NOTICE OF REGULAR BOARD MEETING OF
THE UPPER SAN JUAN HEALTH SERVICE DISTRICT
dba PAGOSA SPRINGS MEDICAL CENTER

Tuesday, March 24, 2020, at 5:30 PM

NO IN-PERSON MEETING

MEETING TO BE HELD VIA zoom

Please use this link to join the meeting: https://zoom.us/j/791231172 or telephone +1 (346) 248-7799 US

Zoom Meeting ID: **791 231 172**

AGENDA

1) **CALL TO ORDER; ADMINISTRATIVE MATTERS OF THE BOARD**
   a) Confirmation of quorum
   b) Board member self-disclosure of actual, potential or perceived conflicts of interest
   c) Approval of the Agenda (and changes, if any)

2) **PUBLIC COMMENT** (This is an opportunity for the public to make comment and/or address USJHSD Board. Persons wishing to address the Board need to notify the Clerk to the Board, Heather Thomas, prior to the start of the meeting. All public comments shall be limited to matters under the jurisdiction of the Board and shall be expressly limited to three (3) minutes per person. The Board is not required to respond to or discuss public comments. No action will be taken at this meeting on public comments.)

3) **PRESENTATION: COVID-19 Pandemic** (Written report to be supplemented on Monday, 03/23/2020.)

4) **REPORTS**
   a) **Oral Reports** (may be accompanied by a written report)

i) Chair Report	Chair Greg Schulte
~~ii) Contracts~~	~~Dir. Kate Alfred and Dir. Karin Daniels~~
~~iii) Strategic Planning~~	~~Dir. Dr. Jim Pruitt and Dir. Karin Daniels~~
iv) CEO Report	Chief Executive Officer, Dr. Rhonda Webb
v) HVAC Project, status report	COO Kathee Douglas and Dir. Matt Mees
vi) Finance Report	CFO, Chelle Keplinger and Treasurer, Dr. Campbell

b) **Written Reports** *(no oral report unless the Board has questions)*

~~i) Operations Report~~ (Postponed until April) ~~COO-CNO, Kathee Douglas~~

ii) Medical Staff Report Chief of Staff, Dr. Ralph Battels

5) DECISION AGENDA

a) **Consideration of Resolution 2020-07** regarding Board consent to Declaration of Local Disaster Emergency. (To be supplemented on Monday, 03/23/2020.)

b) **Consideration of Resolution 2020-08** regarding approval of proposed amendments to the Medical Staff Bylaws. (To be supplemented on Monday, 03/23/2020.)

c) **Consideration of Resolution 2020-09** regarding approval of air evacuation insurance coverage for all PSMC employees.

6) CONSENT AGENDA (The Consent Agenda is intended to allow Board approval, by a single motion, of matters that are considered routine. There will be no separate discussion of Consent Agenda matters unless requested.)

a) Approval of Board Member absences:

i) Regular meeting of 03/24/2020

b) Approval of Minutes for the following meeting(s):

i) Regular meeting of: 02/25/2020

c) Approval of Medical Staff report recommendations for new or renewal of provider privileges.

7) OTHER BUSINESS

a) DEO Report: Status of May 5, 2020 election matters.

8) ADJOURN

TO: PSMC Board of Directors
FROM: PSMC Incident Command
DATE: 3/24/2020
RE: COVID-19 Pandemic

1. PSMC SUPPORT TO ENSURE HEALTH OF THE COMMUNITY
    a. PANDEMIC: COVID-19 is a worldwide pandemic (the world, national, state and local orders through last Friday are all listed on resolution 2020-07).
    b. FLATTEN THE CURVE: We must flatten the pandemic curve to avoid exceeding the capacity of all hospitals in the region to care for patients. To slow the spread, we need all to heed the advice of local Public Health to: stay home as possible, practice social distancing, and wash hands often.
    c. TESTING:
        i. Testing is in short supply across the country. PSMC made decisions early to assure supply of tests for our critical or hospitalized patients. At PSMC (we assume every patient who has symtoms is positive for COVID-19 and receives the COVID-19 treatment plan. PSMC led early with this and CDPHE followed 2 days later as advice through the State of Colorado. We feel it is likely in our area and encourage people to follow the advice of local public health.
        ii. Testing at PSMC as of 3/24/2020: 10 patients tested, 3 negative, 6 pending.
        iii. Testing in Colorado as of noon on 3/24/2020:
            1. 6,224 tested (limited to those who have symptoms)
            2. 720 positive (11.56% positive of those tested)
        iv. *The number of COVID-19 hospitalized patients in CO has nearly tripled in the last 6 days* (if this continues, this results in decreased capacity to meet patient needs):
            1. 3/23: 72
            2. 3/22: 58
            3. 3/21: 49
            4. 3/20: 44
            5. 3/19: 38
            6. 3/18: 26
    d. COMMUNITY COORDINATION:
        i. On March 12th, PSMC facilitated a community meeting with other governmental entities on issues and preparedness.
        ii. Coordinating very positively and effectively with San Juan Basin Public Health regarding communication and epidemiological testing as possible.
        iii. Archuleta County initiated its incident command for broad based community issues that are reported in there including:
            1. Archuleta County Health in Human Services – isolation spaces for homeless or persons who cannot return to home for isolation;

applications for government programs (e.g. Medicaid, food stamps).
2. Security – addresses needs including requests for National Guard support.
3. Coordinates food delivery programs;
4. Chamber of Commerce facilitating business needs (started with collective work on business interruption insurance).

2. PREPARATION FOR A SURGE
   a. OVERVIEW: We have a comprehensive Emergency Operations Plan (EOP) and Surge Plan that has helped us prepare for any emergency, including a pandemic. We implemented the EOP on 2/26/2020 and activated incident command on 3/12/2020. Through incident command we identify and resolve the issues related to COVID-19.
   b. FACILITY:
      i. Negative air pressure: PSMC has one room in the ED with negative air pressure (known as the "decontamination room") and one inpatient room with negative air pressure. Negative air pressure is used to limit the spread of infectious diseases. Through some creative thinking and work of the Facilities staff, PSMC has the ability to convert all inpatient and 4 ED rooms to negative air pressure (this is a high level statement as there limitations, consequences and nuances evaluated and understood by operational staff).
      ii. Beds: PSMC has a plan to address surge capacity for beds including, as needed, expanding beds to the pre-post op surgery area and the outpatient clinic.
   c. SUPPLY: Supply is critical to being able to care for the community and treat a surge of COVID-19 patients. We maintain counts and assess use on all of the following:
      i. Vents: We have worked creatively to find ways to expand our capacity for vents. There are some complex issues to this still being resolved. Note, PSMC has 3 vents in the hospital, 5 vents on ambulances, and 1 anesthesia machines that could be used as vents.
      ii. Air/Gases: PSMC has made considerable evaluation of oxygen and gases required for a surge and use of vents. Arrangements have been made for additional oxygen.
      iii. Masks: We have a limited supply of N95s and like all healthcare providers, seek more. We also have a limited supply of other face masks and pursue more. We have community volunteers sewing cloth masks which we would employ as needed in a manner to cover N95 or surgical masks that we have to anticipate would be reused unless supply becomes available. In addition, Voormi donated 100 neck gaitors that could be used like the cloth masks.

iv. Gowns: "Yellow gowns" (impervious to liquid and wrap around the person) are in short supply everywhere and we seek more. An infectious disease patient in isolation typically requires at least 22 yellow gowns per day.
v. Gloves. Monitoring and ordering as available.

d. WORKFORCE:
i. Remote - IT has taken on a substantial role of helping to move as many nonclinical staff as possible to remote off-site work.
ii. Cross-training – we have commenced crossed training of staff in the event certain staff are sick or quarantined.
iii. HR policy for the pandemic addresses a wide variety of issues including handling, per CDC guidance, exposures of employees.
iv. Hiring freeze - given the negative financial impact of canceling elective surgeries and nation-wide advice for all to stay at home, we have a universal hiring freeze in place.
v. Depth – we still working through complex plans for depth of coverage for a variety of scenarios. In addition, we are issuing a call for volunteers who have active licenses in clinical areas including: EMT, paramedic, respiratory therapists, and nurses. We have depth on PSMC team of providers but are looking at temporary privileges for the pandemic of volunteer physicians.

e. HVAC:
i. PSMC's HVAC project is started with equipment arriving during April and the project is scheduled to take place in June. However, with the COVID-19 pandemic, we may not be able to proceed with the project in June for various reasons including: (1) safety and the need to limit interactions of contractors at PSMC so as not to spread COVID-19; and (2) like most hospitals, we have suspended certain services to preserve PPE and our ability to respond to a surge of patients -- as a young critical access hospital with limited funds, this presents very difficult challenges for us.
ii. PSMC requested an extension of the deadline to use the grant funds by 10/31/2020; if we don't need the extension, no harm.

3. <u>ENSURE CONTINUITY OF SERVICES AS POSSIBLE AND SAFETY</u>
a. SERVICES CONTINUING AND SERVICES SUSPENDED
i. Almost all services are still available to patients – Emergency Department, Inpatient, Surgery (non-elective as determined by the treating physicians), Oncology and Infusion, Outpatient Clinic Care, lab, radiology and ancillary services.
ii. On 3/18, PSMC suspended elective surgeries – we determined it was the right thing to do to preserve PPE should we need it for a surge of COVID-19 patients. On 3/20, the Governor of Colorado ordered all elective surgeries to stop in Colorado except the order allowed them at CAHs and rural hospitals.

b. MEDICAL VISITS BY PHONE/TELE - PSMC is offering physician/provider phone appointments with patients for care. Medicare has relaxed the prior restriction on this.
c. VISITORS - No visitors to see/support patients except limited circumstance such as parent/guardian of minor child, support person to disabled person, or end of life event.
d. NEW SCREENING AT FRONT ENTRANCE – PSMC has changed the front lobby, by converting part of it in to a room. We have wrapped the fireplace and floor (for infection control), have a sink on order to use the space to screen patients. Screening is a series of questions about a person's health including potential exposure to the virus and scanning for fever. Screened patients are masked. Those suspected of COVID-19 are swabbed, when possible, in the car to minimize spread in the facility.

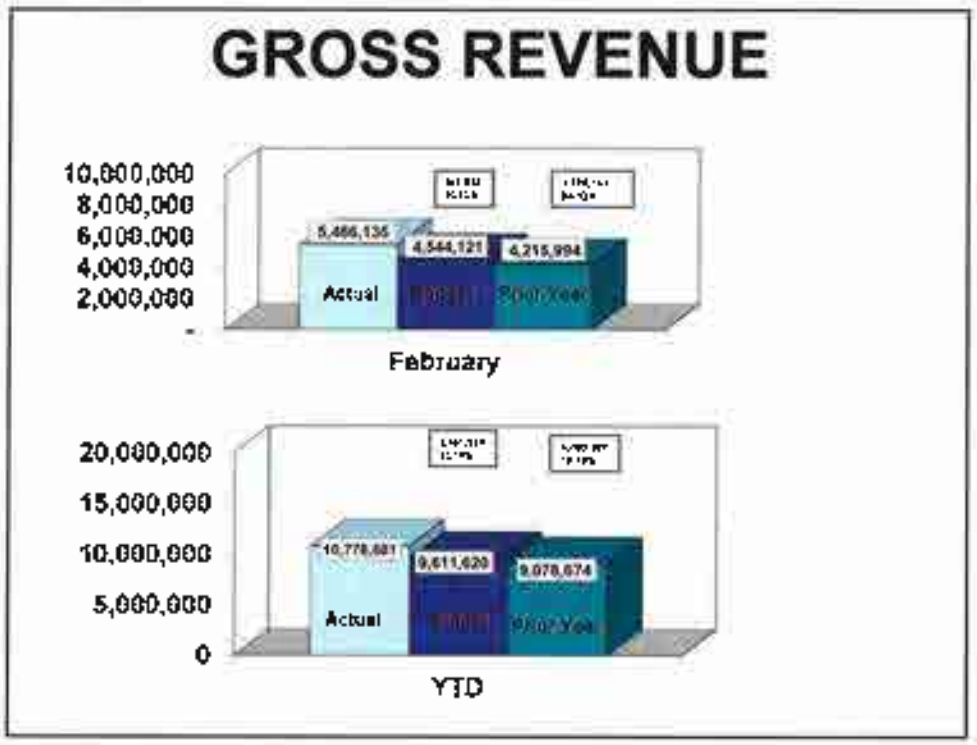
4. <u>COMMUNICATION</u>
   a. It is a priority that all support the communication and need to "flatten the curve" so we avoid being like Italy and all hospitals continue to meet the needs of all.
   b. Internally, a daily briefing has been issued daily.
   c. External and internal sources of information have been:
      i. The Pagosa Sun has posted press releases regarding the impact of COVID-19 on medical center operations.
      ii. PSMC website
      iii. PSMC's FaceBook
      iv. Signage
      v. Advertising

PAGOSA SPRINGS
Medical Center
THE CARE YOU DESERVE IN THE MOUNTAINS YOU LOVE

FINANCIAL PRESENTATION
YTD FEBRUARY 2020

Summary of Financials

	January		
Gross Revenue	$ 3,289,768		
Net Revenue	$ 2,693,561	50.6%	
Expenses	$ 2,973,057		
Sales, SCIP and Tax Revenue	$ 196,017		
Charitable Gifts		$	167,758
Tax Revenue		$	9,579
Net Income	$ 62,839		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8,000,000
6,000,000
4,000,000
2,000,000
-
5,466,135
4,544,121
4,215,994
Actual
February
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15,000,000
10,000,000
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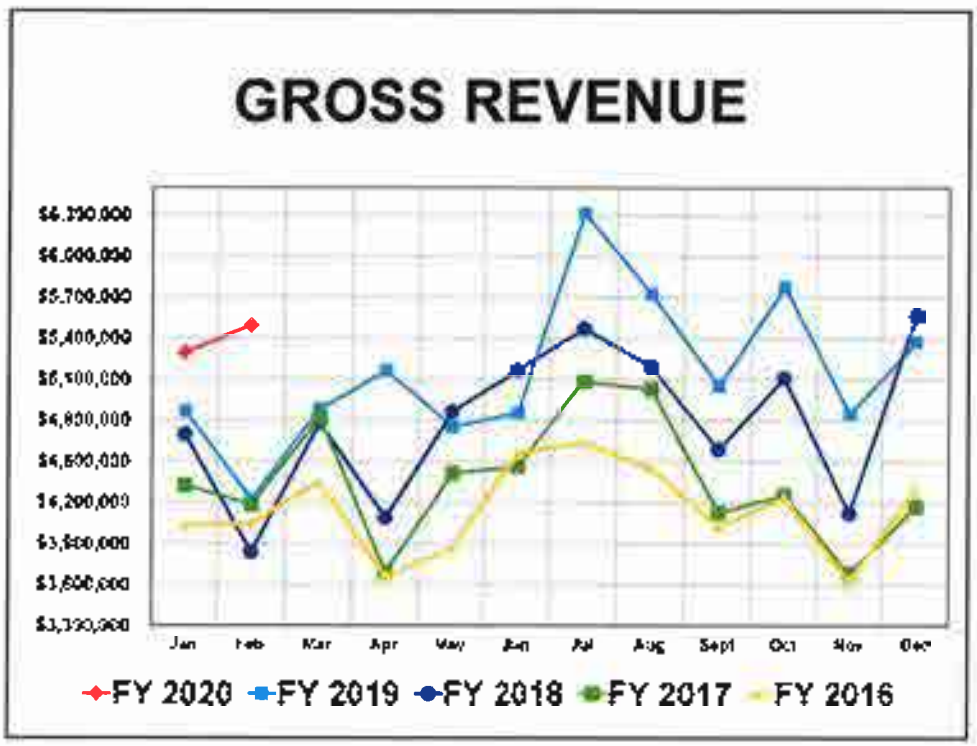
0
10,778,681
9,611,620
9,078,674
Actual
YTD


GROSS REVENUE
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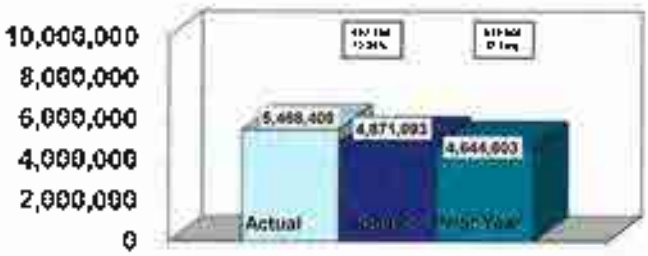
FY 2018
FY 2017
FY 2016

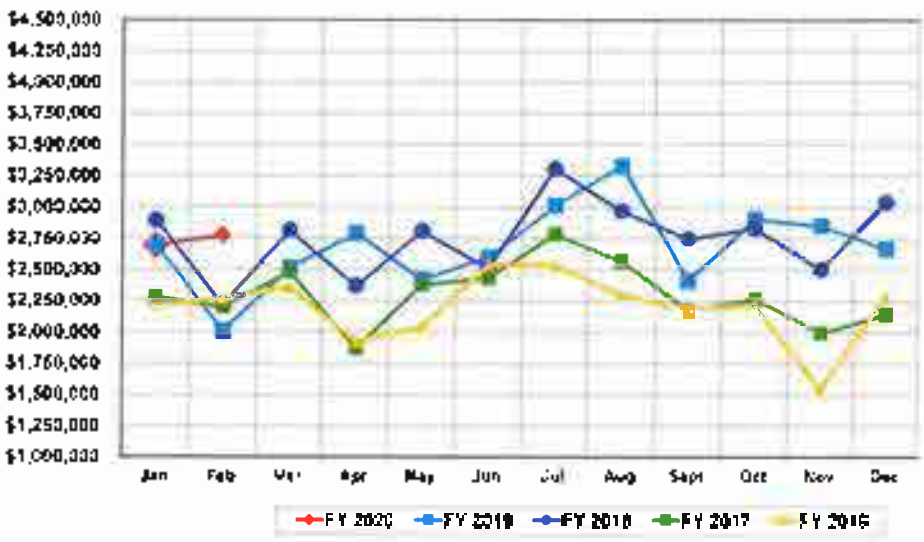
NET PATIENT REVENUE

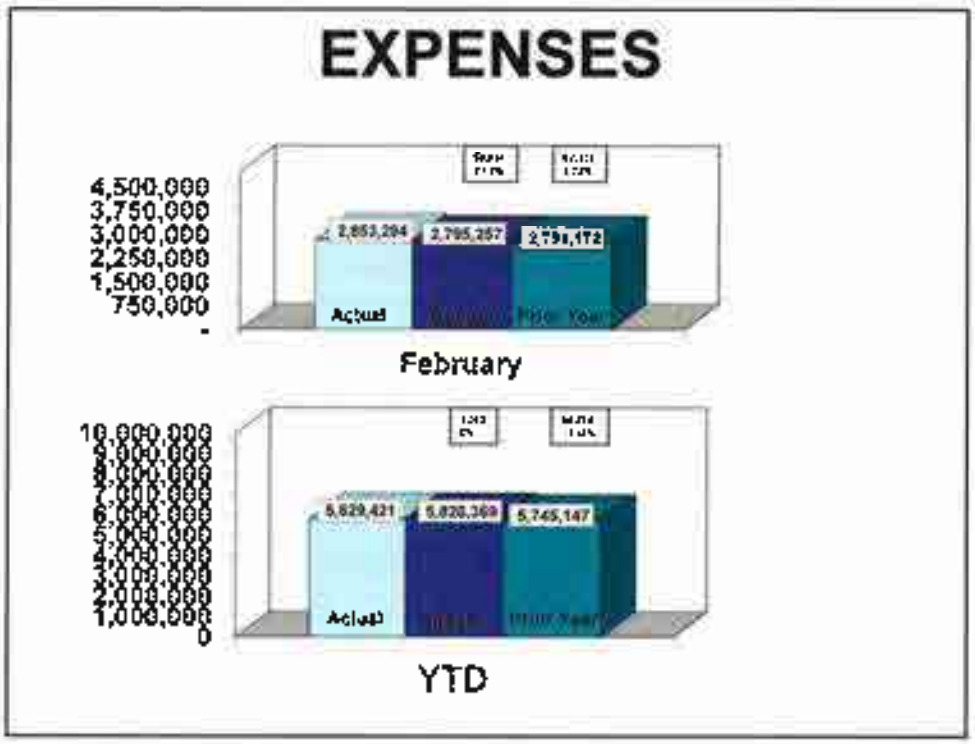
February



YTD

NET REVENUE




EXPENSES
4,500,000
3,750,000
3,000,000
2,250,000
1,500,000
750,000
-
2,853,294
2,795,357
2,791,172
Actual
February
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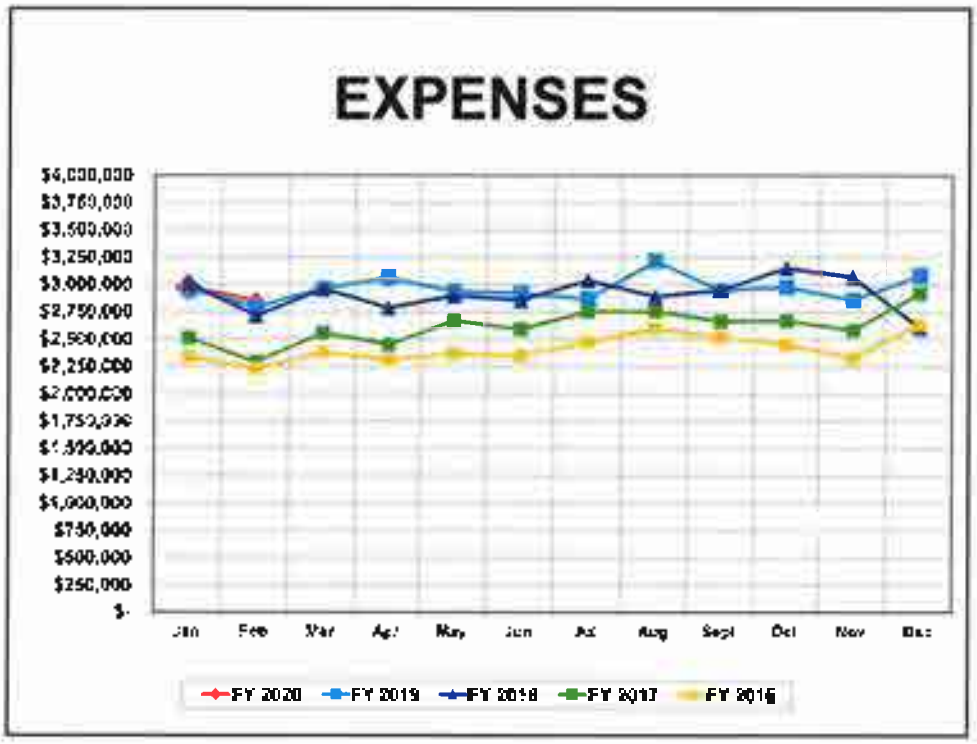
5,829,421
5,820,368
5,745,147
Actual
YTD


