employees or agents of the hospital or other health care institution; a medical staff entity and any member, officer, attorney, department or committee thereof, or organization of health practitioners, a professional review organization, professional review or peer review body or committee, a state or local board of medical or professional quality assurance, and any members, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific Information gathering, analysis, use or disseminating functions.

10.1.4. The term "THIRD PARTIES" is defined as both individuals and organizations providing Information to any representative, including the national practitioner data bank and other databases.

10.2. **Authorizations and Conditions**

10.2.1. A practitioner who applies for or exercises clinical or practice privileges at the hospital authorizes representatives to obtain, provide and act on Information related to his professional ability, ethics and other qualifications and authorizes third parties and their representatives to provide such Information, even if the Information is otherwise privileged or confidential. The health practitioner waives all legal claims against any representative or third party for providing, obtaining or acting on the Information, to the fullest extent permitted by law.

10.2.2. The provisions of this article are express conditions of application for and continuation of membership on the medical staff and the exercise of clinical or practice privileges at the hospital.

10.2.3. The hospital, medical staff and other practitioners are obligated by state and federal law to report certain conduct or actions, and any health practitioner who applies for or exercises clinical or practice privileges at the hospital waives all legal claims against any person who makes such a report, to the fullest extent permitted by law.

10.3. **Confidentiality of Information** - Information with respect to any health practitioner submitted, collected or prepared by any representative or any other health care facility or organization or medical staff for the purpose of peer review, utilization review or the evaluation or improvement of the quality of patient care provided at the Hospital shall, to the fullest extent permitted by law, and in these bylaws, be confidential and shall not be disclosed to anyone

other than a representative nor be used in any way except as provided in these bylaws or as required by law. Such confidentiality shall also extend to Information of like kind that may be provided by third parties. This Information shall not become part of any particular patient's record.

10.4. **Immunity from Liability**

10.4.1. For action taken – Each representative shall be immune and exempt to the fullest extent permitted by law, and these bylaws, from liability to a health practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his duties as a representative and for providing Information, including otherwise privileged or confidential information, to a representative or third party concerning a health practitioner.

10.4.2. Activities and Information Covered – The confidentiality and immunity provided by this section shall apply to all acts, communications, reports or disclosures performed or made in connection with the hospital's or any other health care facilities or organization's activities concerning, but not limited to:

a. Applications for appointment and reappointment of medical staff memberships and clinical or practice privileges.
b. Investigations and corrective action, including summary suspension and automatic suspension.
c. Hearings and appellate reviews.
d. Hospital, department, committee, section or other medical staff activities related to monitoring, maintaining, and improving the quality and efficiency of patient care, appropriate utilization and appropriate professional conduct.
e. Peer review activities, recommendations or reports, reports to federal, state or local reporting bodies, including, but not limited to, the national practitioner data bank, quality assurance bodies and the boards of medical examiners.

10.5. **Release** – Each health practitioner, upon request of the hospital or the medical executive committee, shall be required to and shall execute general and specific releases to comply with this Article. Execution of such releases shall be a prerequisite to the processing of applications and reapplications for medical staff membership and for clinical or practice privileges. Execution of such releases is not, however, necessary to carry out the provisions of this section.

10.6. **Cumulative Effect** – Provisions in these bylaws and application forms relating to authorizations, confidentiality of information and immunities and exemptions from liability are in addition to other protections provided by federal and Colorado law.

## SECTION 11. REVIEW, REVISION, ADOPTION, AND AMENDMENT

11.1. **Medical Staff Responsibility**

11.1.1. The organized medical staff has the responsibility to formulate, review at least biennially, and recommend to the board, any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules and regulations shall be effective when approved by the board.

11.1.2. Neither the organized medical staff nor the board may unilaterally amend the medical staff bylaws or rules and regulations.

11.2. **Methods of Adoption and Amendment to these Bylaws**

11.2.1. Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty-five percent (25%) of the members of the active or employed community based categories. Any amendment proposed by petition shall be submitted to the MEC for review and comment before it is submitted to the voting members of the organized medical staff, and if approved, shall be submitted to the board along with the comments of the MEC.

11.2.2. Each active or employed community based member of the organized medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active or employed community based members of the organized medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment will pass if a majority of the ballots returned are marked yes.