EXPENSES
$4,000,000
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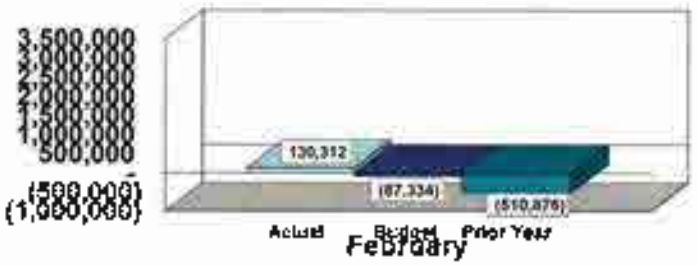
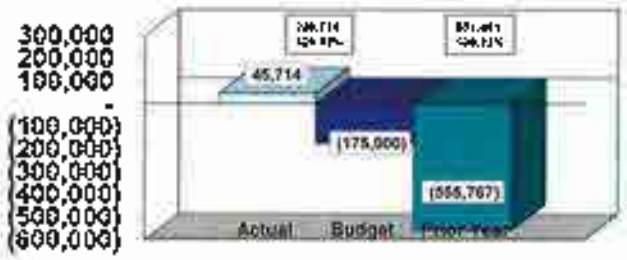
FY 2016

NET INCOME

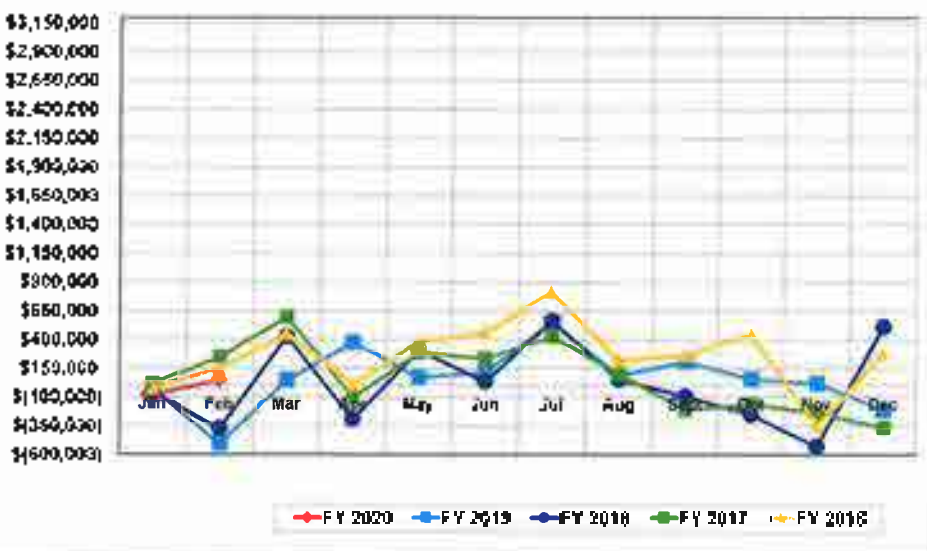


February



YTD

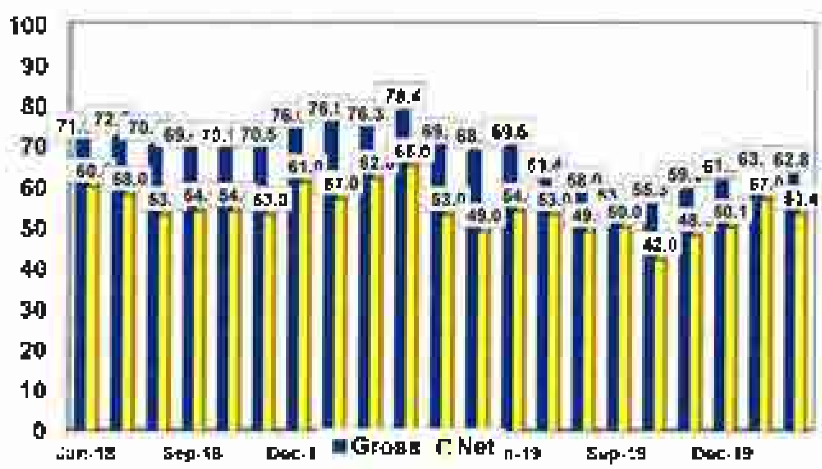
NET INCOME



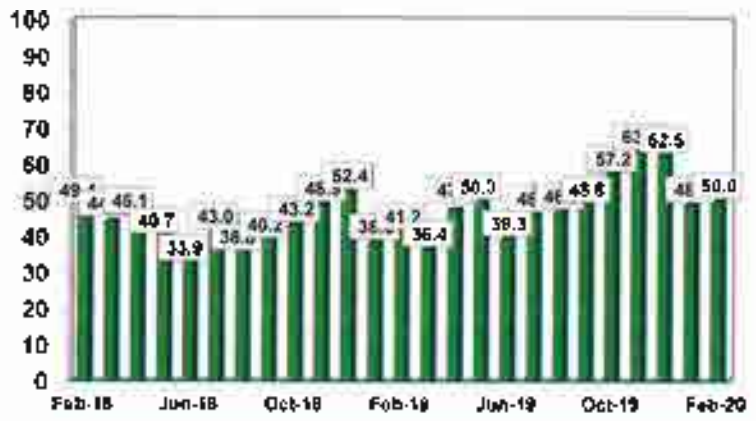
Summary of Financials

	February	
Gross Revenue	[illegible]	
Net Revenue	[illegible]	[illegible]
Expenses	[illegible]	
Grants, 340B and Tax Revenue	$ [illegible]	
Grants and 340B		$ [illegible]
Tax Revenue		$ [illegible]
Net Income	$ [illegible]	

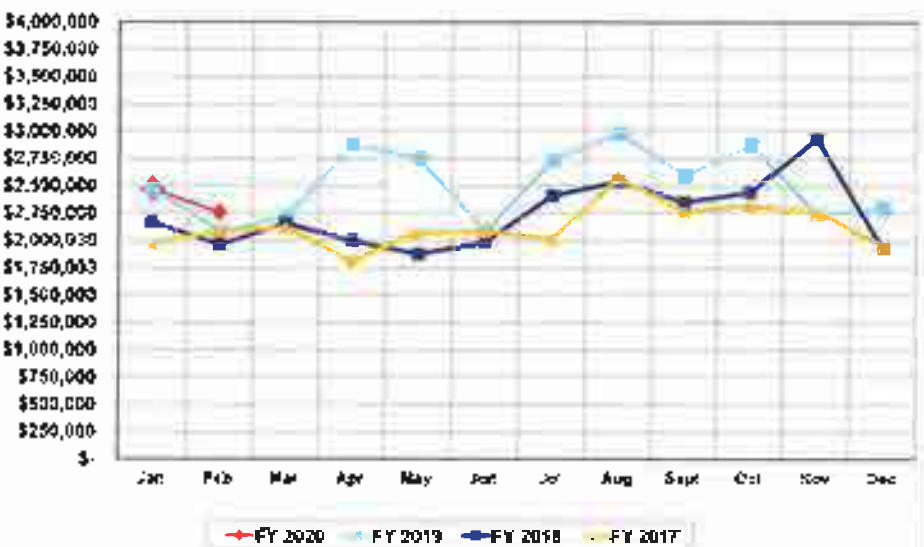
DAYS IN ACCOUNTS RECEIVABLE



DAYS CASH ON HAND



CASH COLLECTIONS



Pagosa Springs Medical Center

Income Statement - - - February 29, 2020

		Current Month				Year-to-Date			
		2020	Budget	Difference	Variance	2020	Budget	Difference	Variance
	Revenue								
7	In patient Revenue	530,942	345,728	185,214	54%	926,449	961,933	(25,484)	-3%
18	Total Out patient Revenue	4,141,109	3,606,044	835,065	23%	8,832,909	7,471,561	1,361,348	18%
19	Professional Fees	514,084	592,349	(78,265)	-13%	1,019,522	1,189,126	(169,604)	-14%
20	**Total Patient Revenue**	**5,486,135**	**4,544,121**	**942,014**	**21%**	**10,778,880**	**9,611,620**	**1,167,260**	**12%**
21	Revenue Deductions & Bad Debt								
22	Contractual Allowances	2,784,665	2,208,460	576,205	26%	5,438,160	4,513,742	924,418	20%
23	Charity	(28,895)	112,889	(141,784)	-126%	(25,644)	189,448	(215,092)	-114%
24	Bad Debt	201,864	194,966	6,898	3%	391,283	373,963	17,320	5%
25	Provider Fee & Other	(746,117)	(169,966)	(576,151)	45%	(493,328)	(336,527)	(156,801)	47%
26	Total Revenue Deductions & Bad Debt	2,711,307	2,346,349	364,958	16%	5,310,471	4,740,526	569,945	12%
27	**Total Net Patient Revenue**	**2,774,828**	**2,197,772**	**577,056**	**26%**	**5,468,409**	**4,871,094**	**597,315**	**12%**
28	Grants	2,059	200,000	(197,941)	-99%	2,059	250,000	(247,941)	-99%
29	Other Operating Income - Misc	123,620	243,529	(119,909)	-49%	312,189	455,485	(143,296)	-31%
30	**Total Net Revenues**	**2,900,507**	**2,641,301**	**259,206**	**10%**	**5,782,657**	**5,576,579**	**206,078**	**4%**
31	**Operating Expenses**								
32	Salary & Wages	1,564,191	1,452,536	111,655	8%	3,186,754	3,092,501	94,253	3%
33	Benefits	202,967	315,785	(112,818)	-36%	375,156	647,885	(272,689)	-42%
35	Professional Fees/Contract Labor	30,167	20,077	10,090	50%	61,534	42,145	19,393	46%
36	Purchased Services	156,685	165,329	(8,644)	-5%	318,322	343,705	(25,383)	-7%
37	Supplies	389,242	353,549	35,693	10%	863,409	704,337	159,072	23%
38	Rent & Leases	37,460	33,693	3,767	11%	76,179	78,726	(2,553)	-3%
39	Repairs & Maintenance	45,218	60,515	(15,297)	-25%	93,558	107,462	(13,904)	-13%
40	Utilities	30,660	66,822	(36,162)	-54%	71,292	133,594	(62,302)	-47%
41	Insurance	25,440	22,755	2,685	12%	52,009	50,696	1,313	3%
42	Depreciation & Amortization	148,653	134,544	14,109	10%	296,816	281,819	14,997	5%
43	Interest	88,872	72,657	16,215	22%	179,508	144,020	35,488	25%
44	Other	133,739	96,996	36,743	38%	254,846	201,479	53,367	26%
45	**Total Operating Expenses**	**2,853,294**	**2,795,258**	**58,036**	**2%**	**5,829,021**	**5,828,369**	**1,052**	**0%**
46	**Operating Revenue Less Expenses**	**47,213**	**(153,957)**	**201,170**	**-131%**	**(46,764)**	**(251,790)**	**205,026**	**-81%**
47	**Non-Operating Income**								
48	Tax Revenue	83,099	66,623	16,476	25%	92,478	76,790	15,688	20%
49	Donations	-	-	-		-	-	-	
50	**Total Non-Operating Income**	**83,099**	**66,623**	**16,476**	**25%**	**92,478**	**76,790**	**15,688**	**20%**
51	**Total Revenue Less Total Expenses**	**$ 130,312**	**$ (87,334)**	**$ 217,646**	**-249%**	**$ 45,714**	**$ (175,000)**	**$ 220,714**	**-126%**

Pagosa Springs Medical Center

Income Statement Comparison - - - February 29, 2020

		Current Month				Year-to-Date			
		2020	2019	Difference	Variance	2020	2019	Difference	Variance
	Revenue								
17	Total In-patient Revenue	560,947	405,117	124,830	31%	976,449	1,009,575	(33,126)	-3%
37	Total Out-patient Revenue	4,441,109	3,379,405	1,112,003	33%	8,837,909	7,076,307	1,761,607	25%
38	Professional Fees	334,084	450,776	33,308	7%	1,059,522	997,499	22,023	2%
39	**Total Patient Revenue**	**5,486,335**	**6,215,994**	**1,270,141**	**30%**	**10,778,880**	**9,078,674**	**1,700,205**	**19%**
20	Revenue Deductions & Bad Debt								
21	Contractual Allowances	2,784,685	2,207,959	576,705	26%	5,438,160	4,378,021	1,059,139	24%
22	Charity	(28,895)	252,242	(281,137)	-111%	(25,644)	227,379	(253,023)	-111%
23	Bad Debt	401,664	324,069	76,594	24%	694,283	288,363	302,920	36%
24	Provider Fee & Other	(246,147)	(235,783)	(10,364)	4%	(393,328)	(459,692)	(33,636)	7%
25	Total Revenue Deductions & Bad Debt	2,711,307	2,247,478	463,829	21%	5,310,471	4,434,071	876,400	20%
26	**Total Net Patient Revenue**	**2,774,828**	**3,968,516**	**806,312**	**41%**	**5,468,409**	**4,644,603**	**823,806**	**18%**
27	Grants	2,059	-	2,059		2,059	-	2,059	
28	Other Operating Income - Misc	123,620	226,469	(102,849)	-45%	312,189	447,716	(135,527)	-30%
29	**Total Net Revenues**	**2,900,507**	**2,193,985**	**706,522**	**32%**	**5,782,657**	**5,092,319**	**690,338**	**14%**
32	**Operating Expenses**								
31	Salary & Wages	1,564,191	1,452,766	111,425	8%	3,186,754	3,022,000	164,754	5%
32	Benefits	202,967	272,619	(69,652)	-26%	375,196	545,689	(170,493)	-31%
34	Professional Fees/Contract Labor	30,167	41,591	(11,424)	-27%	61,538	72,589	(11,051)	-15%
35	Purchased Services	156,685	124,683	32,002	26%	318,322	261,468	56,854	22%
36	Supplies	389,242	354,410	35,832	10%	853,409	692,372	171,037	25%
37	Rent & Leases	37,490	25,578	11,912	47%	76,173	92,499	(16,326)	-18%
38	Repairs & Maintenance	45,218	65,584	(21,366)	-32%	93,538	109,376	(15,838)	-14%
39	Utilities	30,649	73,994	(43,754)	-59%	73,792	143,028	(69,736)	-49%
40	Insurance	75,440	86,944	(11,434)	-13%	82,009	88,929	(6,920)	-12%
41	Depreciation & Amortization	348,653	353,893	(5,267)	-1%	479,836	342,508	(85,692)	-13%
42	Interest	88,877	88,526	346	0%	379,508	375,171	4,337	2%
43	Other	133,709	100,721	33,015	33%	254,866	231,538	23,328	10%
44	Total Operating Expenses	2,853,294	2,791,171	62,123	2%	5,829,421	5,765,147	64,274	1%
45	**Operating Revenue less Expenses**	**47,213**	**(597,186)**	**644,399**	**-108%**	**(46,764)**	**(652,828)**	**606,064**	**-93%**
46	**Non-Operating Income**								
47	Tax Revenue	83,099	86,310	(3,211)	-4%	92,478	97,061	(4,583)	-5%
48	Donations	-		-		-		-	
49	**Total Non-Operating Income**	83,099	86,310	(3,211)	-4%	92,478	97,061	(4,583)	-5%
50	**Total Revenue Less Total Expenses**	**$ 130,312**	**$ (510,876)**	**$ 641,188**	**-126%**	**$ 45,714**	**$ (555,767)**	**$ 601,481**	**-108%**

Pagosa Springs Medical Center

Balance Sheet - - - February 29, 2020

	Assets	Current Month	Prior Month
2	Current Assets		
3	Cash		
4	Operating	$ 3,501,668	$ 3,415,870
5	Debt Svc. Res. 2016 Bonds	878,731	878,731
6	Bond Funds - 2016 Bonds	79	79
7	Bond Funds - 2006	1,104,415	1,032,235
8	Capital Escrow	-	-
9	Total Cash	5,484,893	5,326,915
10			
11	Accounts Receivable		
12	Patient Revenue - Net	4,774,890	4,505,617
13	Other Receivables	328,747	391,371
14	Total Accounts Receivable	5,103,637	4,896,988
15			
16	Inventory	1,539,481	1,538,065
17			
18	Total Current Assets	12,128,011	11,761,988
19			
20	Fixed Assets		
21	Property Plant & Equip (Net)	7,852,356	7,942,304
22	Electronic Health Record (Net)	814	2,045
23	Clinic Expansion	13,377,405	13,377,405
24	Work In Progress	75,800	73,031
25	Land	101,000	101,000
26	Total Fixed Assets	21,407,375	21,495,786
27			
28	Other Assets		
29	Prepaids & Other Assets	443,657	413,897
30	Total Other Assets	443,657	413,897
31			
32	**Total Assets**	**$ 33,979,043**	**$ 33,671,671**

	Liabilities	Current Month	Prior Month
	Current Liabilities		
	Accts Payable - System	$ 1,104,966	$ 1,176,600
	Accrued Expenses	1,414,070	1,196,969
	Cost Report Settlement Res	(69,551)	(42,381)
	Wages & Benefits Payable	843,958	765,430
	Deferred Revenue	3,333	3,333
	Current Portion of LT Debt-2006	320,000	320,000
	Current Portion of LT Debt-2016	320,000	320,000
	Total Current Liabilities	3,936,776	3,739,951
	Long-Term Liabilities		
	Leases Payable	190,645	200,514
	Equipment Lease (Wells Fargo)	234,777	243,136
	Bond Premium (Net) - 2006	230,218	231,330
	Bond Premium (Net) - 2016	133,393	133,817
	Bonds Payable - 2006	8,705,000	8,705,000
	Bonds Payable - 2016	9,920,000	9,920,000
	Total Long-Term Liabilities	19,414,033	19,433,797
	Net Assets		
	Un-Restricted	10,582,520	10,582,521
	Current Year Net Income/Loss	45,714	(84,598)
	Total Un-Restricted	10,628,234	10,497,923
	Restricted		
	Total Net Assets	10,628,234	10,497,923
	Total Liabilities & Net Assets	**$ 33,979,043**	**$ 33,671,671**

Monthly Trends

	Activity	Feb-19 28	Mar-19 31	Apr-19 30	May-19 31	Jun-19 30	Jul-19 31	Aug-19 31	Sep-19 30	Oct-19 31	Nov-19 30	Dec-19 31	Jan-20 31	Feb-20 29
2	In Patient Admissions	29	40	31	27	39	33	31	25	22	28	30	28	28
3	In Patient Days	69	114	98	79	89	113	85	75	67	94	98	91	73
4	Avg Stay Days (In-patients)	2.4	2.9	3.2	2.9	2.3	3.4	2.7	3.0	3.1	3.4	3.2	3.4	2.6
5	Swing Bed Admissions	0	1	0	0	0	0	1	0	2	0	0	0	0
6	Swing Bed Days	0	4	0	0	0	0	2	0	2	0	0	0	0
7	Avg Length of Stay (Swing)	0.0	4.0	0.0	0.0	0.0	0.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0
8	Average Daily Census	2.5	3.8	3.3	2.5	3.0	3.8	2.8	2.5	2.2	3.0	3.2	2.9	2.5
	Statistics													
9	ER Visits	453	543	462	563	561	702	616	557	697	646	627	599	576
10	Observ Hours	33	37	27	40	25	36	67	49	35	29	41	542	295
11	Lab Tests	1,340	1,577	1,670	1,628	1,609	1,810	1,767	1,634	1,679	1,433	1,566	5,250	1,118
12	Radiology/CT/MRI Exams	795	940	859	925	972	1,057	1,021	902	1,029	789	862	1,435	1,378
14	OR Cases	63	80	98	86	80	80	104	54	85	99	87	82	86
15	Clinic Visits	1,805	1,845	2,165	1,950	1,881	1,997	2,087	1,940	2,087	2,478	1,838	2,100	1,884
16	Spec Clinic Visits	182	210	255	210	177	219	211	158	116	183	175	247	149
17	Oncology Clinic Visits	58	83	52	53	54	80	72	106	82	89	65	117	96
18	Oncology/Infusion Patients	65	67	63	45	42	80	68	37	81	59	71	46	70
19	Infusion Patients	78	85	77	72	81	79	67	104	78	90	80	58	59
20	EMS Transports	89	89	78	82	85	100	105	96	100	94	86	114	116
21	Total Scans	4,510	5,571	5,902	5,687	5,467	6,254	6,161	5,636	5,876	4,973	5,468	10,984	10,506

Pagosa Springs Medical Center --- Statistical Review

Statistical Review

	2020	February			February				February Prior Y-T-D				
		Current Month Actual	Current Month Budget	Variance	Y-T-D Actual	Y T D	Budget	Variance	Y-T-D	Actual	Prior Y-T-D Actual	Difference	Variance
1	**In-Patient**												
2	Admissions												
3	Acute	28	40	(12)	66		94	(28)		66	66	-	0%
4	Swing Bed	-	1	(1)	-		2	(2)		-		-	
5	Total	28	41	(13)	66		96	(30)		66	66	-	0%
7	Patient Days:												
8	Acute	71	102	(31)	162		235	(73)		162	190	(28)	-15%
9	Swing Bed	-	3	(3)	-		6	(6)		-		-	
10	Total	71	105	(34)	162		241	(79)		162	190	(28)	-15%
12	Average Daily Census												
13	# Of Days	29	29		60		60			60	59		
14	Acute	2.4	3.5	(1.1)	2.7		3.9	(1.2)		2.7	3.2	(0.5)	-16%
15	Swing Bed	-	0.1	(0.1)	-		0.1	(0.1)		-		-	
16	Total	2.4	3.6	(1.2)	2.7		4.0	(1.3)		2.7	3.2	(0.5)	-16%
18	Length of Stay:												
19	Acute	2.5	2.6	(0.0)	2.5		2.5	(0.0)		2.5	2.9	(0.4)	-15%
20	Swing Bed	-	-	-	-		-	-		-	-	-	0%
21	Total	2.5	2.6	(0.0)	2.5		2.5	(0.1)		2.5	2.9	(0.4)	-15%
23	**Out-Patient**												
24	Out-Patient Visits												
25	E/R Visits	576	465	111	1,166		963	203		1,165	932	234	25%
26	Observ admissions	37	30	7	77		64	13		77	61	16	26%
27	Lab Tests	5,111	1,394	3,717	10,361		2,962	7,399		10,361	2,976	7,385	248%
28	Radiology/CT/MRI Exams	1,371	894	487	2,796		1,864	932		2,793	1,736	1,030	61%
29	OR Cases	86	75	11	168		156	12		168	132	36	27%
40	Clinic Visits	1,987	1,733	254	4,087		3,591	496		4,087	3,880	207	5%
41	Spec. Clinic Visits	149	185	(36)	391		383	8		391	402	(11)	-3%
42	Oncology Clinic Visits	96	64	32	213		131	82		213	163	50	31%
43	Oncology/Infusion Patients	70	57	13	114		116	(2)		114	137	(23)	-17%
	Infusion Patients	39	60	(21)	97		124	(27)		97	146	(49)	-34%
45	EMS Transports	138	77	59	250		169	81		250	169	81	48%
46	Total	8,658	5,024	4,634	19,720		10,513	9,207		19,720	10,419	9,301	89%

Pagosa Springs Medical Center

Cerner/Healthland Accounts Receivable for Hospital by Payer and Days Outstanding -- As of February 29, 2020

	0-30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151-180 Days	181+ Days	Total	Percent of Total	Amt sent to Collections
1 Medicare	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
2 Medicaid	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
3 Third Party	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
4 Self Pay	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Current Month Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%	0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Jan 20	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Dec 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Nov 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Oct 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Sep 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Aug 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Jul 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Jun 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
May 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		0
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Apr 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Mar 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Feb 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Jan 19	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Dec 18	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Nov 18	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		
Oct 18	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]
Pct of Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100%		

Sep-18	$ 1,679,190	$ 1,290,669	$ 1,040,250	$ 1,042,678	$ 794,883	$ 582,876	$ 2,960,669	$ 11,891,479	
Pct of Total	33%	11%	9%	9%	7%	5%	26%	100%	100,575
Aug-18	$ 4,240,896	$ 1,575,042	$ 1,208,428	$ 767,055	$ 676,878	$ 606,354	$ 2,797,919	$ 12,046,072	
Pct of Total	35%	13%	10%	6%	6%	5%	23%	100%	48,619
Jul-18	$ 4,160,618	$ 1,749,111	$ 1,146,454	$ 773,848	$ 736,453	$ 537,580	$ 3,855,767	$ 12,516,675	
Pct of Total	33%	14%	9%	6%	6%	4%	21%	100%	74,956
Jun-18	$ 4,552,947	$ 1,685,671	$ 985,710	$ 649,457	$ 630,055	$ 576,480	$ 3,411,092	$ 13,222,338	
Pct of Total	34%	13%	8%	6%	4%	5%	23%	100%	195,150
May-18	$ 4,159,605	$ 1,766,159	$ 1,308,166	$ 778,965	$ 670,048	$ 495,847	$ 2,069,816	$ 11,058,963	
Pct of Total	38%	16%	12%	7%	6%	4%	18%	100%	47,477
Apr-18	$ 3,097,043	$ 1,602,575	$ 853,079	$ 787,332	$ 586,670	$ 551,742	$ 3,604,094	$ 9,556,124	
Pct of Total	33%	17%	9%	7%	6%	6%	28%	100%	256,717
Mar-18	$ 3,922,516	$ 1,460,791	$ 1,050,793	$ 662,355	$ 459,945	$ 299,068	$ 1,758,366	$ 9,596,969	
Pct of Total	41%	15%	11%	7%	5%	3%	18%	100%	154,770
Feb-18	$ 3,744,379	$ 1,569,822	$ 852,901	$ 495,044	$ 510,765	$ 279,575	$ 1,712,151	$ 9,044,112	
Pct of Total	45%	17%	10%	5%	5%	3%	22%	100%	40,116
Jan-18	$ 3,803,654	$ 1,418,959	$ 468,354	$ 398,631	$ 351,143	$ 254,293	$ 1,376,876	$ 8,073,719	
Pct of Total	47%	18%	7%	5%	5%	3%	20%	100%	33,378
Dec-17	$ 3,539,341	$ 996,668	$ 561,938	$ 594,670	$ 495,671	$ 322,938	$ 1,667,252	$ 8,302,848	
Pct of Total	44%	12%	7%	7%	5%	4%	20%	100%	655,125
Nov-17	$ 3,255,885	$ 1,037,274	$ 635,325	$ 552,510	$ 583,054	$ 475,077	$ 1,964,898	$ 8,266,425	
Pct of Total	39%	15%	6%	7%	7%	5%	24%	100%	39,331
Oct-17	$ 3,659,774	$ 1,367,806	$ 752,698	$ 717,476	$ 567,620	$ 417,224	$ 1,990,353	$ 9,355,058	
Pct of Total	40%	13%	8%	5%	6%	3%	20%	100%	216,114
Sep-17	$ 3,724,932	$ 1,355,198	$ 1,002,854	$ 671,450	$ 445,305	$ 377,607	$ 2,575,437	$ 9,725,747	
Pct of Total	38%	14%	10%	7%	5%	4%	21%	100%	407,406
Aug-17	$ 4,255,656	$ 1,552,374	$ 833,999	$ 434,568	$ 490,321	$ 441,067	$ 3,449,574	$ 10,572,620	
Pct of Total	39%	15%	8%	6%	5%	6%	29%	100%	311,075
Jul-17	$ 4,653,498	$ 1,525,160	$ 953,154	$ 653,748	$ 546,650	$ 503,521	$ 3,298,997	$ 11,055,865	
Pct of Total	42%	14%	9%	6%	5%	5%	21%	100%	265,789
Jun-17	$ 5,255,167	$ 1,590,296	$ 805,730	$ 632,544	$ 667,796	$ 458,049	$ 1,503,625	$ 12,005,563	
Pct of Total	45%	13%	8%	5%	7%	5%	21%	100%	529,721
May-17	$ 3,805,712	$ 1,198,727	$ 1,050,035	$ 770,365	$ 477,935	$ 364,848	$ 1,972,559	$ 9,590,790	
Pct of Total	40%	12%	11%	8%	5%	4%	21%	100%	155,481
Pct Settled (Current)		60.5%	56.7%	19.5%	9.5%	53.4%	469.3%		
Pct Settled (Jan from Dec)		66.9%	45.4%	37.4%	15.5%	28.6%	282.1%		
Pct Settled (Dec from Nov)		70.3%	16.8%	0.3%	13.7%	83.5%	508.2%		
Pct Settled (Nov from Oct)		48.4%	44.5%	16.9%	51.9%	33.2%	-406.1%		
Pct Settled (Oct from Sept)		71.7%	36.4%	26.0%	58.6%	24.1%	-650.2%		

Pagosa Springs Medical Center

Pagosa Springs Medical Center - - - Net Days In A/R 2020

	31	28	31	30	31	30
	Jan-20	Feb-20	Mar-19	Apr-19	May-19	Jun-19
Net Accounts Receivable	$ 4,660,869	$ 4,774,890	$ 4,992,507	$ 4,763,770	$ 4,371,767	$ 4,645,356
Net Patient Revenue	$ 2,693,591	$ 2,774,828	$ 2,601,105	$ 2,697,839	$ 2,523,644	$ 2,703,510
Net Patient Rev/Day (2 month Avg)	$ 86,399	$ 91,287	$ 77,105	$ 90,251	$ 89,001	$ 85,762
Net Days in A/R	54	52	65	53	49	54

	31	31	30	31	30	31
	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Net Accounts Receivable	$ 4,939,510	$ 4,721,499	$ 4,742,984	$ 3,614,699	$ 4,367,929	$ 4,580,312
Net Patient Revenue	$ 3,009,707	$ 3,018,228	$ 2,409,652	$ 2,899,313	$ 2,650,917	$ 2,663,157
Net Patient Rev/Day (2 month Avg)	$ 93,607	$ 97,275	$ 88,842	$ 86,921	$ 90,947	$ 87,136
Net Days in A/R	53	49	53	42	48	53

Pagosa Springs Medical Center - - - Gross Days Target

Medicare	33%	21	$ 91,140	$ 631,601
Medicaid	7%	35	$ 91,140	$ 223,293
Blue Cross	15%	48	$ 91,140	$ 656,209
Commercial	26%	65	$ 91,140	$ 1,540,769
Self Pay	19%	150	$ 91,140	$ 2,597,494
Total:	100%			$ 5,648,866
				$ 91,140
		Gross Days in A/R Target		62

Pagosa Springs Medical Center
Financial Forecast
Statement of Cash Flows

Cash Flows from operating activities	**February 2020**
Change in net assets	130,312
Adjustments to reconcile net assets to net cash	
Depreciation and amortization	148,653
Patient accounts receivable	(269,273)
Accounts payable and wages payable	6,893
Accrued liabilities	217,101
Pre-paid assets	(20,760)
Deferred revenues	-
Other receivables	62,624
Reserve for third party settlement	(27,170)
Inventory	(1,390)
Net Cash Provided by (used in) operating activities	237,564
Cash Flows from investing activities	
Purchase of property and equipment	(50,000)
Work in progress	(2,769)
Proceeds from sale of equipment/(Loss)	-
Net Cash Provided by (used in) investing activities	(51,770)
Cash Flows from financing activities	
Principal payments on long term debt	-
Proceeds from debt	-
Change in Prior Year Net Assets	-
Change in lease payable	(18,224)
Net Cash Provided by (used in) financing activities	(18,224)
Net Increase(Decrease) in Cash	167,570
Cash Beginning of Month	5,320,916
Cash End of Month	5,484,893

Pagosa Springs Medical Center
Revenue and Usage by Financial Class
February 29, 2020

Financial Class	Inpatient MTD	Outpatient MTD	Total MTD	% MTD	
Auto/Liability Insurance	-	23,479.70	23,479.70	0.43%	Commercial
Blue Cross	65,711.60	639,662.27	705,373.87	12.86%	Commercial
Champus	-	30,373.20	30,373.20	0.55%	Champus
Commercial Insurance	216,562.20	631,114.03	847,676.23	15.45%	Commercial
Medicaid	72,177.50	1,002,513.84	1,074,691.34	19.59%	Medicaid
Medicare	763,156.22	1,309,961.68	2,073,117.90	37.79%	Medicare
Medicare HMO	99,292.30	337,245.98	436,538.28	7.96%	Managed Care
Self Pay	-	140,639.10	140,639.10	2.56%	Self Pay
Self Pay - Client Billing	-	4,680.20	4,680.20	0.09%	Self Pay
Veterans Administration	50,181.50	179,243.90	229,425.40	4.18%	Other
Workers Compensation	-	50,139.37	50,139.37	0.91%	Other
Total	**637,081.32**	**4,849,053.27**	**5,486,134.59**	**100.00%**	

Financial Class	Inpatient YTD	Outpatient YTD	Total YTD	% YTD	12/31/19 % YTD	12/31/18 % YTD	12/31/17 % YTD	12/31/16 % YTD
Auto/Liability Insurance	11,098.70	86,963.80	97,591.50	0.91%	1.15%	1.06%	1.24%	1.11%
Blue Cross	93,051.60	1,170,840.17	1,263,891.97	11.73%	15.40%	15.42%	15.60%	15.83%
Champus	-	83,771.80	83,771.80	0.78%	0.32%	0.68%	0.07%	0.19%
Commercial Insurance	186,548.50	1,124,648.90	1,311,197.40	12.16%	13.34%	13.08%	11.79%	13.08%
Medicaid	171,328.80	2,026,194.06	2,197,522.86	20.39%	18.75%	18.22%	20.78%	21.56%
Medicare	435,265.12	3,739,446.79	4,174,711.91	38.54%	36.95%	35.75%	35.27%	35.98%
Medicare HMO	127,892.40	608,739.49	736,631.89	6.83%	7.78%	4.67%	3.55%	2.76%
Self Pay	17,944.60	290,998.00	308,942.60	2.87%	4.40%	5.40%	6.56%	5.26%
Self Pay - Client Billing	-	15,718.00	15,718.00	0.15%	0.18%	0.18%	0.19%	0.17%
Veterans Administration	105,909.30	359,945.70	465,854.00	4.32%	2.74%	4.13%	3.58%	2.74%
Workers Compensation	-	343,365.57	343,365.57	3.33%	1.52%	1.22%	1.17%	1.37%
Total	**1,128,965.72**	**9,649,914.78**	**10,778,880.50**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**99.97%**
Blank								0.00%
HMO (Health Maint Org)								0.03%
Total					100.00%	100.00%	100.00%	100.00%

Pagosa Springs Medical Center
Cash Forecast as of end of February 2020
Forecast Months Based on Budget and Actual

ORAL REPORTS 4.a.vi.

Prepared 2/20/2020
Cash balance at 12/31/19 5,772,109

	(1) Patient Collections	(2) Tax Revenues	(3) Provider Fees	(4) Grants & Donations	(5) Other	(6) Other Expen. New Debt/ Leases	Total Collections	(7) Operating Expenses	(8) Capital	(9) Medicare/ Medicaid Repayment	(10) Bond & Lease Interest & Principal Payments	(11) Other	Total Cash Spending	Balance
January 2020 (Actual)	2,457,183	9,379	247,251	-	187,259	-	2,911,079	2,824,694	-	113,140	-	413,249	3,350,783	5,326,915
February 2020 (Actual)	2,257,037	83,530	246,157	7,069	123,670	-	2,771,594	2,615,749	75,934	95,419	-	(233,177)	2,550,014	5,486,891
March 2020 (Budget)	2,650,064	314,472	174,598	400,000	233,155	-	3,533,139	3,049,553	400,000	50,000	-	(350,000)	3,149,553	5,877,479
April 2020 (Budget)	2,208,293	150,666	167,376	250,000	241,218	-	3,077,553	2,970,803	500,000	50,000	-	(350,000)	3,170,803	5,784,229
May 2020 (Budget)	2,387,563	233,960	264,586	215,000	247,127	-	3,341,840	3,030,649	477,000	50,000	-	(350,000)	3,557,649	5,975,420
June 2020 (Budget)	2,337,876	176,082	264,684	250,000	252,494	-	3,176,972	2,992,717	400,000	50,000	1,540,000	(350,000)	4,232,212	4,972,130
July 2020 (Budget)	2,785,429	165,059	300,685	-	215,630	-	3,476,453	3,158,617	-	50,000	-	(350,000)	2,858,617	5,508,926
August 2020 (Budget)	2,613,039	46,375	325,655	125,000	235,227	-	3,355,386	3,172,938	125,000	50,000	-	(350,000)	2,997,938	5,847,374
September 2020 (Budget)	2,072,915	20,794	300,476	-	256,736	-	2,650,921	3,051,238	-	50,000	-	(350,000)	2,765,238	5,693,067
October 2020 (Budget)	2,393,061	111,625	265,182	-	198,345	-	2,953,703	3,163,677	-	50,000	-	(350,000)	2,863,677	5,792,583
November 2020 (Budget)	2,278,477	15,938	253,828	-	219,452	-	2,758,736	3,070,499	-	50,000	-	(350,000)	2,770,499	5,780,820
December 2020 (Budget)	2,596,078	29,453	254,789	-	95,033	-	3,175,511	3,394,577	-	50,000	475,000	(350,000)	3,569,577	5,346,815
Totals	29,420,979	1,315,688	3,056,850	906,059	2,422,173	-	37,205,047	36,257,376 981,635	1,922,934	703,579	2,015,000	(3,314,878)	37,279,006	5,346,815

	at 12/31/20
Bond Requirements (90 days cash)	6,378,793
Bond Requirements (60 days cash)	5,467,537

Notes:
(1) Forecast based on projected revenue.
(2) Forecast is based on the actual percentages from prior year.
(3) Based on current payment from Colorado Health and Hospitals
(4) Forecast is based on budget adjusted by YTD actual
(5) Forecast is based on budget adjusted by YTD actual
(6) Forecast new loans and equipment for capital purchases.
(7) Forecast is based on budget excluding depreciation.
(8) Assumes forecast capital expenditures of 2,000,000
(9) Medicare Cost Report Settlement for 2018 and 2019 and Medicaid for 2018 and 2019
Most of the estimated settlement dates are placeholders only, Medicare and Medicaid operate on their own schedule.
(10) Forecast based on bond principal and interest payments.
(11) Other balance sheet changes i.e., changes in accounts payable, receivables, etc

2020				
Month	Cash Goal	Actual Cash	Variance	% Collected
20-Jan	$2,440,100.00	$2,467,181.00	$27,081.00	101.11%
20-Feb	$2,349,634.00	$2,257,097.00	($92,537.00)	96.06%
20-Mar				
20-Apr				
20-May				
20-Jun				
20-Jul				
20-Aug				
20-Sep				
20-Oct				
20-Nov				
20-Dec				
Totals YTD	$4,789,734.00	$4,724,278.00	($65,456.00)	98.63%

Finance Committee & CFO Report for the
USJHSD Board Meeting on March 17, 2020

This report provides a summary of the discussions of the Board's Finance Committee that met, via phone, on March 17, 2020.

1) **Review of February 2020 Financials:** The Board Finance Committee reviewed the February 2020 Financials, the CFO's slide presentation, and check expenditures. The Finance Committee raised no concerns.

2) **Overview of February 2020 Income Statement**:
   a) February gross revenue exceeded budget by 21%, and even after deductions (for payer contractual allowances, charity, bad debt and the Medicaid provider fee) net patient revenues exceeded budget by 26%.
   b) PSMC's February expenses were 2% over budget.
   c) PSMC's February net income exceeded budget by 249% and with year-to-date net income exceeded budget by 126%.
   d) *February was an excellent income month for PSMC (its best February ever). All of this is good because like most businesses, the pandemic presents new financial challenges for PSMC.*

3) **Cash and collections**:
   a) Patient collections were $2,257,097 MM for the month, 92.5K less than forecasted.
   b) As of the end of February, PSMC is at 62.8 days of gross A/R (53.4 net days of A/R); and PSMC's gross accounts receivable balance is $11,273,737.
   c) All payables are current and cash increased to 50 days cash on hand.

4) **Progress Report Re Plan to Increase Days of Cash:** PSMC presented and discussed in-depth with the Finance Committee the progress on the plan to increase days of cash.

5) Audit: The auditor is proceeding with the audit as a "tele-audit."

6) **Actions and/or recommendations of the Finance Committee:**
   a) Accept the February 2020 financials.
   b) At the request of Finance Committee, a March presentation of service line analysis for an existing service has been tabled due to COVID-19.

THE UPPER SAN JUAN HEALTH SERVICE DISTRICT
DOING BUSINESS AS PAGOSA SPRINGS MEDICAL CENTER

MEDICAL STAFF REPORT BY CHIEF OF STAFF, RALPH BATTELS
March 24, 2020

I. STATEMENT OF THE MEDICAL STAFF'S RECOMMENDATIONS FOR THE USJHSD BOARD ACCEPTANCE OF NEW POLICIES OR PROCEDURES ADOPTED BY THE MEDICAL STAFF:

RECOMMENDATION	DESCRIPTION
Waiver of Board Certification Requirement for Dr. Dennis Phelps	For upcoming reappointment in April; this waiver process is a requirement of the Medical Staff Bylaws.