11.2.3. Proposed amendments approved by the organized medical staff shall be forwarded to the board, which shall approve, disapprove or approve with modifications. If the board modifies any bylaw amendments approved by the organized medical staff, such amendments, as modified, shall be returned to the MEC, which may accept, or reject the modifications. If the MEC accepts the modifications, the amendment shall be submitted to the organized medical staff for approval or disapproval in accordance with Section 9.2.2 above. If the MEC rejects the modifications, the amendment shall again be submitted to the Board, which may either approve or disapprove the amendment. The MEC or the Board may refer any disputes regarding proposed bylaw amendments to the joint conference committee for discussion and further recommendation to the MEC and the board.

11.2.4. These bylaws and all amendments to these bylaws shall be effective upon approval by the board, unless otherwise stated in the bylaw provision or amendment approved by the board, and shall apply to all pending matters to the extent practical, unless the board directs otherwise.

11.2.5. The MEC may adopt such amendments to these bylaws that are in the committee's judgment, technical or legally required modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO.

11.3. **Methods of Adoption and Amendment to any Medical Staff Rule, Regulation, Associated Manual, or Policy.**

11.3.1. Such rules, regulations, associated manuals, and policies as may be necessary to

implement more specifically the general principles found within these bylaws and to regulate the proper conduct of medical staff organizational activities and the clinical practices that are required of each practitioner in the hospital may be adopted by the MEC or proposed by majority vote of the medical staff, subject to the approved of the board of directors, in accordance with the following procedures:

a. Any proposed rule or regulation being considered by the MEC shall be distributed to the members of the active and employed community based medical staff for review and comment, in accordance with such procedures as are approved by the MEC, before the proposed rule or regulation is adopted by the MEC and sent to the board for approval.
b. Any policy adopted by the MEC and approved by the board shall be promptly communicated to the medical staff.
c. Rules, regulations and policies may also be proposed to the board of directors by the medical staff by majority vote of the members of the active and employed community based staff entitled to vote. Proposed rules, regulations or policies may be brought before the active medical staff by petition signed by twenty-five (25%) of the members of the active or employed community based medical staff. Any such proposed rules, regulations or policies proposed by a majority of the active staff shall be submitted to the MEC for review and comment before such rule, regulation, or policy is voted on by the active and employed community based members. Any rule, regulation or policy approved by the active and employed community based staff shall be presented to the board along with any comments from the MEC.
d. All proposed medical staff rules, regulations or policies shall become effective only after approval by the board.

11.4. The MEC may adopt such amendments to these rules, regulations, associated manuals, and policies that are in the committee's judgment, technical or legally required modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire board but must be approved by the hospital CEO.

11.5. In the event there is a documented need for an urgent amendment to rules and regulations, or the adoption of a new rule or regulation to comply with a law or regulation, the MEC may provisionally approve an urgent amendment to the rules and regulations without prior notification to the organized medical staff. In such event the medical staff shall be immediately notified of the amendment and members of the organized medical staff may within thirty (30) days submit to the MEC any comments regarding the provisional amendment. Upon petition signed by twenty-five percent (25%) of the organized medical staff members entitled to vote, the provisional amendment may be submitted to the conflict management process set forth in Sections 2.9.1 through 2.9.4 of Part 1 of these bylaws. The results of the conflict management process shall be communicated to the MEC, the medical staff and the board. In the event no petition is filed, the provisional amendment shall be submitted to the board for approval in accordance with these bylaws. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

## SECTION 12. DEFINITIONS

12.1 **Allied Health Professional or AHP** – an individual, other than licensed physician, podiatrist, dentist, or oral surgeon, who practices in areas identified by the board and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the board, bylaws, rules, regulations, associate manuals and policies of the hospital and the medical staff. Notwithstanding any other provision of these bylaws, allied health professionals are not eligible for medical staff membership and are not entitled to any procedural rights under Part 2 of these bylaws (investigations, corrective actions, hearing and appeal plan). Any procedural rights afforded to AHPs are set forth in the AHP manual and approved by the governing board.

12.2 **Appointee** – a practitioner appointed to the medical staff and/or granted clinical privileges.

12.3 **Associated Manuals** – the credentialing manual, rules and regulations, quality assessment plan and organization and functions manual ("Manuals"), which have been recommended by the medical executive committee and adopted by the board.

12.4 **Board of Directors, Governing Board, or Board** – the individuals responsible for conducting the ordinary business affairs of Boulder Community Health in Boulder, Colorado, which for purposes of these bylaws and, except as the context otherwise requires, shall be deemed to act through the authorized actions of the officers of the corporation and through the chief executive officer of Boulder Community Health.