~~II. STATEMENT OF THE MEDICAL STAFF'S RECOMMENDATIONS FOR THE USJHSD BOARD ACCEPTANCE OF PROVIDER PRIVILEGES (ACCEPTANCE BY THE BOARD RESULTS IN THE GRANT OF PRIVILEGES):~~

III. REPORT OF NUMBER OF PROVIDERS BY CATEGORY
Active: 19
Courtesy: 22
Telemedicine: 120
Allied Health Professionals: 26
Honorary: 1
Total: 188

UPPER SAN JUAN HEALTH SERVICE DISTRICT
d/b/a PAGOSA SPRINGS MEDICAL CENTER
ARCHULETA COUNTY AND PORTIONS OF MINERAL AND HINSDALE COUNTIES, COLORADO

BOARD CONSENT TO AND CONTINUATION OF DECLARATION OF LOCAL DISASTER EMERGENCY

RESOLUTION 2020-07

WHEREAS, pursuant to Colorado Revised Statutes ("C.R.S.") Sections 32-1-1001-1007, the District has all rights and powers necessary or incidental to or implied from the specific powers granted to special districts pursuant to Title 32, Article 1; and

WHEREAS, Colorado Revised Statutes ("C.R.S.") Section 24-33.5-709 provides that the principal executive officer of a political subdivision, in this case, the Chief Executive Officer of the Upper San Juan Health Service District, a Colorado governmental special district that does business under the trade name Pagosa Springs Medical Center ("USJHSD"), is authorized to declare a local disaster; and

WHEREAS, pursuant to C.R.S. § 24-33.5-709, the local disaster declaration issued by the principal executive officer shall not be continued or renewed for a period in excess of seven (7) days *except* by the USJHSD Board of Directors ("Board") as the governing board of the political subdivision; and

WHEREAS, COVID-19 is a highly contagious virus that originated in China and has since spread to many countries around the world, including the United States; and

WHEREAS, there is significant consensus that COVID-19 results in a world-wide pandemic and local disaster emergency as evidenced by the following:

- On January 30, 2020, the World Health Organization declared the worldwide outbreak of COVID-19 a "public health emergency of international concern";
- On January 31, 2020, the United States Department of Health and Human Services declared the virus a public health emergency;
- On February 26, 2020, the CEO of USJHSD activated USJHSD's emergency operations plan for a pandemic;
- On March 11, 2020, the World Health Organization declared COVID-19 to be a global pandemic;
- On March 11, 2020, the Governor of Colorado issued an Executive Order declaring Colorado a state of disaster emergency due to the presence of COVID-19 in Colorado;
- On March 12, 2020, the CEO of USJHSD activated its Incident Command as part of its emergency operations plan to prepare and respond to the pandemic;

- On March 13, 2020 the President of the United States issued a Proclamation that the "COVID-19 outbreak constitutes a national emergency";

- On March 16, 2020, the Executive Director of San Juan Basin Public Health, the public health district for Archuleta and La Plata counties, declared a local disaster emergency for its entire district for a period up to seven days, and on March 17, 2020 the Board of Public Health for the San Juan Basin Public Health consented to the continuation of the declaration of local disaster emergency for so long as is necessary to address the COVID-19 pandemic as determined by its Executive Director or Board;

- On March 16, 2020, the Mayor of the Town of Pagosa Springs declared a local disaster emergency for a period of up to seven days and on March 19, 2020, the Town Council consented to a continuation of the declaration of local disaster emergency;

- On March 16, 2020, the County Administrator of Archuleta County declared a local disaster emergency and on March 17, 2020, the Board of County Commissioners extended its declaration of local disaster emergency through April 21, 2020;

- During the week of March 16, 2020, the Southern Ute Indian Tribe ceased nonessential tribal governmental operations due to COVID-19.

WHEREAS, as of March 23, 2020, the Colorado Department of Public Health and Environment (CDPHE) has confirmed 591 cases of COVID-19 within the State of Colorado and public health experts anticipate that, due to the contagiousness of the illness and the fact that numerous travelers from around the world visit the USJHSD, the USJHSD residents are at significant risk of spread of COVID-19; and

WHEREAS, there must be emergency efforts to: (i) flatten the pandemic curve so as not to exhaust the USJHSD's hospital and EMS resources beyond its capacity to care for the residents of USJHSD; and (ii) to be as prepared as possible for a surge of COVID-19 cases in the USJHSD and such surge presents substantial risk of serious illness or death for certain members of the community and for the functioning of the USJHSD and the community; and

WHEREAS, the COVID-19 pandemic presents an imminent threat to the health and wellbeing of the USJHSD residents and visitors, requiring the USJHSD to take emergency action to avert the spread of COVID-19 and deaths; and

WHEREAS, the cost and magnitude of responding to and recovery from the impact of COVID-19 is far in excess of the USJHSD's available resources;

WHEREAS, pursuant to C.R.S. § 24-33.5-709 the effect of a declaration "is to activate the response and recovery aspects of any and all applicable local and interjurisdictional disaster emergency plans and to authorize the furnishing of aid and assistance under such plans"; and

WHEREAS, the CEO of USJHSD has declared a Local Disaster Emergency for a period not to exceed seven days; further, the CEO recommends to the USJHSD Board of Directors to consent to and continue and expand the Declaration of Local Disaster Emergency, until such future time, as determined by the Board of Directors as advised by the CEO, in order to minimize the spread of COVID-19 and the resulting illnesses/death.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Upper San Juan Health Service District does hereby consent to:

1. Consent to the continuation of the Declaration of Local Disaster Emergency until such future time, as subsequently determined by the Board of Directors upon the advice of the CEO; and, the effect of such Declaration activates the response and recovery aspects of any and all applicable local and interjurisdictional disaster emergency plans and to authorize the furnishing of aid and assistance under such plans. And,
2. The Chief Executive Officer shall, as deemed reasonably necessary, be authorized to take actions to address the COVID-19 pandemic including, without limitation, the following:
    a. Prioritize the USJHSD's resources and efforts to protect the health, safety and welfare of the residents and visitors of the USJHSD while ensuring the safety of patients and personnel.
    b. Discontinue or suspend services as necessary to address the COVID-19 pandemic.
    c. Implement policies and practices for employee and public contact consistent with the delivery of services as balanced with the intent and advice of the federal government, State of Colorado government and orders, San Juan Basin Public Health orders and advisories, epidemiology data, and/or other relevant advisories (e.g., the American Medical Association, medical societies, the Colorado Hospital Association, etc.).
    d. Take such personnel actions as necessary to carry out the USJHSD's priority of hospital and emergency services, including but not limited to establishing wellness for work, assigning personnel to work from home, reassigning personnel, placing a freeze on hiring, and conducting lay-offs of personnel; denying, or revoking previously approved leave requests; requiring reasonable documentation for extended sick leave requests, including COVID-19 testing, if appropriate; and placing on leave or in quarantine or isolation any employee reasonably believed to have been exposed to or exhibiting symptoms consistent with infection from the COVID-19 virus.
    e. Make purchases or suspend such procurement to address the COVID-19 pandemic and report on the same to the Board's Finance Committee and to the Board at its next regular meeting of the Board or special meeting of the Board if deemed necessary by the CEO and/or the Board Finance Committee.
    f. Apply for and accept any available local, state or federal assistance and reporting the same to the Board's Executive Committee and to the Board at its next regular meeting.
    g. In consultation with the Board Chair and USJHSD's legal counsel, arrange for meetings of the Board of Directors to be held via telephone, video conference, or other electronic means, in a manner which as fully as possible given the emergency situation complies with the Colorado Open Meetings Law as well as Orders of the State of Colorado (e.g., to limit any meeting to no greater than ten persons and employ social distancing of six feet).
    h. Take such other actions as reasonably necessary to carry out this declaration and ensure the reliability of the USJHSD's services, while ensuring the safety of the USJHSD's patients and personnel.

Effective and approved this ___ day of March, 2020.

UPPER SAN JUAN HEALTH SERVICE DISTRICT

_____
Greg Schulte, its Board Chair

UPPER SAN JUAN HEALTH SERVICE DISTRICT
d/b/a PAGOSA SPRINGS MEDICAL CENTER
ARCHULETA COUNTY AND PORTIONS OF MINERAL AND HINSDALE COUNTIES, COLORADO

CEO DECLARATION OF LOCAL DISASTER EMERGENCY

WHEREAS, pursuant to Colorado Revised Statutes ("C.R.S.") Sections 32-1-1001-1007, the District has all rights and powers necessary or incidental to or implied from the specific powers granted to special districts pursuant to Title 32, Article 1; and

WHEREAS, Colorado Revised Statutes ("C.R.S.") Section 24-33.5-709 provides that the principal executive officer of a political subdivision, in this case, the Chief Executive Officer of the Upper San Juan Health Service District, a Colorado governmental special district that does business under the trade name Pagosa Springs Medical Center ("USJHSD"), is authorized to declare a local disaster; and

WHEREAS, pursuant to C.R.S. § 24-33.5-709, the local disaster declaration issued by the principal executive officer shall not be continued or renewed for a period in excess of seven (7) days except by the USJHSD Board of Directors ("Board") as the governing board of the political subdivision; and

WHEREAS, COVID-19 is a highly contagious virus that originated in China and has since spread to many countries around the world, including the United States; and

WHEREAS, there is significant consensus that COVID-19 results in a world-wide pandemic and local disaster emergency as evidenced by the following:

- On January 30, 2020, the World Health Organization declared the worldwide outbreak of COVID-19 a "public health emergency of international concern";
- On January 31, 2020, the United States Department of Health and Human Services declared the virus a public health emergency;
- On February 26, 2020, the CEO of USJHSD activated USJHSD's emergency operations plan for a pandemic;
- On March 11, 2020, the World Health Organization declared COVID-19 to be a global pandemic;
- On March 11, 2020, the Governor of Colorado issued an Executive Order declaring Colorado a state of disaster emergency due to the presence of COVID-19 in Colorado;
- On March 12, 2020, the CEO of USJHSD activated its Incident Command as part of its emergency operations plan to prepare and respond to the pandemic;
- On March 13, 2020 the President of the United States issued a Proclamation that the "COVID-19 outbreak constitutes a national emergency";

- On March 16, 2020, the Executive Director of San Juan Basin Public Health, the public health district for Archuleta and La Plata counties, declared a local disaster emergency for its entire district for a period up to seven days, and on March 17, 2020 the Board of Public Health for the San Juan Basin Public Health consented to the continuation of the declaration of local disaster emergency for so long as is necessary to address the COVID-19 pandemic as determined by its Executive Director or Board;

- On March 16, 2020, the Mayor of the Town of Pagosa Springs declared a local disaster emergency for a period of up to seven days and on March 19, 2020, the Town Council consented to a continuation of the declaration of local disaster emergency;

- On March 16, 2020, the County Administrator of Archuleta County declared a local disaster emergency and on March 17, 2020, the Board of County Commissioners extended its declaration of local disaster emergency through April 21, 2020;

- During the week of March 16, 2020, the Southern Ute Indian Tribe ceased nonessential tribal governmental operations due to COVID-19.

WHEREAS, as of March 18, 2020, the Colorado Department of Public Health and Environment (CDPHE) has confirmed 216 cases of COVID-19 within the State of Colorado and public health experts anticipate that, due to the contagiousness of the illness and the fact that numerous travelers from around the world visit the USJHSD, the USJHSD residents are at significant risk of COVID-19 spread; and

WHEREAS, there must be emergency efforts to: (i) flatten the pandemic curve so as not to exhaust the USJHSD's hospital and EMS resources beyond its capacity to care for the residents of USJHSD; and (ii) to be as prepared as possible for a surge of COVID-19 cases in the USJHSD and such surge presents substantial risk of serious illness or death for certain members of the community and for the functioning of the USJHSD and the community; and

WHEREAS, the COVID-19 pandemic presents an imminent threat to the health and wellbeing of the USJHSD residents and visitors, requiring the USJHSD to take emergency action to avert the spread of COVID-19 and deaths; and

WHEREAS, the cost and magnitude of responding to and recovery from the impact of COVID-19 is far in excess of the USJHSD's available resources;

WHEREAS, pursuant to C.R.S. § 24-33.5-709 the effect of a declaration "is to activate the response and recovery aspects of any and all applicable local and inter-jurisdictional disaster emergency plans and to authorize the furnishing of aid and assistance under such plans";

NOW, THEREFORE, BE IT DECLARED: Pursuant to the provisions of C.R.S. Section 24-33.5-709 and any other applicable legal authority I, Rhonda P. Webb, M.D., the chief executive officer for the Upper San Juan Health Service District, on behalf of the District, do hereby declare a local disaster within the District due to the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property, resulting from the following condition or situation: COVID-19 pandemic. The purpose of this declaration of a local disaster emergency is to activate the response and recovery aspects of any and all applicable local and

inter-jurisdictional disaster emergency plans, emergency funding and Board meeting procedures, and to authorize the furnishing of aid and assistance under such plans. This declaration shall be valid for a period not to exceed seven (7) days, unless continued or expanded by the Board of Directors of the Upper San Juan Health Service District.

Dated this 18th day of March, 2020.

Rhonda P. Webb, M.D., as the CEO/CMO for the
Upper San Juan Health Service District
which does business as the Pagosa Springs Medical Center

UPPER SAN JUAN HEALTH SERVICES DISTRICT D/B/A PAGOSA SPRINGS MEDICAL CENTER
Formal Written Resolution 2020-08 on March 24, 2020

WHEREAS, the Board of Directors of the Upper San Juan Health Service District will consider to approve or deny proposed amendments to the Medical Staff Bylaws (as such amendments are shown on the attached redline) with the understanding that the following process has been followed:

STEP 1 –AMENDMENTS MAY BE PROPOSED BY THE MEDICAL EXECUTIVE COMMITTEE ("MEC") OR 33% OF THE ELIGIBLE MEDICAL STAFF:

a. The MEC proposed amendments of the Medical Staff Bylaws by unanimous vote on November 18, 2019 and again on January 16, 2020.

2. STEP 2 – THE BOARD HAS AN OPPORTUNITY TO COMMENT ON THE PROPOSED AMENDMENTS PRIOR TO A VOTE OF THE ELIGIBLE MEDICAL STAFF:
   a. The Board received the proposed amendments to the Medical Staff Bylaws on 1/20/2020 and had opportunity to comment on the proposed amendments from 1/20/2020 through 2/25/2020.
   b. On 2/17/2020, the MEC had received comments from Board Director Dr. Pruitt and in response the MEC unanimously voted to make two proposed amendment clarifications to address part of his comments.
   c. On 2/25/2020, the Board of Directors met at its regular board meeting and each Director provided its comments to the proposed amendments. All Director comments were compiled by the Medical Staff Office manager. On 2/26/2020 at 8:30 a.m., the MEC met and unanimously voted to propose amendments to clarify the amendment process to address comments of Board members Schulte and Cox.

3. STEP 3 – VOTE OF ACTIVE MEDICAL STAFF:
   a. On 2/26/2020, the Medical Staff Office issued 7 days advance notice to every eligible voting Medical Staff member with the following: the proposed amendments to the Bylaws, the document setting forth all Board member comments, MEC comments, and the voting time period.
   b. From 3/4/2020 through 3/18/2020: all eligible voting Medical Staff had the opportunity to vote on the proposed amendments.
   c. On 3/19/2020, the Medical Staff Office Manager affirmed that the eligible voting Medical Staff passed, by a majority vote, the proposed amendments to the Medical Staff Bylaws.

4. STEP 4 – IF PASSED BY MEDICAL STAFF, VOTE OF THE BOARD OF DIRECTORS:
   a. 3/24/2020: At the regular meeting of the Board of Directors, the Board will consider whether to approve or deny the proposed amendments.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE UPPER SAN JUAN HEALTH SERVICE DISTRICT HEREBY RESOLVES to approve the proposed amendments to the Medical Staff Bylaws (in the redline form attached hereto).

_____ _____

Greg Schulte, Chairman of the USJHSD Board Date

From: Krista Starr <Krista.Starr@PSMedicalCenter.org>
Date: Thursday, March 19, 2020 at 3:50 PM
To: [PSMC Active Medical Staff]
Cc: Ann Bruzzese <Ann.Bruzzese@PSMedicalCenter.org>, Rhonda Webb <Rhonda.Webb@PSMedicalCenter.org>, Davienne Fiorenza <Davienne.Fiorenza@PSMedicalCenter.org>
Subject: Notification of Vote Result for Proposed Amendments to the PSMC Medical Staff Bylaws

Hello Everyone,

As promised, this email is to notify you that the Proposed Amendments to the PSMC Medical Staff Bylaws has passed by a majority vote of the Active Medical Staff.

The next step is for the Board of Directors to vote on the amendments.

After that is completed, another update will go out to you.

Take care and Be Well!

Krista

Krista Starr | Medical Staff Office & Credentialing Manager

Medical Staff Office
95 South Pagosa Blvd. | Pagosa Springs, CO 81147
Medical Staff Office phone: (970) 731-3700 x3748

Direct phone: (970) 507-3818

Fax: (970) 731-2226

krista.starr@psmedicalcenter.org

pagosaspringsmedicalcenter.org

From: Krista Starr <Krista.Starr@PSMedicalCenter.org>
Date: Wednesday, March 4, 2020 at 9:24 AM
To: [PSMC Active Medical Staff]
Cc: Ann Bruzzese <Ann.Bruzzese@PSMedicalCenter.org>, Rhonda Webb <Rhonda.Webb@PSMedicalCenter.org>
Subject: PSMC Amended Medical Staff Bylaws Vote: Ballot Enclosed, Due by 3/18/2020

To: All Active Medical Staff
Re: Amended Medical Staff Bylaws Vote: Ballot Enclosed

THIS BALLOT MUST BE RETURNED BY EMAIL TO KRISTA STARR BY END OF DAY, WEDNESDAY, MARCH 18th, 2020.

Pursuant to the Pagosa Springs Medical Center Medical Staff Bylaws, Article 16, the Medical Executive Committee has proposed the attached amendments to the Medical Staff Bylaws. Notification of this impending vote was sent to you via email on February 26th, 2020. The attached amended bylaws were unanimously approved by the Medical Executive Committee to be put forward to the Active Medical Staff.

Please vote by: 1: Replying to this email and 2: **Placing an "x" in either the "Yes" or "No"** box and then send to me with your selection made. Your vote will be retained as confidential.

YES: I vote TO APPROVE all of the proposed amendments to the Medical Staff Bylaws.
☐

NO: I vote TO NOT APPROVE all of the proposed amendments to the Medical Staff Bylaws.
☐

Votes will be counted at the end of 15 days (last day to vote is Wednesday, March 18th) and results will be emailed out. If the majority of the voting Medical Staff votes to approve the amended bylaws, they will then be sent to the Board of Directors for their vote. If the majority of the voting Medical Staff votes to not approve the amended bylaws, they will not be sent to the Board of Directors.

Thank you for your vote!
Krista

Krista Starr | Medical Staff Office & Credentialing Manager

Medical Staff Office
95 South Pagosa Blvd. | Pagosa Springs, CO 81147
Medical Staff Office phone: (970) 731-3700 x3748
Direct phone: (970) 507-3818 | Fax: (970) 731-2226
krista.starr@psmedicalcenter.org
pagosaspringsmedicalcenter.org

From: Krista Starr <Krista.Starr@PSMedicalCenter.org>
Date: Wednesday, February 26, 2020 at 1:40 PM
To: [PSMC Active Medical Staff]
Cc: Ann Bruzzese <Ann.Bruzzese@PSMedicalCenter.org>, Rhonda Webb <Rhonda.Webb@PSMedicalCenter.org>
Subject: Notification of Proposed Amendments to the PSMC Medical Staff Bylaws

To: All Active Medical Staff

Re: Notification of Proposed Amendments to the PSMC Medical Staff Bylaws

Please note: This is NOT a ballot, it is a notification only, a ballot will be issued to Active Medical Staff on Wednesday, March 4th.

Pursuant to the Pagosa Springs Medical Center Medical Staff Bylaws, Article 16, the Medical Executive Committee has proposed the attached amendments to the Medical Staff Bylaws. The attached amended bylaws were unanimously approved by the Medical Executive Committee to be put forward to the Active Medical Staff.

Also pursuant to Article 16, the Board of Directors has had the opportunity to provide comments which are to be distributed with the proposed amendments to the bylaws. The Medical Executive Committee has provided responses to the Board of Directors comments.

Attached are the following documents:

- 2020.02.26 REDLINE REV 16 PSMC Med Staff Bylaws: A redline version of the Medical Staff Bylaws with proposed amendments.
- 2020.02.25 Board member comments Re the Bylaws
- 2020.02.26 MEC report re Bylaws and response to Dr. Pruitt

If you would like to receive a copy of the Med Exec Committee's Summary of proposed amendments to the bylaws, please let me know and I will send that to you as well.

Again, this is not a ballot, but a notification of the proposed amendments. A ballot, where you may vote for or against the attached revised bylaws, will be sent out on March 4th and there will be a 15 day voting period starting on that date.

Please contact myself, Dr. Ralph Battels, or Ann Bruzzese with any questions.

Thank you,

Krista
Krista Starr | Medical Staff Office & Credentialing Manager

Medical Staff Office
95 South Pagosa Blvd. | Pagosa Springs, CO 81147
Medical Staff Office phone: (970) 731-3700 x3748

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PAGOSA SPRINGS
Medical Center
THE CARE YOU DESERVE, IN THE MOUNTAINS YOU LOVE

TO: ELIGIBLE ACTIVE (VOTING) MEDICAL STAFF
FROM: MEDICAL STAFF MANAGER, KRISTA STARR
DATE: 02/26/2020
RE: COMMENTS OF BOARD MEMBERS REGARDING THE PROPOSED AMENDMENTS

- Chair Greg Schulte:
  - I have no comments on the proposed Bylaws except to please clarify the amendment process in Article 16 to avoid future confusion.
- Vice-Chair Matt Mees:
  - I would like to state that I have no issues with the med executive committee's proposed bylaw changes as viewed on February 21, 2020.
- Treas. King Campbell:
  - I have no comments on the proposed Bylaws.
- Director Kate Alfred:
  - I have no comments on the proposed Bylaws.
- Director Karin Daniels:
  - I have no comments on the proposed Bylaws.
- Director Jason Cox:
  - I have no comments on the proposed Bylaws except to please clarify the amendment process in Article 16 to avoid future confusion.
- Director Dr. Jim Pruitt:
  - A full list of Dr. Pruitt's written comments are set forth in his email dated 02/12/2020(attached). Other than the comments made in the attached email Director Pruitt raised concern that amendments proposed by the MEC should allow for a comment period by Medical Staff.

Chief of staff and MEC Feb. 12, 2020
re; pending bylaw changes

Dear Dr. Battels and members of the MEC,

The proposed modifications of the current Med Staff Bylaws were submitted to the BOD at the Jan. 2020 BOD meeting with instructions to submit comments by Feb. 25th. The following are my comments.

1. As per current bylaws any changes proposed by staff are to be submitted by petition of at least 1/3 of active staff to the MEC one month prior to submission of proposed changes to the BOD 16.1-3. A number of current staff members were unaware of the submission date to the board and thus have not had opportunity to submit by petition any desired changes to the current bylaws to the MEC one month prior to submission to the board.

2. Changes to criteria for active staff status includes providing services in the hospital 700 or more hours per year. This effectively eliminates anyone except employees from active staff status thus creating a closed active staff consisting of employed providers. Why not leave 2.2-2f in place. This affords providers in the community the option of active staff status.

3. Why was the indemnification clause deleted?

4. 15.1-2 How new policies are proposed is redlined and to my reading is not replaced. Current bylaws allow staff committees, departments, med star officers, and petition by med staff to submit proposed policy changes. Bylaw amendments are addressed in 16.1-3 with the addition of administration's ability to propose amendments and policies. Again 16.1-3 addresses timely submission by staff to MEC prior to submission of bylaw changes by MEC to the BOD. My concerns are lack of process in staff notification of timeline for submission of bylaw changes and what appears to be the elimination of Med staff's ability to submit proposed changes to policy replaced by administration's ability to recommend med staff policy changes.

5. The following items are not redlined but constitute a number of concerns.
   A. Lack of inclusion of community members in continuing education program
   B. 2.4-2a Loss of staff status/privileges upon termination of employment or contract. This issue is addressed in contract form with individual providers and does not need ratification in the bylaws. It also places an undue burden on providers to reapply for staff privileges should they elect to terminate an employment contract and still desire to maintain their status on the medical staff in order to offer continued care for their patients in the PSMC facility.
   C. 4.4-1 Pre-Application, the criteria for administration(CEO, CMO, COS) to consider when evaluating a pre-app should include additional criteria especially 1. Whether the provider is currently providing services in our community for community members. 2. Whether the provider is providing services for community members outside of the community that the provider

would provide for those community members in PSMC facilities.

3. Consider elimination of the pre-app and allow MEC to consider all Med Staff applications.

D. 4.4-4 Replace PSMC's needs with "the community needs".

Sincerely,

James C. Pruitt, MD
Current member of the active staff PSMC
Current member of the BOD PSMC

cc: current members of the Med Staff PSMC
current members of the BOD

TO: Board of Directors
FROM: Chief of Staff Ralph Battels for the Medical Executive Committee
RE: Proposed Amendments to Medical Staff Bylaws
DATE: 2/26/2020

The Medical Executive Committee (the MEC) is comprised of the following seven physician positions: the Chief of Staff, the Vice Chief of Staff, the Medical Directors of the E.D., In-patient, Surgery, Trauma, and Primary Care. As permitted by the Bylaws (first sentence of Section 16.1-2), the MEC voted to propose the Bylaw amendments.

On February 17, 2020 and on February 26, 2020, the MEC reviewed the comments of Board members and unanimously voted to respond to the comments as follows:

1. **Verbal request to clarify the steps of Article 16 to avoid further confusion and concern of Board member Dr. Pruitt to add a step to the MEC proposed amendment process to assure notice to the Medical Staff**. Response: The MEC unanimously voted, on 02/26/2020, to address the concerns by further adjusting Article 16 (as set forth in the proposed amended Bylaws) to set forth clearly numbered steps for the amendment processes and to propose a notice and comment period to the Medical Staff when amendments are proposed by the MEC.
2. **Response to written comments of Dr. Pruitt's 02/12/2020 email:**
    a. **Item 1, Dr. Pruitt *appears* to object to the Bylaw amendments being proposed by the MEC**. Response: The Bylaws at 16.1-3 allow for amendments to be proposed either through MEC *or* by petition of 33% of the Medical Staff. The Bylaws state: "Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least thirty-three percent of the voting Medical Staff members." There are additional sentences in this section of the Bylaws that address the process. Since Dr. Pruitt interprets this section in a way that no one on MEC interprets it, the MEC unanimously voted to clarify the language to its proposed amendments to be voted upon by the Medical Staff.
    b. **Item 2, Dr. Pruitt objects to the MEC's proposed amendment requiring physicians to work an average of 700 hours or more per year either through clinical or administrative duties to be active (voting) medical staff**. The MEC considered Dr. Pruitt's concern but the MEC unanimously voted to retain its proposal of 700 hours so that those physicians who are active (and thus have the right to vote for the Chief of Staff, the Vice Chief of Staff, and on how the Medical Staff governs itself via Bylaws and policies) be significantly involved with PSMC. Those who have less than 700 hours of annual involvement at PSMC, can be involved as "Courtesy staff" without the right to vote.
    c. **Item 3, Dr. Pruitt's concern regarding the deletion of the indemnification**. Response: Per in-house legal counsel (and affirmed by outside legal counsel, CCC), indemnification provisions are unenforceable against a governmental entities because governmental entities are precluded from being responsible for the liability/debt of third parties (an indemnification would be agreeing to an unknown, open-ended debt of another). MEC states that to leave the

unenforceable provision would be misleading to Medical Staff and should be removed. As to PSMC's *employed* physicians and providers, as governmental employees, they all have the benefit of Colorado governmental immunity (and State legislated cap on liability) for negligent actions taken in the scope of their employment.

d. **Item 4, Dr. Pruitt's concern that it appears to him that no one is permitted to propose Medical Staff policies**. The MEC did not intend for this interpretation and MEC unanimously voted to add clarifying language (see attached) to its proposed amendments to be voted upon by the Medical Staff.

e. **Item 5, concerns raised by Dr. Pruitt**. The MEC unanimously voted not to add any of the new amendments to address concerns raised by Dr. Pruitt. The MEC's reasoning is:

   i. **Dr. Pruitt request for an amendment to involve non-employed providers in PSMC Medical Staff Education**: Medical Staff sometimes includes community providers in Medical Staff education but sometimes does not when Medical Staff wants to address matters specific to PSMC. The MEC prefers to decide on a situational basis when to invite other providers in the community rather than to always mandate it in the Medical Staff Bylaws.

   ii. **Dr. Pruitt request for an amendment to delete a section that states a physician loses privileges upon termination of contract**. Since 2014, the Bylaws have included a provision that upon termination of a physician's contractual relationship with PSMC, the physician's privileges automatically terminate but the physician can reapply. The MEC has not found this to place an undue burden on physicians who end a contractual relationship with PSMC.

   iii. **Dr. Pruitt request to change the pre-application process and criteria**. The preapplication process has been in the Bylaws since 2014 and MEC believes it has served PSMC well to have the CEO (with input from the Chief of Staff and applicable Medical Director) determine whether a physician has requisite training, whether PSMC has need for a particular physician's services (including the impact to services already provided by employees of PSMC), whether PSMC has appropriate equipment, facilities and support staff for a service/provider. This also saves staff time and expense of completing an entire background evaluation of a physician and the risk of a reportable event if the physician is denied privileges.

   iv. **Change criteria for reappointment of privileges to be a "community need" standard rather than "PSMC need" standard for services**. The reappointment criteria has been in the Bylaws since 2014 and the MEC believes it has served PSMC well to have the standard be a PSMC need for a service (on the other hand, a community need standard may result in services that are not workable or sustainable for PSMC to offer).

UPPER SAN JUAN HEALTH SERVICE DISTRICT

doing business as

PAGOSA SPRINGS
MEDICAL CENTER

MEDICAL STAFF BYLAWS

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History of Approval of Medical Staff Bylaws: third amended and restated approved by MEC on DATE and by USJHSD Board on DATE; second amendment approved on September 23, 2014 (USJHSD Board approved following affirmative vote of Active Med. Staff, per section 3.4 and Article 16, on 9/19/2014 to add the Trauma Director to the MEC); first amendment approved on August 26, 2014 (USJHSD Board approved following MEC approval, per Section 10.2-2, on 8/18/2014 to add department designation for surgery); these Bylaws were originally approved on December 17, 2013 (USJHSD Board approved following affirmative vote of the Medical Staff on December 4, 2013) and such Bylaws approved on 12/17/2013 replaced and superseded, in their entirety, any Bylaws previously adopted for the Medical Staff of PSMC.

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Medical Staff Bylaws

PREAMBLE

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body of Upper San Juan Health Service District in protecting the quality of medical care provided Pagosa Springs Medical Center and assuring the competency of the Medical Staff for the same. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments, and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff Officers; and they address the respective rights and responsibilities of the Medical Staff and the Governing Body.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of Pagosa Springs Medical Center. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith; and in approving these Bylaws, the Governing Body commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

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DEFINITIONS

~~1. **Allied Health Professional** or **AHP** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, psychological *or* podiatric care under the supervision or direction of an active Medical Staff member possessing privileges to provide such care at PSMC, and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and Governing Body, these Bylaws and the Rules. AHPs are not eligible for Medical Staff membership. Without limitation, examples of AHPs are: Physician Assistant, Nurse Practitioner, Clinical Psychologist.~~

1. ~~2.~~ Advanced Practice Professional (APP) means a provider who by state law may or may not be authorized to practice independently (and may or may not be required by PSMC contract or PSMC policy to work under the supervision or in collaboration with a physician who is a member of the Medical Staff) who must be processed through PSMC's medical staff process and granted privileges in accordance with Medicare Conditions of Participation:
    - Nurse Practitioner (NP) or Advanced Registered Nurse Practitioner (ARNP)
    - Physician Assistant (PA)
    - Certified Registered Nurse Anesthetist (CRNA). The COPs require that we notice that PSMC allows CRNAs to practice independently as allowed by the CO state exemption.
    - Registered Nurse First Assistant (RNFA)

2. **Behavioral Health Provider (BHP)** means a provider who by state law may or may not be authorized to practice independently (and may or may not be required by PSMC contract or PSMC policy to work under the supervision or in collaboration with a physician who is a member of the Medical Staff) who must be processed through PSMC's medical staff process and granted privileges in accordance with Medicare Conditions of Participation:
    - Licensed Clinical Psychologist (LCP)
    - Licensed Professional Counselor (LPC)
    - Licensed Professional Counselor Candidate (LPCC)
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Social Worker (LSW)
    - Licensed Marriage and Family Therapist (LMFT)

3. Chief Executive Officer (CEO) means the person appointed by the Governing Body to serve in an administrative capacity or his or her designee.
4. ~~3.~~ **Chief Medical Officer (CMO)** means a ~~practitioner~~physician appointed, from time to time as and when desired, by the Governing Body to serve as a liaison between the Medical Staff and the administration.
5. ~~4.~~ **Chief of Staff** means the chief officer who is a physician and an active member of the Medical Staff elected by the Medical Staff.

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6. ~~5.~~ **Date of Receipt** means the date any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail. (See also, the definitions of **Notice** and **Special Notice**.)

7. ~~6.~~ **Days** means calendar days unless otherwise specified.

8. **Department** means the designated clinical departments/programs of PSMC that have Department Medical Director representation on MEC:

   - Acute Care (which includes inpatient care, Oncology, and Telemedicine);
   - Clinic (which means the rural health clinic for primary care and certain specialty care at Pagosa Springs Medical Center, and includes all outpatient locations and services operated under the auspices of the Rural Health Clinic's license);
   - Emergency Department;
   - Surgery Department; and
   - Trauma Program.

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

~~1. 7. **Ex Officio** means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.~~

10. ~~8.~~ **Governing Body or Board of Directors** means the board of directors of Upper San Juan Health Service District doing business as Pagosa Springs Medical Center. As appropriate to the context and consistent with these Bylaws, it also means any Governing Body committee or ~~individual authorized~~position (e.g., the CEO) to whom responsibilities have been delegated with authorization to act on behalf of the Governing Body. By regulation, the Governing Body may not delegate the approval or acceptance of Medical Staff appointment, reappointment, and revisions to Medical Staff Bylaws.

11. ~~9.~~ **Hospital** means the hospital division of Pagosa Springs Medical Center, and includes all inpatient and outpatient locations and services operated under the auspices of the hospital's license.

~~10.~~

12. **Medical Executive Committee** or **Executive Committee** (MEC) means the executive committee of the Medical Staff. To the extent the MEC or any portion of the MEC serves as the Professional Review Committee, the MEC shall have the immunities set forth in the definition of the Professional Review Committee.

13. ~~11.~~ **Medical Director** of a clinical department means an active Medical Staff member appointed by the CEO to serve, per a contract, and provide oversight of the department's clinical care to assess and address appropriate quality of clinical care in the department.

14. **Medical Staff** means the organizational component of PSMC that includes all physicians (M.D. or D.O.), APPs, BHPs, dentists, oral surgeons, and podiatrists who have been granted recognition as members pursuant to these Bylaws.

15. ~~12.~~ **Medical Staff Year** means the period from January 1 through December 31.

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~~13.~~

16. **Member** means any ~~practitioner~~physician, APP, BHP, dentist, oral surgeon, or podiatrist who has been appointed to the Medical Staff.

17. ~~14.~~**Notice** means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or PSMC. (See also, the definitions of **Date of Receipt** and **Special Notice**.)

~~15. **Pagosa Springs Medical Center ("PSMC").** Is a trade name for Upper San Juan Health Service District. Any reference to PSMC shall be intended to mean any division (e.g., hospital, clinic, EMS, ambulance) of Upper San Juan Health Service District.~~

18. ~~16.~~ **Physician** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

19. ~~17.~~**Practitioner** means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, oral surgeon, or podiatrist.

~~18. **Primary Care Clinic at Pagosa Springs Medical Center ("Clinic")** means the rural health clinic division of Pagosa Springs Medical Center, and includes all outpatient locations and services operated under the auspices of the Rural Health Clinic's license.~~

~~19.~~

20. **Privileges** or **Clinical Privileges** means the permission granted to a Medical Staff member or ~~AHP~~ to render specific patient services.

21. ~~20.~~**Professional Review Committee** means a committee established pursuant to C.R.S. Section 12-36.5-102(6), et seq., to review and evaluate the competence, professional conduct of, or the quality and appropriateness of patient care provided by, persons licensed under Article 36 of Title 12 of the Colorado Revised Statutes. Further, such professional review committee shall be granted certain immunities, to the maximum extent allowed under law/regulation, from liability arising from actions taken within the scope of the committee's activities. The proceedings, recommendations, records, and reports of the Professional Review Committee (and the governing board with respect to its role for professional review) shall be confidential to the maximum extent allowed under law/regulation.

22. ~~21. **Rules**~~**Policies** refers to the Medical Staff ~~Rules~~Policies, to the extent any are adopted in accordance with these Bylaws unless specified otherwise.

23. ~~22.~~**Special Notice** means a notice sent by certified or registered mail, return receipt requested. (See also, the definitions of **Date of Receipt** and **Notice** above.)

24. ~~23.~~**Telemedicine** is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications from a remote location.

~~24~~25. **Upper San Juan Health Service District ("USJHSD")** means a health service district as described in C.R.S. Section 32-1-101, et seq. Upper San Juan Health Service District operates under the trade name of Pagosa Springs Medical Center. The Bylaws shall apply to all services offered under and through Upper San Juan Health Service District doing business as Pagosa Springs Medical Center.

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Article 1 Name and Purposes

1.1 Name

The name of this organization shall be the Medical Staff of Pagosa Springs Medical Center.

1.2 Description

1.2-1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon the nature of the Staff member's practice at PSMC. All members are assigned to one of the Staff categories described in Bylaws, Article 3, Categories of the Medical Staff.

1.2-2 Members are also assigned to one or more departments (as listed in Section 10-2-1 of these Bylaws), depending upon their specialties.

1.2-3 There are also Medical Staff committees, which perform staff-wide responsibilities, and which oversee related activities being performed by the departments.

1.2-4 Overseeing all of this is the Medical Executive Committee, comprised of the persons set forth in Section 9.3 of these Bylaws.

1.3 ~~Purposes and~~ Responsibilities

~~**1.3-1** The Medical Staff's purposes are:~~

1.3-1 The Medical Staff's responsibilities are to recommend appointments and reappointments to the Governing Body, and monitor quality of care via professional review activities. Within the scope of these responsibilities the Medical Staff is responsible to report to the Governing Body. These responsibilities include:

a. To ~~assure that all patients admitted or treated by PSMC receive a uniform standard of~~ provide quality patient care~~, treatment~~ that is uniform and ~~efficiency~~ consistent ~~with generally accepted standards attainable within PSMC's means and circumstances.~~

~~b.~~ To provide for a level of professional performance that is consistent with generally accepted standards attainable within PSMC's means and circumstances.

~~c. To organize and support professional education and community health education and support services.~~

~~d. To initiate and maintain Rules for the Medical Staff to carry out its responsibilities for the professional work performed in and by PSMC.~~

~~e. To provide a means for the Medical Staff, Governing Body and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.~~

~~f. To provide for accountability of the Medical Staff to the Governing Body.~~

~~g. To exercise its rights and responsibilities in a manner that does not jeopardize the licenses of PSMC, Medicare and Medicaid provider status, AND accreditation.~~

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~~1.3 2 The Medical Staff's responsibilities are:~~

~~a. To provide quality patient care.~~

b. To account to the Governing Body for the quality of patient care provided by all members authorized to practice at PSMC through the following measures:

1. Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
2. An organizational structure and mechanisms that allow on-going monitoring of Medical Staff patient care practices;
3. A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;
4. A continuing education program based at least in part on needs demonstrated through the medical care evaluation program;
5. ~~A utilization review program to provide for the appropriate use of all medical services.~~ An organizational structure and mechanisms that allow on-going monitoring of Medical Staff professional behavior;

c. To recommend to the Governing Body action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action.

d. To establish and enforce, subject to the Governing Body approval, professional standards related to the delivery of health care within PSMC.

e. To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities.

f. ~~To initiate and pursue corrective action with respect to members where warranted~~To cooperate with other community health facilities and/or educational institutions or efforts.

~~g. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts.~~

~~h.~~g. To establish and amend from time to time as needed Medical Staff Bylaws~~, Rules and policies~~ or Medical Staff Policies, for the effective performance of Medical Staff responsibilities, as further described in these Bylaws.

~~i~~h. To select and remove Medical Staff officers.

~~j~~i. To assess Medical Staff dues (if any) and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

Article 2 Medical Staff Membership

2.1 Nature of Medical Staff Membership

Being a member of the Medical Staff of PSMC does not make the Medical Staff member an employee or an independent contractor of PSMC; instead being a member of the Medical Staff means that a Practitioner, APP, or BHP has ~~a privilege~~permission, in the form of a revocable license, to use PSMC's

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facilities for the treatment of patients.~~–~~ Medical Staff membership and/or privileges may be extended to and maintained by only those professionally competent practitioners, APPs, or BHPs who continuously meet the qualifications, standards, and requirements, unless otherwise waived, set forth in these Bylaws and the ~~Rules~~Policies. A practitioner, APP, or BHP, including one who has a contract with PSMC to provide medical-administrative services, may ~~admit or~~ provide services to patients at PSMC only if the practitioner, APP, or BHP is a member of the Medical Staff or has been granted privileges in accordance with these Bylaws and the ~~Rules~~Policies. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been established by the Medical Staff and granted by the Governing Body~~ in accordance with these Bylaws. This Article 2 discusses qualifications and responsibilities of Medical Staff membership; Article 3 of these Bylaws describes the categories of Medical Staff membership, and Article 4 describes the procedures for appointment/reappointment to the Medical Staff.~~ .

2.2 Qualifications for Membership

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2.2-1 General Qualifications

Membership on the Medical Staff ~~and privileges~~ shall be extended only to practitioners, APPs, and BHPs who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and ~~Rules~~Policies. Medical Staff membership (except honorary Medical Staff) shall be limited to practitioners, APPs, and BHPs who are currently licensed or qualified to practice medicine, behavioral health, podiatry, or dentistry in Colorado.

2.2-2 Basic Qualifications

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A practitioner, APP, and BHP must demonstrate compliance with all basic standards set forth in this Section in order to have an application for Medical Staff membership accepted for review. The practitioner, APP, or BHP must:

a. Qualify under Colorado law to practice with an out-of-state license or be licensed as follows:

1. Physicians must possess an unrestricted license, from the Colorado Medical Board, to practice medicine;
2. Dentists must be licensed to practice dentistry by the Colorado Board of Dental Examiners;
3. Podiatrists must be licensed to practice podiatry by the Colorado Board of Podiatric Medicine.
4. APPs and BHPs must be licensed to practice in their applicable discipline by the appropriate Colorado Board.

b. Except where not required for the Practitioner's privileges at PSMC (for example, without limitation, telemedicine, pathologist, radiologist), if practicing clinical medicine, dentistry, or podiatry, have a federal Drug Enforcement Administration number. Nurse Practitioners who are in the process of obtaining Prescriptive Authority in the State of Colorado are exempt from this requirement until they are eligible to obtain a Federal DEA Registration.

~~c. Bec~~. Physicians and podiatrists must be certified by or currently qualify and eligible to take the board certification examination of a board recognized by the American Board of Medical

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Specialties, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, or a board or association with equivalent requirements approved by the Colorado Medical Board in the specialty that the practitioner will practice at PSMC. This section shall not apply to dentists. Certification requirements for APPs and BHPs are listed on their respective specialty-specific privilege form.

~~c~~d. Be eligible to receive payments from the federal Medicare and state Medicaid programs.

e. Have liability insurance or equivalent coverage meeting the standards specified by the Governing Body.