12.5 **Chief Executive Officer or CEO** – the individual appointed by the board of directors to act on its behalf in the overall management of the hospital. The term chief executive officer includes a duly appointed acting administrator serving when the chief executive officer is away from the hospital. Unless otherwise set forth in these bylaws or the bylaws of the board, the medical staff may rely upon all actions of the chief executive officer as being the actions of the board of directors taken pursuant to a proper delegation of authority from the board of directors.

12.6 **Clinical Privileges or clinical practice privileges or permission to practice** – the permission granted to a member of the medical staff or an AHP, based upon an individual's professional license and experience, competence, ability and judgment, to render specific diagnostic or therapeutic services to hospital patients.

12.7 **Current Clinical Competence** – Affirmation of ongoing clinical practice and current clinical competence is evidenced by an active practice and experience in the privileges requested. Evidence shall include, but not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations; documentation of continuing education; case logs indicating number and types of procedures performed; the results of performance improvement and peer review(MEC 6/12).

12.8 **Designee** – a qualified individual identified to fulfill the role of a medical staff officer, department or committee chair, or hospital CEO or director. In order to ensure effectiveness and fairness, a medical staff or hospital leader may, at their own discretion, designate an appropriate individual to serve in their role for any given circumstance or task. The established chain of command will typically be implemented when determining a designee.

12.9 **Good Standing** – "good standing" means the staff member, at the time the issue is raised, has met the attendance and committee participation requirements, if applicable, during the previous medical staff year, is not in arrears in dues payments, and has not received a suspension or restriction of his or her appointment, admitting or clinical privileges in the previous twelve (12) months; provided, however, that if a staff members has been suspended in the previous twelve (12) months for failure to comply with the hospital's policies or regulations regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the staff member's good standing status.(MEC 6/12)

12.10 **He, his** – pronouns apply equally to both genders, male or female.

12.11 **Hospital** – Boulder Community Health.

12.12 **Medical Executive Committee or MEC** – the executive committee of the medical staff (MEC), unless specific reference is made to the executive committee of the governing board of the Hospital.

12.13 **Medical Staff** – All licensed independent practitioners (D.O., M.D., D.M.D., D.D.S., PhD) privileged through the organized medical staff process that is subject to the medical staff bylaws and associated manuals/policies.

12.14 **Member** – any physician, podiatrist, oral surgeon, dentist or psychologist appointed to, and maintaining membership in, any category of the medical staff in accordance with these bylaws.

12.15 **Organized Medical Staff** – a self-governing entity accountable to the governing body that operates under the medical staff bylaws and associated manuals policies developed and adopted by the voting members of the organized medical staff and approved by the governing body. The organized medical staff is comprised of doctors of medicine and osteopathy, and, in accordance with the medical staff bylaws, may include other practitioners.

12.16 **Patient** – any person at the hospital undergoing diagnostic evaluation or receiving medical treatment.

12.17 **Physician** – an individual with an M.D. or D.O. degree who is licensed to practice medicine in Colorado.

12.18 **Physician Extenders**– identifies the following practitioners: Nurse Practitioners, Physician Assistants, Anesthesia Assistants, Certified Nurse Midwives, Registered Nurses.

12.19 **Practitioner** – any physician, podiatrist, dentist, oral surgeon, or AHP, unless otherwise expressly provided, applying for medical staff membership/affiliation or clinical privileges/practice privileges/permission to practice at the Hospital; or, any medical staff member or AHP Staff member who has been granted privileges at the Hospital.

12.20 **Voting Members** – Those practitioners within the organized medical staff who have the right to vote on adopting and amending medical staff bylaws, rules and regulations, and policies.

## SECTION 13. HISTORY AND PHYSICAL REQUIREMENTS (BOD 8/15)

13.1. A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services (moderate sedation or above) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

13.1.1. If an H&P has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

13.1.2. Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

13.1.3. The H&P update shall be recorded on an H&P update form or in a progress note provided the progress note includes the following required information:

a. That the patient has been examined;
b. That the original H&P was reviewed:
c. Whether there are any changes to the patient's condition;
d. Documentation of any changes to the patient's condition.

13.1.4. A physician who does not hold clinical privileges at BCH may perform the H&P, provided that the H&P form is reviewed and countersigned by a physician with clinical privileges at BCH.

13.1.5. H&Ps performed by a qualified advanced physician assistant (PA) must be reviewed and countersigned by a physician with clinical privileges at BCH. H&P's performed by a qualified nurse practitioner (NP) do not require a physician review and/or countersignature unless required by the NP's employment agreement.

13.1.6. Outpatient Procedures in the Emergency Department

a. An H&P is required for all procedures requiring moderate or deep sedation which are performed in the emergency department ("ED") (including urgent care). The ED assessment may serve as the H&P, provided that it contains the information required for an outpatient H&P.
b. In the event a patient is transferred from the ED to surgery, an H&P shall be performed by the attending surgeon, unless an H&P or ED assessment containing the required information was performed in the ED or the surgery is an emergency surgery.
c. In the event an outpatient who has received anesthesia services (moderate sedation or above) is admitted as an inpatient after the procedure, the attending physician is responsible for performing an inpatient H&P within 24 hours of admission. If the patient has had an H&P within thirty days outside the hospital, an update may be performed.

13.1.7. When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be appended to the initial admission history and physical. This assumes the original information is readily available. Otherwise, a new document must be provided.

13.1.8. All ECT patients are required to undergo an H&P by medical doctor or other qualified medical professional prior to starting ECT treatments and annually thereafter. For patients receiving ongoing ECT treatments, the psychiatrist involved in the treatment will complete an H&P update prior to the procedure. An ECT Interval H&P is conducted by the treating ECT psychiatrist and anesthesiologist every thirty days for patients receiving ongoing ECT on a maintenance schedule.

13.1.9. Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

13.1.10. Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry. Podiatrist may request privileges to perform preoperative history and physicals for patients designated as ASA I and ASA II.

13.1.11. An H&P examination is not required for outpatient procedures identified as using local or no anesthesia. However, a progress note stating the reason for procedure and diagnosis is required. The following list is not all inclusive.

a. Blood patches
b. Breast biopsy (ultrasound, stereotactic)
c. Breast hookwire localization (ultrasound, mammography)
d. Chest tube placement (without moderate sedation)
e. Fine needle aspiration (breast, thyroid, salivary gland, lymph nodes)
f. Imaging guided musculoskeletal procedures (i.e. PRP)
g. Intrathecal chemotherapy
h. Joint injections via fluoroscopy, CT or ultrasound (spine and extremities)
i. Laser procedures of the eye
j. Lumbar puncture (including fluoroscopic guided)
k. Myelogram
l. Nuclear medicine therapeutic dose administration (6/12)
m. Paracentesis
n. PICC placement
o. Pseudoaneurysm thrombin injection (ultrasound guided)
p. Thoracentesis

13.2. **Minimal Content Requirements**:

13.2.1. *Inpatient history and physical examinations*:

a. Chief complaint
b. History of present illness
c. Pertinent past history
d. Pertinent social history
e. Pertinent family history
f. Pertinent physical examination

g. Pertinent inventory of body systems
h. Impression and plan of care.

*13.2.2. Outpatient history and physical examinations – moderate or deep sedation:*

a. Symptoms/indications for the procedure;
b. Allergies;
c. Current medications and significant medical history;
d. A focused physical examination that includes the relevant body area or organ system;
e. Assessment of mental status;
f. Assessment of heart and lung; and
g. Assessment of airway by the person responsible for the sedation.

*13.2.3. Outpatient history and physical examinations – General, spinal, epidural anesthesia:*

a. Chief complaint;
b. History of present illness;
c. Pertinent past, social or family history;
d. A focused physical examination that includes the relevant body area or organ system;
e. Assessment of heart and lungs to be completed by the person responsible for the anesthesia.

13.2.4. *Obstetrical Patients*

A copy of the office/clinical prenatal record is acceptable as the H&P. A written interval admission note that includes the pertinent additions to the history and subsequent changes in the physical findings is acceptable as the H&P update. Cesarean Sections require a new current H&P with the same requirements as the inpatient surgical H&P.

*13.2.5. Newborns*

For newborns, completion of the "Admission/Discharge Summary" form is acceptable as the H&P for any procedure.

13.3. Cancellations, Delays, and Emergency Situations

13.3.1. The H&P requirement may be waived in emergency cases, as long as the physician or nursing documentation reflects the emergent situation. For example, a provider may dictate the emergent situation in the procedure report, or nursing staff may document the situation in the OR record or cath lab record. An emergency case is defined as potential loss of life, limb or body function and no delay is possible.

13.4. Non-compliance with H&P Requirements

13.4.1. If an H&P or H&P update is not performed, recorded and available as required:

a. The patient shall not proceed to surgery or other procedure requiring anesthesia services (moderate sedation or above).
b. The admitting physician/surgeon will be advised of the need for an H&P or an H&P update prior to surgery or other procedure requiring anesthesia.
c. Violations shall be reported through the Safety Event Management reporting system.