~~f. Have actively practiced not less than part-time (generally an average of at least 20 hours per week) in the specialty he or she will practice at PSMC for the previous 24 months.~~

~~g. Except for Practitioners with only Telemedicine privileges at PSMC, be located close enough (office and residence) to PSMC to provide continuous care to his or her patients. The distance to PSMC will vary depending upon the Medical Staff category and the privileges that are involved and the feasibility of arranging alternative coverage and as such any distances shall be established by Rules.~~

f~~h~~. ~~Pledge~~Maintain ability to provide continuous care to his or her patients.

g~~i~~. If requesting privileges only in services operated under an exclusive contract, be a member, employee or subcontractor of the group or person that holds the contract.

~~A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards and applicants for the Telemedicine Staff need not comply with paragraph (g) of this Section 2.2-2.~~hi. Provide ~~If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is *not* entitled to the procedural rights set forth in these Bylaws, but may submit an application for waiver together with the applicant's comments and a request for reconsideration of the specific standards which adversely affected such practitioner (additional information regarding waiver is noted in Section 2.2-4). Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Bylaws, Section 2.2-4, below.~~

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~~2.2-3 Additional Qualifications for Membership~~

~~In addition to meeting the basic standards, the practitioner must provide~~ an application (that will be generally subject to the approval of the Medical Executive Committee and the Governing Body) ~~and:~~

~~a~~ik. Document his or her:

1. Adequate experience, education, and training in the requested privileges;
2. Current professional competence;
3. Good judgment; and
4. Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is

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sufficiently healthy and professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality and safety of care for this community. Without limiting the foregoing, with respect to communicable diseases, practitioners, APPs, and BHPs are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others present in PSMC, and to comply with all reasonable precautions established by PSMC and/or Medical Staff policy respecting safe provision of care and services at PSMC.

~~b~~j~~l~~. Be determined to:

1. Adhere to the lawful ethics of his or her profession;
2. Have a good reputation and character;
3. ~~Have adequate liability insurance coverage;~~Be able to work cooperatively and harmoniously with others at PSMC so as not to adversely affect patient care or PSMC operations; and

~~4. Be able to work cooperatively and harmoniously with others at PSMC setting so as not to adversely affect patient care or PSMC operations; and~~

~~5~~4. Be willing to participate in and properly discharge Medical Staff responsibilities.

A practitioner, APP, or BHP who does not meet the standards in section 2.2-2 is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is *not* entitled to the procedural rights set forth in these Bylaws, but may submit an application for waiver together with the applicant's comments and a request for reconsideration of the specific standards which adversely affected such practitioner~~**2.2-4 Waiver of Qualifications**~~

~~Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Committee, if it determines that the practitioner~~, APP, or BHP (additional information regarding waiver is noted in Section 2.2-3). Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Bylaws, Section 2.2-3, below.

2.2-3 Waiver of Qualifications

A practitioner, APP, or BHP who does not meet the qualifications for membership may submit a written request for waiver and a request for reconsideration of the specific standards which adversely affected such practitioner, APP, or BHP at the time of pre-application for initial appointment and upon every reappointment cycle. The Medical Executive Committee shall review the request for waiver and make a recommendation to the Governing Body. This recommendation shall include, at a minimum, the MEC's determination that the practitioner, APP, or BHP has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests

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of the patients and of PSMC. ~~There~~Even upon reappointment, there is no obligation to grant any such waiver, and practitioners, APPs, and BHPs have no right to have a waiver considered and/or granted. A practitioner, APP, or BHP who is denied a waiver or consideration of a waiver upon pre-application for initial appointment shall not be entitled to any hearing and appeal rights under these Bylaws.

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2.3 ~~Effect of Other Affiliations~~Non-discrimination

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

~~2.4 Nondiscrimination~~

Medical Staff membership or particular privileges shall not be denied on the basis of age, gender, religion, race, creed, color, national origin, or any physical or mental impairment and must adhere to applicable laws and PSMC Policy regarding non-discrimination, if, after any necessary reasonable accommodation, the applicant complies with the Bylaws ~~or Rules~~and Policies of the Medical Staff ~~or~~of PSMC.

2.~~5~~4 Administrative and Contract Practitioners, APPs, and BHPs

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2.~~5~~4-1 Employed or Contracted Practitioners~~.~~, APPs, and BHPs with No Clinical Duties

A practitioner, APP, or BHP employed by or contracting with PSMC solely in ~~a purely~~an administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of PSMC and to the terms of his or her contract or other conditions of employment and may be, but need not be, a member of the Medical Staff.

2.~~5~~4-2 Employed or Contracted Practitioners, APPs, and BHPs Who Have Clinical Duties

a. A practitioner, APP, or BHP with whom PSMC contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws~~.~~ and, if applicable, PSMC policies. Unless a written contract or agreement specifically provides otherwise or unless otherwise required by law, those privileges ~~made exclusive or semi-exclusive all clinical privileges~~ of such staff member will automatically terminate, without the right of access to the review, hearing, and appeal procedures of the Bylaws, Article 14, Hearings and Appellate Reviews, upon termination or expiration of such ~~practitioner's~~practitioner, APP, or BHP's contract or agreement with PSMC.

~~b. Contracts between practitioners and PSMC shall prevail over these Bylaws and the Rules, except that the contracts~~b. Contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Colorado Medical Board or the ~~federal~~ National Practitioner Data Bank.

2.5 ~~3 Subcontractors~~

~~Practitioners who subcontract with practitioners or entities who contract with PSMC may lose privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their Medical Staff membership) if their relationship with the contracting practitioner or entity is terminated,~~

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~~or PSMC and the contracting practitioner's or entity's agreement or exclusive relationship is terminated. PSMC may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right.~~

~~2.6~~ Basic Responsibilities of Medical Staff Membership

Except for honorary members, each Medical Staff member and each practitioner ~~exercising privileges~~, APP, and BHP shall continuously meet all of the following responsibilities:

2.~~6~~5-1 Provide his or her patients with care that is generally recognized professional level of quality and efficiency.

2.~~6~~5-2 Abide by the Medical Staff Bylaws and ~~Rules~~Policies and all other lawful standards, ~~policies and Rules~~Policies of the Medical Staff and PSMC.

2.~~6~~5-3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable accreditation standards.

2.~~6~~5-4 Discharge such Medical Staff, department, committee and service functions for which he or she is responsible by appointment, election or otherwise.

2.~~6~~5-5 Abide by all applicable requirements for timely completion and recording of a physical examination and medical history, as further described at Section 5.4-3.

2.~~6~~5-6 Acquire a patient's informed consent for all procedures and treatments where required by law, PSMC policies ~~and/or rules~~, or by these Bylaws (Section ~~15.1-~~ 5.4-3) and abide by the procedures for obtaining such informed consent.

2.~~6~~5-7 Prepare and complete, in a timely and accurate manner, the medical and other required records for all patients to whom the practitioner, APP, or BHP in any way provides services in PSMC, including compliance with such electronic health record (EHR) policies and protocols as have been implemented by PSMC.

2.~~6~~5-8 Abide by the ethical principles of his or her profession.

2.~~6~~5-9 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

2.~~6~~5-10 Refrain from any unlawful harassment or discrimination against any person (including any patient, PSMC employee, PSMC independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, gender, religion, race, creed, color, national origin, health status, ability to pay, or source of payment, and adherence to applicable laws and PSMC policy regarding non-discrimination.

2.~~6~~5-11 Refrain from delegating the responsibility for diagnosis or care of PSMC patients to a practitioner or ~~Allied Health Professional~~APP and BHP who is not qualified to undertake this responsibility or who is not adequately supervised.

2.~~6~~5-12 Coordinate individual patients' care, treatment and services with other practitioners and PSMC personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the ~~Rules or policies and procedures~~Policies of the Medical Staff.

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2.65-13 Actively participate in and regularly cooperate with the Medical Staff in assisting PSMC to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement, peer review, utilization management, quality evaluation, ~~ongoing~~Ongoing and Focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

2.65-14 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients.

2.65-15 Communicate with appropriate Medical Staff Officers and/or department ~~chairs~~Medical Directors when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

2.65-16 Accept responsibility for participating in Medical Staff proctoring in accordance with the ~~Rules and policies and procedures~~Policies of the Medical Staff.

2.65-17 Complete continuing medical education ~~that meets all licensing~~to be current in skills for practitioner, APP, or BHP's specialty as well as any required for practitioner, APP, or BHP's board specialty requirements~~ and is appropriate to the practitioner's specialty~~.

2.65-18 Adhere to the PSMC Code of Conduct and the Medical Staff Standards ~~of Conduct~~ (as further described in Section 2.~~7~~6, below), so as not to adversely affect patient care or PSMC operations.

2.65-19 As applicable, participate in emergency service coverage and consultation panels as allowed and as required by Medical Staff ~~Rules~~Policies, PSMC policies or otherwise.

~~**2.6-20** Cooperate with the Medical Staff in assisting PSMC to meet its uncompensated or partially compensated patient care obligations.~~

2.5-20 Agree to provide care to patients regardless of their ability to pay.

2.65-21 Participate in patient and education activities, as determined by the Medical Staff ~~Rules~~Policies, or the Medical Executive Committee.

2.65-22 Promptly notify, in writing, the Governing Board's designee (the CEO) **and** the Medical Staff's Chief of Staff, no later than ten (10) calendar days, following any action taken regarding the member's license, Drug Enforcement Administration registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action or change in circumstances that could affect his/her qualifications for Medical Staff membership and/or clinical privileges at PSMC.

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2.~~6~~5-23 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee. ~~This~~To the extent permitted by law this shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the Medical Executive Committee.

2.~~6~~5-24 Discharge such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

2.~~7~~6 Standards of Conduct

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Members of the Medical Staff are expected to adhere to the Medical Staff Standards of Conduct and the PSMC Code of Conduct including, but not limited to, the following:

2.~~7~~6-1 General

a. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees and visitors.

b. Rude, combative, obstreperous behavior, as well as willful refusal to communicate (as well as incomplete or ambiguous communications) or comply with reasonable ~~rules~~policies of the Medical Staff and PSMC may be found to be disruptive behavior. It is specifically recognized that patient care and PSMC operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

c. In assessing whether particular circumstances in fact are affecting quality patient care or PSMC operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces—in addition to medical outcome—matters such as timeliness of services, appropriateness of services, timely and thorough completion of medical records, timely and thorough communications with patients, their families, and their insurers (or third party payers) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

2.~~7~~6-2 Conduct Guidelines

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a. Upon receiving Medical Staff membership and/or privileges at the PSMC, the member enters a common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

b. Members of the Medical Staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, PSMC staff, visitors, and others in and affiliated with PSMC.

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c. Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with PSMC.

d. Complaints and disagreements shall be aired constructively, in a nondemeaning manner, and through official channels.

e. Cooperation and adherence to the PSMC Code of Conduct and reasonable ~~Rules~~Policies of PSMC and the Medical Staff is required.

f. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

2.~~7~~6-3 Adoption of ~~Rules~~Policies

The Medical Executive Committee may promulgate ~~Rules~~Policies further illustrating and implementing the purposes of this Section including, but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and, where appropriate, progressive or other remedial measures. These measures may include alternative avenues for medical or administrative disciplinary action, which in turn may include but are not limited to conditional appointments and reappointments, requirements for behavioral contracts, mandatory counseling, practice restrictions, and/or suspension or revocation of Medical Staff membership and/or privileges.

Article 3 Categories of the Medical Staff

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3.1 Categories

Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in this Article 3. The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in ~~the~~these Bylaws Section 3.4 and ~~Rules~~Policies. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the Bylaws or ~~Rules~~Policies. Members who fail to achieve the minimum requirements of his/her category shall be automatically transferred to the appropriate category; the Medical Executive Committee is authorized to cause such transfers/assignments/changes. Transfers/assignments/changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

3.2 ~~General Exceptions to~~ Prerogatives and Exceptions

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Regardless of the category of membership in the Medical Staff, podiatrists, and dentists:

3.2-1 May not hold any general Medical Staff office.

3.2-2 Shall have the right to vote only on matters within the scope of their licensure. Any disputes over voting rights shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee.

3.2-3 Shall exercise privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and ~~Rules~~Policies.

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NOTE: ~~AHPs are not members of the Medical Staff~~APPs and ~~as such~~BHPs have no right to be an officer of the Medical Staff or vote on any Medical Staff matter.

3.~~3Assignment~~3 Assignment and Transfer in Staff Category. ~~PSMC~~The MEC shall assign Medical Staff members to an applicable staff category of active, courtesy, honorary~~ or~~, telemedicine~~.~~ or APP/BHP. Any transfers of category shall occur pursuant to PSMC Medical Staff Policy.

Active Category shall be further defined as practitioners who, through clinical or administrative duties, perform work on-site an average of 700 or more hours per calendar year; however, any provider with active status in 2019 who does not meet this hourly requirement will be grandfathered to preserve his/her active status.

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3.4 Summary of Prerogatives and Responsibilities of the Medical Staff

CATEGORY	ACTIVE	COURTESY	HONORARY	TELEMEDICINE	AHP/BHP
PREROGATIVES					
Admits, consults and refers inpatients and outpatients	Yes[1]	Yes[2]	No	No (Admission) / Yes (consults and refers patients)[3]	No (Admission) /Yes (consults and refers patients)[4]
Eligible for clinical privileges	Yes	Yes	No	Yes	Yes
Vote	Yes	No	No	No	No
Hold Office	Yes	No	No	No	No
RESPONSIBILITIES					
~~Medical Staff functions~~	~~Yes[4]~~		~~No~~	~~No~~	
Consulting	Yes	Yes	No	Yes	Yes
Call	Yes[5]	No	No	No	Yes[6]
Attend Meetings	Yes	No	No	No	No
Pay Application Fee	Yes	Yes	No	Yes	Yes
Pay Dues	Yes	Yes	No	Yes	Yes
ADDITIONAL PARTICULAR QUALIFICATIONS					

[1] Must reside within 100 miles of ~~hospital~~PSMC unless call coverage obligations require the staff member to be closer for call coverage obligations (see footnote 4 regarding call coverage obligations). In addition to Practitioner being within a category to admit, the Practitioner must have privileges to admit.

[2] If there are limitations on the number of patients cared for on an annual basis, this will be established by ~~Rules.~~Policies. In addition to Practitioner being within a category to admit, the Practitioner must have privileges to admit.

[3] If there are limitations on the number of patients cared for on an annual basis, this will be established by the ~~Rules~~Policies.

[4] If there are limitations on the number of patients cared for on an annual basis, this will be established by the Policies.

[5] Call is an inherit obligation of all Active Staff and will be addressed on a department and/or an individualized basis.

[6] Call will be addressed on a department and/or an individualized basis.

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Malpractice Insurance	Yes	Yes	No	Yes	Yes
File application and apply for reappointment	Yes	Yes	No	Yes	Yes

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Article 4 Procedures for Appointment and Reappointment

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4.1 General

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The Medical Staff shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and the ~~Rules~~Policies. The Medical Staff shall perform this function also for practitioners who seek temporary privileges and for ~~Allied Health Professionals.~~ APPs and BHPs. The Medical Staff shall investigate each applicant for appointment or reappointment and make an objective, evidence-based decision based upon assessment of the applicant vis-à-vis PSMC's "general competencies," (as further described at Bylaws, Section 5.2), before recommending action to the Governing Body. The Governing Body shall ultimately be responsible for granting membership and privileges (provided, however, that these functions may be delegated to the Chief of Staff and Chief Executive Officer with respect to requests for temporary privileges). By applying to the Medical Staff for appointment or reappointment (or by accepting honorary Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and ~~Rules~~Policies as they exist and as they may be modified from time to time.

4.2 Overview of the Process

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The following chart depicts the basic steps of the appointment, reappointment, and temporary privileges processes.

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APPOINTMENT AND REAPPOINTMENT		
Person or Body	**Function**	**Report to**
CEO	Determine whether to issue application for appointment or reappointment.	Governing Body
Medical Staff ~~Coordinator~~Office Manager	~~Verify~~Collect, verify and organize application information.	Medical Executive Committee
Medical Executive Committee	~~Review~~If for initial appointment, review applicant's qualifications set forth in the Medical Staff Bylaws, any qualifications established by departments; Recommend appointment and privileges. If for reappointment, review applicant's performance problems, if any; review applicant's performance in accordance with the general standards set forth in the Medical Staff Bylaws and any standards established by departments; Recommend reappointment and privileges.	Governing Body~~.~~

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TEMPORARY PRIVILEGES
Temporary privileges (if any) are addressed by Medical Staff Policy which policy is approved by the MEC and the Board of Directors.

Governing Body	Review recommendations of the Medical Executive Committee; make decision to accept or not accept MEC recommendations.	Final Action.

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REAPPOINTMENT AND PRIVILEGES		
Person or Body	**Function**	**Report to**
Medical Staff Coordinator	Collect, verify and organize reappointment information	Medical Executive Committee
Medical Executive Committee	Review applicant's performance problems, if any; review applicant's performance in accordance with the general standards set forth in the Medical Staff Bylaws and any standards established by departments; Recommend reappointment and privileges.	Governing Body.
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final action.

TEMPORARY PRIVILEGES		
Person or Body	**Function**	**Report to**
Medical Staff Coordinator	Verify key information	Chief of Staff
Chief of Staff	Review applicant's qualifications vis-à-vis standards developed by department; recommend temporary privilegesTemporary privileges (if any) are addressed by Medical Staff Policy which policy is approved by the MEC and the Board of Directors.	Chief E… Bylaws Section 5.5-2d.)
Chief Executive Officer	Make decision	

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4.3 Applicant's Burden

4.3-1 An applicant for appointment, reappointment, advancement, transfer, and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. Subject to any reporting obligations of PSMC, applicant's provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information may be deemed a voluntary withdrawal of applicant's application; alternatively, in the discretion of the Medical Executive Committee, such misrepresentations, omissions and/or failure to meet applicant's burden of producing information may be treated as grounds for denying an application or request. Applicant's burden may include submission to a physical or mental health examination at the applicant's expense, if deemed appropriate and requested by the Medical Executive Committee. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee.

4.3-2 Any individual or any committee charged under these Bylaws with responsibility of reviewing the appointment or reappointment application and/or request for clinical privileges may request further documentation or clarification. If the applicant~~/practitioner~~ or member fails to respond within one month, the application or request shall be deemed withdrawn, and processing of the application or request will be discontinued. Such a withdrawal shall not give rise to hearing and appeal rights pursuant to Bylaws, Article 14, Hearings and Appellate Reviews.

4.4 Application for Initial Appointment and Reappointment

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4.4-1 Pre-Application Required

An applicant desiring appointment to the Medical Staff must request and obtain a pre-application form for Medical Staff appointment from PSMC's Medical Staff ~~Coordinator~~Office Manager; the applicant must complete the pre-application form in full and return it to PSMC's Medical Staff ~~Coordinator and CEO.~~Office Manager. The specific contents of the pre-application form will be as determined, from time to time, by the CEO after consultation with the Medical Executive Committee. Completed pre-application forms will be reviewed by the CEO to determine whether the applicant shall be issued an Application for Medical Staff Appointment. When reviewing the completed pre-application form(s), the CEO will consult with the COS and the CMO to consider whether: (a) the pre-applicant has the requisite training and licensure;~~ and~~ (b) PSMC has a need for the type of services the pre-applicant proposes to perform; and (c) PSMC has the appropriate facilities and support personnel for the privileges requested. If, after review of the pre-application, PSMC is willing to provide the pre-applicant with an Application for Medical Staff Appointment, then PSMC will also supply the applicant with a copy, or access to a copy of PSMC ~~Bylaws and~~ Medical Staff Bylaws~~, and Medical Staff Rules and Regulations (if any).~~.

4.4-2 Application Form

If ~~practitioner/~~applicant has completed the pre-application process (above) and has received an Application for Medical Staff Appointment, ~~-~~applicant shall complete the Application for Medical Staff Appointment,~~-~~ which includes applicant's agreement to disclosure of applicant's

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documents/information to PSMC, applicant's agreement to abide by the Medical Staff Bylaws and ~~Rules~~Policies (including the standards and procedures for evaluating applicants contained therein), and applicant's release of all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and ~~Rules~~Policies. Following its ~~investigation~~inquiry, the Medical Executive Committee shall recommend to the Governing Body whether to appoint, reappoint and/or grant specific privileges.

4.4-3 Basis for Appointment

a. Except ~~as next provided with respect to~~ telemedicine ~~practitioners,~~applicants (see subparagraph b, below), recommendations for appointment to the Medical Staff and for granting privileges shall be based upon appraisal of all information provided in the application (including, but not limited to, health status and written peer recommendations regarding the ~~practitioner's~~practitioner, APP, or BHP's current proficiency with respect to PSMC's general competencies, as further described at Bylaws, Section 5.2), the ~~practitioner's~~practitioner, APP, or BHP's training, experience, and professional performance (at PSMC, if applicable, and in other settings~~,~~), whether the practitioner, APP, or BHP meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the ~~Rules~~Policies, and upon PSMC's patient care needs and ability to provide adequate support services and facilities for the practitioner~~)~~. APP, or BHP. Recommendations from peers in the same professional discipline as the practitioner, APP, or BHP, and who have personal knowledge of the applicant, are to be included in the evaluation of the ~~practitioner's~~practitioner, APP, or BHP's qualifications.

b. ~~The initial appointment~~Appointment and reappointment of telemedicine practitioners ~~to the Telemedicine Staff may be~~ , APPs, or BHPs is based upon~~:~~

~~1. The practitioner's full compliance with PSMC's credentialing and privileging standards; or~~

~~2. By using this PSMC's standards but relying in whole or in part on information provided by the hospital(s) at which the practitioner routinely practices;~~

~~i. If the hospital where the practitioner normally practices is a Medicare participating hospital, this~~ Medical Staff ~~may use a copy of that hospital's credentialing packet for privileging purposes. This packet shall include a list of all privileges granted by that hospital and a copy of the letter appointing the Practitioner to the medical staff where the practitioner normally practices (if no such letter exists, PSMC may work with the Practitioner to obtain an attestation, signed by an authorized representative at that hospital, affirming information required by PSMC) .~~Policy.

~~ii. In its discretion, this Medical Staff may also require that the Medicare hospital where the practitioner normally practices provide a comprehensive report of its assessment of the practitioner's quality of care, treatment, and services, This must include, at a minimum: all adverse outcomes related to sentinel events that result from the services provided by practitioner/applicant; and any complaints received at that hospital relating to the telemedicine services provided at PSMC.~~

4.4-4 Basis for Reappointment

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Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of PSMC's overall need for the services, PSMC's patient care needs and PSMC's ability to provide adequate ~~(or determination to divert resources for adequate)~~ support services ~~and,~~ facilities, and financial resources for the services provided by practitioner, APP, or BHP. Further, recommendation will be based upon reappraisal of the staff member's health status, current proficiency in PSMC's general competencies (as further described at Bylaws, Section 5.2) in light of his/her performance at PSMC and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, the Medical Staff ~~Rules~~Policies, the Medical Staff, and PSMC policies. Such reappraisal should also include relevant member-specific information from evaluations (generally described under Article 7 of these Bylaws) performance improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills. Where applicable, the results of specific peer review activities will also be considered. If sufficient peer review data is unavailable, peer recommendations may be used instead. Other past performance matters that will be taken into consideration include, but are not limited to, the following: prompt and satisfactory completion of medical records; attendance, when required, at Medical Staff (including committees) meetings; ethical behavior; and use of PSMC in a manner consistent with applicable policies and laws. ~~In the case of reappointment of a member of the Telemedicine Staff, reappointment may be based upon information provided by the hospital(s) where the practitioner routinely practices or as otherwise allowed under federal regulation including, but not limited to, 42 CFR Part 485, Subpart F.~~ To facilitate the evaluation of reappointment, the MEC and Governing Body may approve an application and/or other forms and procedures to be completed by the member regarding changes to the member's qualifications since his/her last review and other matters that sufficiently address the basis for reappointment.

4.4-5 Duration of Appointment; Limitations on Extension of Appointment

a. Duration of Appointment. Appointments to any staff category shall be for a maximum period of twenty-four (24) months ~~to the day.~~ , except if reappointment is not accomplished due to no fault of the practitioner, APP, or BHP, then such appointment may be automatically extended for 60 days.

b. Limitations on Extension of Appointment. If the reappointment application has not been fully processed before the member's appointment expires, the membership status and privileges of such Medical Staff member shall ~~be automatically suspended until the review is completed,~~not renew unless~~:~~

~~i. Good~~ good cause exists for ~~the care of a specific patient or patients and no other health professional currently privileged possesses the necessary skills and is available to provide care to the specific patient(s), in which case the member's privileges may be temporarily extended while his or her full credentials information is verified and approved; or~~

~~ii. The delay is due to the member's failure to timely return the reappointment application form or provide other documentation or cooperation, in which case the appointment will be terminated as provided in Section 4.4-6. An~~ an extension ~~of an appointment does not create a vested right for the member to be reappointed.~~

4.4-6 Failure to Timely File Reappointment Application

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Failure without good cause to timely file (sixty (60) or more days prior to the end of the current Medical Staff appointment) a completed application for reappointment shall result in the automatic ~~suspension~~non-renewal of the ~~practitioner's admitting and other~~practitioner, APP, or BHP's privileges and prerogatives at the end of the current Medical Staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Governing Body, pursuant to Bylaws, Section 4.4-5, above. Prior to ~~suspension~~non-renewal, the practitioner, APP, or BHP will be sent at least one letter warning the practitioner, APP, or BHP of the impending ~~suspension~~non-renewal. If an application for reappointment is not submitted or completed before the end of the current appointment, the practitioner, APP, or BHP shall be deemed to have resigned his/her privileges and membership in the Medical Staff, effective the date his/her appointment expired. In the event privileges and membership terminates for the reasons set forth herein, the practitioner shall not be entitled to any hearing or review. Members who are deemed to have voluntarily resigned under this provision will be processed as new applicants should they wish to reapply.

4.5 Approval Process for Appointments and Reappointments

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4.5-1 Recommendations and Approvals

After receipt by the Medical Staff ~~Coordinator~~Office Manager of all required information for an ~~applications~~application, the Medical Executive Committee shall review applications, engage in further consideration if appropriate regarding staff appointments, reappointments and clinical privileges; the Medical Executive Committee may, in its discretion, request review and recommendations from departments and/or committees formed (if any) to address credentialing. The Medical Executive Committee shall make a recommendation to the Governing Body that is either favorable, adverse or defers the recommendation. If the Medical Executive Committee's recommendation to the practitioner, APP, or BHP is adverse, the Medical Executive Committee shall also assess and determine whether the adverse recommendation is for a "medical disciplinary" cause or reason. A medical disciplinary action is one taken for cause or reason that involves that aspect of a ~~practitioner's~~practitioner, APP, or BHP's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 14, Hearings and Appellate Reviews hearing purposes.

4.5-2 The Governing Body's Action

The Governing Body shall review any favorable recommendation from the Medical Executive Committee and take action by ~~adopting~~accepting, rejecting, modifying or sending the recommendation back for further consideration.

a. After notice, the Governing Body may also take action on its own initiative if the Medical Executive Committee does not give the Governing Body a recommendation in the required time. The Governing Body may also receive and take action on a recommendation following procedural rights described at Bylaws, Article 14, Hearings and Appellate Reviews.

b. The Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal

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responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of PSMC.

4.5-3 Expedited Review

The Governing Body may, in its sole discretion upon review of facts and circumstances, use an expedited process for appointment, reappointment or when granting privileges.

4.5-4 Notice of Final Decision

The Chief Executive Officer ~~or~~shall cause his/her designee ~~shall~~to give notice ~~of the Governing Body's final decision~~ to the Medical Executive Committee and to the applicant of the Governing Body's final decision.

4.6 Leave of Absence from Medical Staff Membership

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4.6-1 Routine Leave of Absence for Active and Courtesy Staff

Except as next provided with respect to military leave of absence, members may request a leave of absence, which must be approved by the Medical Executive Committee and cannot exceed twenty-four months. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the ~~Rules~~Policies for reappointment review. The member must provide information regarding his or her professional activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at PSMC, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee. Telemedicine Staff leave of absence will be addressed by the distant-site Telemedicine Hospital or Entity.

4.6-2 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Bylaws, Section 4.6-1, above, but may be granted subject to focused professional practice evaluation, as determined by the Medical Executive Committee.

4.7 Waiting Period after Adverse Action

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4.7-1 Who is Affected

a. A waiting period shall apply to the following practitioners, APPs, or BHPs:

1. An applicant who:

   i. Has received a final adverse decision regarding appointment; or
   ii. Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body.

2. A former member who has:

   i. Received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or
   ii. Resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Medical Executive Committee or Governing Body issuing an adverse recommendation.

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3. A member who has received a final adverse decision resulting in:

i. Termination or restriction of his or her privileges; or
ii. Denial of his or her request for additional privileges.

b. Ordinarily, the waiting period shall be 24 months. However, for practitioners, APPs, or BHPs whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Governing Body, to waive ~~the24~~the 24-month waiting period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application.

c. An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

4.7-2 Commencement Date of the Waiting Period

The waiting period commences on the latest date on which the application or request was withdrawn, a member's resignation became effective, or upon completion of:

a. All Medical Staff and PSMC hearings and appellate reviews, and

b. All judicial proceedings pertinent to the action served within two years after the completion of PSMC proceedings.

4.7-3 Effect of the Waiting Period

Except as otherwise allowed (per Bylaws, Section 4.7-1(b), above), practitioners, APPs, or BHPs subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the practitioner, APP, or BHP may reapply. The application will be processed like an initial application or request, plus the practitioner, APP, or BHP shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

4.8 Confidentiality; Impartiality

To maintain confidentiality and to ~~assure~~ensure the ~~unbiased performance~~impartial process of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws and ~~Rules~~Policies for processing applications for appointment and reappointment.

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Article 5 Privileges

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5.1 Exercise of Privileges

Except as otherwise provided in these Bylaws or the ~~Rules~~Policies, every ~~practitioner~~Practitioner or ~~Allied Health Professional~~APP and BHP providing direct clinical services at ~~PSMCshall~~PSMC shall be entitled to exercise only those ~~setting~~specialty-specific privileges granted to him or her.

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Practitioners, APPs, and BHPs who wish to participate in the delivery of telemedicine services (whether to patients of PSMC, or to patients of another facility that PSMC is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. (Additionally, ~~practitioners~~Practitioners, APPs, and BHPs who are not otherwise members of PSMC's Medical Staff who wish to provide services via telemedicine technology must apply for and be granted membership and privileges as part of the Telemedicine Staff -in order to provide services to patients of PSMC.)

5.2 Criteria for Privileges/General Competencies

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5.2-1 Criteria for Privileges

Subject to the approval of the Medical Executive Committee and Governing Body, the Medical Staff will be responsible for developing criteria for granting ~~setting~~specialty-specific privileges (including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine~~).~~ if the distant-site telemedicine entity does not have its own criteria or privilege forms). These criteria shall address PSMC's general competencies (as described below) and ~~assure~~ensure uniform quality of patient care, treatment, and services. Insofar as feasible, affected ~~categories of Allied Health Professionals~~APPs and BHPs shall participate in developing the criteria for privileges to be exercised by ~~Allied Health Professionals.~~APPs and BHPs. Such criteria shall not be inconsistent with the Medical Staff Bylaws, ~~Rules or policies.~~Policies and/or State law/regulation (e.g., Physician Assistants are subject to supervision per Colorado Medical Board Rule 400; a CRNA at a Critical Access Hospital may administer anesthesia).

5.2-2 General Competencies

The Medical Staff shall assess all practitioners', APPs', and BHPs' current proficiency in the general competencies of the PSMC, which shall be established by the Medical Staff and shall include assessment of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The Medical Staff shall define how to measure these general competencies as applicable to the privileges requested, and shall use them to regularly monitor and assess each practitioner's, APP's, and BHP's current proficiency.

5.3 Delineation of Privileges in General

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5.3-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The basic steps for processing requests for privileges are described at Bylaws, Section 4.2.

5.3-2 Basis for Privilege Determinations

Requests for privileges shall be evaluated on the basis of PSMC's needs and ability to support the requested privileges and assessment of the applicant's general competencies with respect to the requested privileges, as evidenced by the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance, (as confirmed by peers knowledgeable of the applicant's professional performance), health status, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge, and compliance

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with any specific criteria applicable to the privileges requested. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges.

5.3-3 Telemedicine Privileges

~~a. The initial appointment~~Granting of telemedicine privileges ~~may be~~is based upon~~:~~

~~1. The practitioner's full compliance with PSMC's privileging standards; or~~

~~2. By using PSMC's standards but relying on information provided by the hospital(s) at which the practitioner routinely practices.~~

~~3. If the hospital where the practitioner routinely practices is accredited by The Joint Commission and agrees to provide a comprehensive report of the practitioner's qualifications, by relying entirely on the privileging of that other hospital~~ Medical~~.~~

~~**b. Reappointment of a Telemedicine**~~ Staff ~~**member's privileges may be based upon performance at PSMC, and, if insufficient information is available, upon information from the hospital(s) where the practitioner routinely practices.**~~ Policy.

5.4 Admissions; Responsibility for Care; History and Physical Requirements; and Other General Restrictions on Exercise of Privileges by ~~Limited License Practitioners~~Medical Staff, APPs and Podiatrists, Oral Surgeons, and Dentists

5.4-1 Admitting Privileges

a. Only ~~Medical Staff members~~physicians (MDs or DOs) with admitting privileges may independently admit patients to the hospital. ~~The following categories of licensees are eligible to independently admit patients to the hospital:~~

~~1. Physicians (MDs or DOs).~~

~~b. The following categories of licensees are eligible to co-admit (together with a licensee meeting the requirements of subparagraph 5.4-1(a), above) patients to the hospital:~~

~~1. Physician Assistants.~~

5.4-2 Responsibility for Care of Patients

a. All patients admitted to ~~the hospital~~PSMC must be under care of a member of the Medical Staff with appropriate privileges.

b. The admitting member of the Medical Staff shall establish, at the time of admission, the patient's condition and provisional diagnosis.

c. For patients admitted by or upon order of a dentist, oral surgeon, or podiatrist, members may not address care outside their scope of practice or clinical privileges, therefore, a physician member of the Medical Staff must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the ~~limited license practitioner's~~podiatrist, oral surgeon, or dentist's lawful scope of practice or clinical privileges.

5.4-3 History and Physicals and Medical Appraisals

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a. Members of the Medical Staff and Advanced Practice Professional staff, with appropriate privileges, may perform history and physical examinations. Pursuant to CMS Conditions of Participation PSMC maintains a record for each patient that includes, as applicable: history and physical, progress notes, discharge summary and informed consent.

b. When evidence of appropriate training and experience is documented, a ~~limited license practitioner~~podiatrist, oral surgeon, or dentist, with appropriate privileges, may perform the history or physical on his or her own patient. Otherwise, a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

c. ~~All patients admitted for care in a hospital by a dentist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the Chief of Staff.~~

~~d.~~ The admitting or referring member of the Medical Staff shall ~~assure~~ensure the completion of a physical examination and medical history on all patients within 24 hours ~~after~~of admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation~~), or immediately before.~~). This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission or registration (the results of which are recorded in PSMC's medical record) so long as an examination for any changes in the patient's condition is completed and documented in PSMC's medical record within 24 hours ~~after~~of admission or registration.

~~e~~d. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation. The practitioner responsible for administering anesthesia may, if granted clinical privileges, perform this updating history and physical.

5.4-4 Surgery and High Risk Interventions by ~~Limited License Practitioners~~Podiatrists, Oral Surgeons, or Dentists

a. Surgical procedures performed by dentists, oral surgeons, and podiatrists shall be under the overall supervision of the ~~applicable department chair~~Surgery Department Medical Director or the ~~department chair's~~Medical Director's designee~~.~~ and may be declined by the Surgery Department Medical Director if he/she determines such procedure is not appropriate for this facility.

b. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the Medical Staff) diagnostic or therapeutic interventions.

5.5 Temporary Privileges

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~~5.5-1 Circumstances~~

~~a. Temporary privileges may be granted after appropriate initial application:~~

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1. For 90-day periods, subject to one additional 90-day period during the pendency of an application or unusual circumstances; and

2. 3. As otherwise necessary to fulfill an important patient care need.

b. Temporary members of the Medical Staff who are granted temporary membership for purposes of serving on a standing or ad hoc committee for investigation proceedings, are not, by virtue of such membership, granted temporary clinical privileges.

5.5-2 Application and Review

a. Temporary privileges may be granted after the applicant completes the initial application procedure and the Medical Staff office completes the application review process. The following conditions apply:

1. There must first be verification of:

i. Current licensure;
ii. Relevant training or experience;
iii. Current competence;
iv. Ability to perform the privileges requested.

2. The results of the National Practitioner Data Bank and Colorado Medical Board queries have been obtained and evaluated.

3. The applicant has:

i. Filed a complete application with the Medical Staff office;
ii. No current or previously successful challenge to licensure or registration;
iii. Not been subject to involuntary termination of Medical Staff membership at another organization; and
iv. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

b. There is no right to temporary privileges. Accordingly, temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's or Allied Health Professional's qualifications, ability and judgment to exercise the privileges requested.

c. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.

d. Temporary privileges may be granted by the Chief Executive Officer (or his or her designee) upon the Chief Executive Officer's receipt of the recommendation of the Chief of Staff.

e. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

f. Temporary privileges are not intended to address delays in the application for reappointment; delays in reappointment are addressed in accordance with Article 4 of these Bylaws.

5.5-3 General Conditions and Termination

a. Members granted temporary privileges may be subject to performance evaluations at the discretion of the Chief of Staff or a Department Chair.

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~~b. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Bylaws, Section 5.5-1(a), or earlier terminated as provided at Bylaws, Section 5.5-3(c), below.~~

~~c. Temporary privileges may be terminated with or without cause at any time by the CMO (if such position is filled) or the Chief Executive Officer after conferring with the Chief of Staff. A person shall be entitled to the procedural rights afforded by the Bylaws, Article 14, Hearings and Appellate Reviews, only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.~~

~~d. Whenever temporary privileges are terminated, the Chief of Staff (or his/her designee) shall assign a member to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.~~

~~e. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules.~~

~~5.6~~ NOTE: CMS is evaluating methods to address the granting of temporary privileges; should CMS issue a regulation or opinion letter that is inconsistent with these Bylaws, the Bylaws shall be restricted to comply with CMS regulation or opinion letter.

The process for granting Temporary Privileges shall follow an approved Medical Staff Policy due to the uncertainty of CMS Conditions of Participation regarding this topic.

5.6 Mass Casualty Events~~—~~, Disaster Privileges, and Emergency Privileges

5.6-1 Mass Casualty Events - Temporary Release of Privilege Restrictions for Active Medical Staff.

A "Mass Casualty Event" is a circumstance where PSMC has more casualties than resources but such event may not rise to the level of a "disaster" as described in Section 5.~~7~~6-2. In a Mass Casualty Event, PSMC's Chief Executive Officer, based upon recommendation of the Chief of Staff ~~(his/her designee or in the absence of the same~~, the appropriate department ~~chair),~~Medical Director, and/or Chief Medical Officer, may temporarily release (on a Member by Member basis) the restrictions to privileges of ~~Active~~ Medical Staff so that such ~~Active~~ Medical Staff Members may do everything reasonably possible, within the scope of each Member's licensure, to address immediate patient needs. Any Member providing care at a Mass Casualty Event based upon such temporary release of privilege restrictions shall yield care to another more qualified Member as one becomes available. To the extent possible, the Chief of Staff, department Medical Directors and ~~Department Chairs~~/or Chief Medical Officer shall arrange for appropriate monitoring of Members providing care pursuant to a temporary release of privilege restrictions during a Mass Casualty Event. The Chief Executive Officer, based upon consultation with the Chief of Staff, will determine when the Mass Casualty Event has concluded; immediately upon such conclusion, all ~~Active~~ Medical Staff will be restored to the same restrictions to privileges as existed immediately prior to the Mass Casualty Event.

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5.~~7~~6-2 Disaster Privileges

~~5.7-1~~ In addition to the release of privilege restrictions described in 5.6-1 above, disaster privileges may be granted when PSMC's disaster plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

a. Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon recommendation of the Chief of Staff (his/her designee or in the absence of the same, the appropriate department ~~chair~~Medical Director), upon presentation of a valid government-issued photo identification issued by a state or federal agency **and** any of the following:

1. A current picture hospital identification card;
2. A current license to practice and primary source verification of the license;
3. Identification indicating that the practitioner or APP is a member of a Disaster Medical Assistance Team;
4. Identification indicating that the practitioner, APP, or BHP has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
5. Presentation by current hospital or Medical Staff member(s) with personal knowledge regarding the ~~practitioner's~~practitioner, APP, or BHP's identity.

b. Persons granted disaster privileges shall wear identification badges denoting their status as a Disaster Medical Assistance Team member.

c. The Medical Staff office shall begin the process of verification of credentials and privileges as soon as the immediate situation is under control, using a process identical to that described in ~~Bylaws, Section 5.5-2, above~~the Medical Staff Temporary Privileges Policy (except that the individual is permitted to begin rendering services immediately, as needed).

d. The Chief of Staff ~~(~~, department Medical Directors and/or ~~his/her designee)~~the Chief Medical Officer shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners, APPs, and BHPs granted disaster privileges.

~~5.7-2~~e. In the event of disaster, any member of the Medical Staff ~~or credentialed Allied Health Professional~~ shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member ~~or Allied Health Professional~~ shall promptly yield such care to a qualified member when one becomes available. If additional practitioners, APPs, or BHPs are needed and available, the emergency credentialing procedure described herein shall be used to grant credentials to the practitioner, APP, or BHP.

5.~~8~~6-3 Emergency Privileges

Emergency privileges are granted in three situations:

a. For a Medical Staff member to exceed his or her clinical privileges to save a patient from serious harm.

b. For any person to do whatever is reasonably possible to save a patient from serious harm.

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c. For known practitioners to provide coverage of a clinical function that is devoid of coverage. The scope and time of these privileges is determined by the COS and CEO.

5.7 Transport and Organ Harvest Teams

Properly licensed practitioners or APPs who individually, or as members of a group or entity, have contracted with PSMC to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with PSMC.

5.~~9~~8 Dissemination of Privileges List

Documentation of current privileges (granted, modified, or rescinded) shall be disseminated to PSMC admissions/registration office and such other scheduling and health information services personnel as necessary to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring to ~~assure~~ensure that practitioners, APPs, and BHPs are appropriately privileged to perform all services rendered.

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Article 6 ~~Allied Health~~ Advanced Practice Professionals and Behavioral Health Providers

6.1 Qualifications of ~~Allied~~Advanced Practice Providers and Behavioral Health ~~Professionals~~Providers

~~Allied~~Advanced Practice Providers and Behavioral Health ~~Professionals (AHPs~~Providers(APPs and BHPs) are ~~not~~ eligible for Medical Staff membership~~.~~, but APPs and BHPs are not eligible to vote nor to hold office as Chief of Staff or Vice Chief of Staff. They may be granted membership and practice privileges if they hold a license, certificate or other credentials in a category of ~~AHPs~~APPs and BHPs that the Governing Body (after securing Medical Executive Committee comments) has identified as eligible to apply for practice privileges, and only if the ~~AHPs~~APPs and BHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and ~~Rules~~Policies.

6.2 Categories

The Governing Body shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those ~~categories~~types of ~~AHPs~~APPs and BHPs that shall be eligible to exercise privileges at PSMC. Such ~~AHPs~~APPs and BHPs shall be subject to the supervision requirements developed by the Medical Executive Committee (or its designee committee), recommended by the Medical Executive Committee, and ~~approved~~accepted by the Governing Body.

6.3 Privileges and Department Assignment

6.3-1 ~~AHPs~~APPs and BHPs may exercise only those ~~setting~~specialty-specific privileges granted to them by the Governing Body. The range of privileges for which each ~~AHP~~APP and BHP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the ~~–~~Medical Executive Committee and the final decision of the Governing Body.

6.3-2 An ~~AHP~~APP or BHP must apply and qualify for practice privileges~~, and practitioners~~. Practitioners who desire to supervise or direct ~~AHPs~~APPs or BHPs who provide dependent services must apply and qualify for privileges to supervise approved ~~AHPs~~APPs or BHPs. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided ~~for practitioners~~ in Article 4 and 5 hereof, unless otherwise specified in the ~~Rules~~Policies.

6.3-3 Each ~~AHP~~APP or BHP shall be assigned to the department or departments appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the ~~Rules~~Policies, shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to ~~AHPs~~APPs or BHPs and appropriately tailored to the particular ~~AHP~~APP or BHP.

6.4 Prerogatives

The prerogatives which may be extended to an ~~AHP shall be defined in the Rules and/~~APP or ~~PSMC policies. Such prerogatives may include~~BHP are as follows:

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6.4-1 Provision of specified patient care services; which services may be provided independently or under ~~the~~ supervision or direction ~~of a Medical Staff member~~as required by Colorado State law and/or PSMC Policy and consistent with the practice privileges granted to the ~~AHP~~APP or BHP and within the scope of the ~~AHP's~~APP's or BHP's licensure or certification. ~~Rules~~Policies may be adopted to further describe matters related to such supervision and direction.

6.4-2 Service on the Medical Staff, department and PSMC committees.

~~**6.4-3** Attendance at the meetings of the department to which the AHP is assigned, as permitted by the department rules (if any), and attendance at PSMC education programs in the AHP's field of practice.~~

6.5 Responsibilities

Each ~~AHP~~APP or BHP shall:

6.5-1 Meet those responsibilities required by the ~~Rules~~Policies and as specified for practitioners in Bylaws, Section 2.~~6~~5, as they may be logically applied to reflect the more limited practice of the ~~AHP~~APP or BHP.

6.5-2 Retain appropriate responsibility within the ~~AHP's~~APP's or BHP's area of professional competence for the care and supervision of each PSMC patient for whom the ~~AHP~~APP or BHP is providing services.

6.5-3 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time. Meet those responsibilities required by Medical Staff Policies and as specified in these Bylaws, Articles 7, 13, and 14.

6.6 Procedural Rights of ~~Allied~~Advanced Practice Providers and Behavioral Health ~~Professionals~~Providers

6.6-1 Fair Hearing and Appeal

Denial, revocation, or modification of ~~AHPs'~~APP's or BHP's privileges shall be the prerogative of the Medical Executive Committee and the Governing Body. The procedural rights described at Bylaws, Article 14, Hearings and Appellate Reviews, shall apply.

6.6-2 Automatic Administrative Suspension, Limitation, or Termination

APPs and BHPs shall be subject to these Bylaws Section 13.3 Automatic Administrative Suspension or Limitation. Notwithstanding the provisions of Bylaws, Section 6.6-1, ~~an AHP's~~any APP or BHP, who is required by state law to be supervised, shall have their privileges ~~shall~~ automatically ~~terminate~~terminated, without right of any review pursuant to Bylaws, Section 6.6-1 or any other Section of the Medical Staff Bylaws, in the event of the following:

a. The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary ~~(NOTE: if~~. If the Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary, the ~~AHP's~~APP's or BHP's privileges shall first be automatically suspended, without right of any review pursuant to Section 6.6.-1 or any other Section of the Medical Staff Bylaws, for a period of up to seven (7) calendar days. If by the end of such non-reportable 7-day suspension, the ~~AHP~~APP or BHP does not: (1) obtain a ~~supervisor~~supervising practitioner with appropriate

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privileges at PSMC; and (2) complete all forms for change in supervisor and submit the same to the Medical Staff ~~Coordinator~~Office Manager, the ~~AHPs~~APP or BHP's membership and/or privileges shall be automatically terminated. If during the 7-day period, the ~~AHP~~APP or BHP meets the two criteria (obtains a supervisor with privileges and completes/submits forms), then the ~~AHP's~~APP's or BHP's privileges suspension shall continue until such substitution of supervisor is appropriately reviewed and approved by PSMC and applicable authorities.

b. The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the ~~AHP~~APP or BHP and the supervising practitioner is otherwise terminated, regardless of the reason therefore~~; or~~.

~~c. The AHP's certification or license expires, is revoked, or is suspended.~~

Where the ~~AHP's~~APP or BHP's privileges are automatically terminated for reasons specified in Section 6.6-2(a), above, the ~~AHP~~APP or BHP may apply for reinstatement as soon as the ~~AHP~~APP or BHP has found another supervising practitioner who agrees to supervise the ~~AHP~~APP or BHP and receives privileges to do so. In this case, the Medical Executive Committee may, in its discretion, expedite the reapplication process.

~~**6.6-3 Review of Category Decisions**~~

~~The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Governing Body, which has the discretion to decline to review the request or to review it using any procedure the Governing Body deems appropriate.~~

Article 7 Performance Evaluation and Monitoring

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7.1 General Overview of Performance Evaluation and Monitoring Activities

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These Bylaws require that the Medical Staff develop ongoing performance evaluation and monitoring activities to meet two goals: ~~-~~(1) to continuously improve towards excellence in medical care; and (2) to improve team functions in providing medical care at PSMC. Further, performance evaluations help to ensure that decisions regarding appointment to membership on the Medical Staff and granting or renewing of privileges are, among other things, detailed, current, accurate, objective and evidence-based. Additionally, performance evaluation and monitoring activities help ~~assure~~ensure timely identification of problems that may arise in the ongoing provision of services at PSMC. Problems identified through performance evaluation and monitoring activities are addressed via the appropriate performance improvement and/or remedial actions as described in Bylaws, Article 13, Performance Improvement and Formal Corrective Action.

7.2 Performance Monitoring Generally

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7.2-1 Except as otherwise determined by the Medical Executive Committee and Governing Body, the Medical Staff shall regularly monitor all members' privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies and/or rules as may be developed, from time to time, by the Medical Staff and approved by the Medical Executive Committee and the Governing Body.

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7.2-2 Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. As more thoroughly set forth in Article 14, performance monitoring (and other actions that are not deemed "adverse") does not give rise to the procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews.

7.2-3 The Medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined necessary.

7.2-4 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

7.2-5 The results of any ~~practitioner~~member-specific performance monitoring shall be considered when granting, renewing, revising or revoking clinical privileges of that practitioner, APP, or BHP.

7.2-6 PSMC Medical Staff complies with CMS Conditions of Participation regarding adverse events and complaints about telemedicine services.

7.3 ~~Periodic~~Ongoing Professional Performance Evaluations

~~**7.3-1** The Medical Staff (which may be designated to departments) will conduct Periodic Professional Performance Evaluations (PPPE) of all Medical Staff at least once every two years. Notwithstanding the foregoing, the Medical Staff will strive to conduct random PPPE, at a rate of the greater of two percent (2%) of the member's cases or ten of the member's cases, each year. For any PPPE conducted, the Medical Staff will recommend, for Medical Executive Committee and Governing Body approval, the following: (1) the defined measures and indicators; (2) who will conduct the review; and (3) the process that will be utilized for PPPE. **7.3-2** Methods that may be used to gather information for Periodic Professional Performance Evaluations include, but are not limited to, the following:~~

~~a. Periodic chart review;~~

~~b. Direct observation;~~

~~c. Monitoring of diagnostic and treatment techniques;~~

~~d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.~~

~~**7.3-3** If PPPE is conducted, such performance reviews shall be factored into the decision to maintain, revise or revoke a practitioner's existing privilege(s).~~

~~**7.4 Focused Professional Practice Evaluation**~~

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~~7.4-1 The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in predetermined situations to evaluate, for a *time-limited* period, a practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with additional rules and the Professional Review Committee may supplement with forms and procedures that may further define the process, including but not limited to, the following: (1) any additional circumstances when a focused evaluation will occur; (2) the defined measures and indicators; (3) who will conduct the review; (4) if proctoring is conducted, who will do it and how it will be maintained in the confidential peer review process; (5) the duration of the evaluation period and requirements for extending the evaluation period; and (6) how the information gathered during the evaluation process will be analyzed and communicated.~~

~~7.4-2 Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:~~

~~a. Retrospective or concurrent chart review;~~

~~b. Monitoring clinical practice patterns;~~

~~c. Simulation;~~

~~d. External peer review;~~

~~e. Discussion with other individuals involved in the care of each patient;~~

~~f. Proctoring, as more fully described at Bylaws, Section 7.4-4, below.~~

~~7.4-3 A Focused Professional Practice Evaluation shall be used in at least the following situations:~~

~~a. Unless PPPE is conducted as a substitution, all initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation in accordance with these Bylaws. Such focused evaluation may include a variety of measures (as described in Section 7.4-2) and may include a period of Level I proctoring in accordance with Bylaws, Section 7.4-4(a), below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.~~

~~b. In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area). Such evaluation may include a variety of measures (as described in Section 7.4-2) and may include Level I proctoring in accordance with Bylaws, Section 7.4-4(a)(1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.~~

~~c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at PSMC as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include a variety of measures (as described in Section 7.4-2) and may include either Level II or III proctoring, in accordance with these Bylaws, Sections Section 7.4-4(a)(1) or (2).~~

~~d. As otherwise defined in these Bylaws or applicable policies or in the absence of the same upon events that may include, but are not limited to, the following: unexpected deaths, unexpected complications, severe drug reactions, severe transfusion reactions, sentinel events, certain compensable events identified by the risk manager, all cases in which a letter of intent has been~~

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filed, written patient complaints concerning members or AHPs, staff reports of concern, or utilization issues.

e. Nothing in the foregoing precludes the use of other Focused Professional Practice Evaluation tools, in addition to or in lieu of proctoring, as deemed warranted by the circumstances.

7.4-4 Proctoring

a. **Overview of Proctoring Levels**

1. Level I proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with Bylaws, Section 7.4-3(a), above, and for review of infrequently used privileges in accordance with Bylaws, Section 7.4-3(b), above.

2. Level II proctoring is appropriate in situations where a practitioner's competency or performance is called into question, in accordance with Bylaws, Section 7.4-3(c), above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available).

3. Level III proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, Section 7.4-3(c), above, and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that practitioner is afforded such procedural rights as provided at Bylaws, Article 14, Hearings and Appellate Reviews.

b. **Overview of Proctoring Procedures**

1. Whenever proctoring is imposed, the Professional Review Committee will establish the proctor and the number (or duration) and types of procedures to be proctored.

2. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.

3. In the event that the new applicant has privileges at a neighboring hospital where members of PSMC's Medical Staff are familiar with the member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information from the neighboring hospital may, at the discretion of the Professional Review Committee, be acceptable to satisfy a portion of the focused professional practice evaluation required for PSMC.

c. **Proctor: Scope of Responsibility**

1. All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the applicable department, the Medical Executive Committee, the Professional Review Committee and the Governing Body. No conflict relationship (i.e., family members, domestic partners, business partners, etc.) shall

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exist between proctor and proctoree; the mere fact that employees of PSMC may be in a position to proctor other employees of PSMC shall not, in itself, be deemed a conflict.

2. The intervention of a proctor shall be governed by the following guidelines:

i. A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. The role of the proctor is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the department Chair (and if the Chair has a conflict of interest, then report to the Chief of Staff, and if the Chief of Staff has a conflict of interest, then report to the Vice Chief of Staff).

ii. A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.

iii. In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so.

d. Completion of Proctoring

Once proctoring commences, the staff member shall remain subject to such proctoring until the Professional Review Committee has been furnished with:

1. A report signed by the Chair of the department (and if the Chair has a conflict of interest, then report to the Chief of Staff, and if the Chief of Staff has a conflict of interest, then report to the Vice Chief of Staff) to which the Staff Member is assigned describing the types and numbers of cases observed and the evaluation of the member's performance, a statement that the member appears to meet all of the qualifications for unsupervised practice at PSMC, has discharged all of the responsibilities of Medical Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made.

e. Effect of Failure to Complete Proctoring

1. **Failure to Complete Necessary Volume.** Any practitioner or member undergoing Level I or Level II proctoring who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Bylaws, Article 14, Hearings and Appellate Reviews. However, the department chair has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews.

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~~2. **Failure to Satisfactorily Complete Proctoring.** If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may have his/her privileges entirely revoked/terminated (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Bylaws, Article 14, Hearings and Appellate Reviews.~~ PSMC's Medical Staff shall conduct confidential peer review of all Medical Staff. PSMC's Medical Staff peer review process shall be set forth in Medical Staff policy, approved by both the MEC and Governing Body; such policy shall meet the minimum standards and criteria set forth in CMS' Conditions of Participation.

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Article 8 Medical Staff Officers

8.1 Medical Staff Officers — General Provisions

8.1-1 Identification

a. There shall be the following ~~general officers~~"Elected Officers" of the Medical Staff:

1. Chief of Staff
2. Vice Chief of Staff

b. In addition, the Medical Staff's department~~ chairs and the Chief~~/program Medical ~~Officer~~Directors described in Section 10.2-1 are deemed to be Medical Staff Officers for purposes of these Bylaws. The CMO is an ex-officio member of all Medical Staff Committees.

8.1-2 Qualifications

All Medical Staff officers shall:

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

b. Understand and be willing to work toward attaining PSMC's lawful and reasonable policies and requirements;

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

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

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

f. Be a physician and an ~~active~~Active Medical Staff member (and remain in good standing as an ~~active~~Active Medical Staff member while in office); and

g. Not have any significant conflict of interest.

8.1-3 Disclosure of Conflict of Interest

a. All nominees for election or appointment to elected Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to Bylaws, Section 8.2-~~3~~1) shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her

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professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a ~~practitioner~~physician who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

8.2 Method of Selection — ~~General~~Elected Officers

8.2-1 ~~Nominating Committee~~Nominations

a. Any person who meets the qualifications of 8.1-2 and wishes to serve as the Chief of Staff or the Vice-Chief of Staff may self-nominate by providing an email, at any time during the month of September in odd-years, to the Manager of the Medical Staff Office (or at any time when there is an impending vacancy of an Elected Officer position). If during the election process in the month of October, there are three or more nominees on the slate and one nominee withdraws, the Manager of the Medical Staff Office will restart the election process so that all qualifying Medical Staff have an opportunity to vote for the amended slate of candidates; the restart of the election process will alter the deadlines set forth herein to allow thirty-one days for the voting.

b. ~~An ad hoc nominating committee composed of the Chief of Staff, two staff members elected by the Medical Executive Committee, and two staff members appointed by the Chief of Staff shall develop a slate of candidates meeting the qualifications of office, as described in Bylaws, Section 8.1-2, above. This slate shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated for each of the following positions:~~

~~a. Chief of Staff, and~~

~~b. Vice Chief of Staff.~~

An election will occur for each Elected Officer position only if there is more than one nominee for that position. If there is only one nominee during the stated nomination period in 8.2-1 (a) for either the Chief of Staff or Vice Chief of Staff positions, then the single nominee shall be declared the officer effective January 1 of the following year without need for a vote by the Medical Staff.

8.2-2 Election

~~Generally, the election shall be by electronic mail secret ballot, and the outcome shall be determined by a majority of the votes cast by electronic mail secret ballots that are returned to the Medical Staff office within 15 days after the secret ballots were emailed to the voting Medical Staff members. Except with respect to legal advice, the medical staff office will receive and retain the ballots as confidential.~~

The election for Elected Officers shall be managed confidentially by the Manager of the Medical Staff Office. On the first business day of October in odd-years, the Manager of the Medical Staff

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Office will issue a ballot (setting forth the names of all nominations submitted in accordance with 8.2-1) to Medical Staff members who have the right to vote (see chart at Section 3.4 of these Bylaws); said medical staff members will have until 5:00 p.m. MST on October 31st to cast votes. By November 7th in odd years, the Manager of the Medical Staff Office shall tally the votes and the persons receiving the most votes for Chief and Vice-Chief shall be declared the new officers as of the following January 1. If there is a tie, the Manager of the Medical Staff Office shall issue a new ballot with the names of only the two persons who tied for an office; such ballot must be issued by November 14th and must be returned to the Medical Staff Office no later than 5:00 p.m. MST on November 30th. Thereafter, the Manager of the Medical Staff Office shall tally the votes and declare the person receiving the most votes for the office as the new officer as of January 1. In the event there is a second tie, the physicians on MEC shall cast votes between the two candidates to break the tie.

8.2-3 Term of Office for Elected Officers

a. Officers shall be elected in the fall of odd-numbered years and shall take office the following January.

b. The term of office for Elected Officers shall be two years. There are no term limits for serving as a Medical Staff Officer.

8.3 Recall of Elected Officers

~~A general~~An Elected Medical Staff Officer may be recalled from office for any valid cause including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of ~~a general Medical Staff~~an Elected Officer may be initiated by the Medical Executive Committee or by a petition signed by at least 33-1/3 percent of the Medical Staff members eligible to vote for ~~officers~~Elected Officers; but recall itself shall require a ~~66-2/3 percent vote of the Medical Executive Committee or~~ 66-2/3 percent vote of the Medical Staff members eligible to vote for general Medical Staff Officers.

8.4 Filling Vacancies

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

8.4-1 A vacancy in the office of Chief of Staff shall be filled by special election held in general accordance with Bylaws, Section 8.2 except the specific months do not apply.

8.4-2 A vacancy in the office of Vice Chief of Staff shall be filled by special election held in general accordance with Bylaws, Section 8.2 except the specific months do not apply.

8.5 Duties of Officers

8.5-1 Chief of Staff

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

a. Enforcing the Medical Staff Bylaws and ~~Rules~~Policies with the Medical Staff, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

b. Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

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c. Serving as Chair of the Medical Executive Committee and the Professional Review Committee, and in that capacity shall be deemed the individual responsible for the organization and conduct of the Medical Staff;

d. Serving as an ex officio member of all other Medical Staff committees without vote, unless his or her membership in a particular committee is ~~required~~established by these Bylaws;

e. ~~Appointing~~Other than MEC, professional review committee and department committees established by these Bylaws, appointing, in consultation with the ~~Medical Executive Committee,~~MEC, the committee members for ~~all standing,~~ ad hoc~~, and~~ or special Medical Staff~~, liaison, or multi-disciplinary committees except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chairs of these~~ committees~~;~~.

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

~~g. Serving on liaison committees~~ with ~~the Governing Body and administration, as well as outside licensing or accreditation agencies~~administration;

~~h. Appointing members of the Medical Staff to participate, as a Medical Staff liaison, in the development of PSMC policies;~~

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

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

~~k. Interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern to PSMC;~~

~~l~~i. Representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer and serving as an ex-officio member of the Governing Body;

~~m. Serving on the Compliance and Accreditation Committee;~~

~~n~~j. Being accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services at PSMC and for the effectiveness of the quality assurance ~~and utilization review~~ programs; and

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

8.5-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive ~~Committee and of the Compliance and Accreditation~~ Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or the Medical Executive Committee.

8.5-3 Delegated Duties to the Medical Staff ~~Coordinator~~Office Manager (or administrative support staff as agreed upon with the CEO):

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The Chief of Staff delegates the following duties to a Medical Staff ~~Coordinator~~Office Manager (who is not a Medical Staff member, officer, nor ex officio member of the Medical Executive Committee):

a. Maintaining a roster of Medical Staff members ~~and AHPs~~;

b. Keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

c. Calling meetings and preparing agendas on behalf of the Chief of Staff or Medical Executive Committee;

d. Attending to correspondence and notices on behalf of the Medical Staff;

e. Receiving and causing to be safeguarded all funds of the Medical Staff;

f. Documenting requests for excused absences from meetings for consideration, as necessary, by the Medical Executive Committee; and

g. Performing such other duties as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.6 Chief Medical Officer

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8.6-1 Appointment

The Chief Medical Officer is an at-will position appointed by the Governing Body (which the Governing Body may designate such duty to the Chief Executive Officer~~) and approved by the Medical Executive Committee~~). In the absence of a CMO, the CEO may assume the committee participation set forth in 8.6-3.

8.6-2 Responsibilities

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

b. In keeping with the foregoing, the Chief Medical Officer shall:

1. Serve as administrative liaison among PSMC administration, the Governing Body, outside agencies and the Medical Staff, as well as licensing and accreditation agencies;

2. Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of PSMC; and

3. In cooperation and close consultation with the Chief of Staff and the Medical Executive Committee, ~~supervise~~provide direction to the ~~day-to-day~~ performance of the Medical Staff ~~office~~Office and PSMC's quality improvement personnel.

8.6-3 Participation in Medical Staff Committees

The Chief Medical Officer:

a. Shall be an ex officio member—without vote—of all Medical Staff Committees~~, except the Compliance and Accreditation Committee (which the Chief Medical Officer shall attend~~

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~~as a resource person) and any hearing committee~~ except as otherwise established by these bylaws.

b. May attend any meeting of any department or section.

Article 9 Committees

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9.1 General

9.1-1 ~~Designation~~Standing Medical Staff Committees

~~The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the~~ The standing committees of the Medical Staff~~. Special or ad hoc committees may be created by~~ shall be: (a) the Medical Executive Committee~~ to perform specified tasks. Any committee — whether Medical Staff-wide or department or other~~; (b) the Professional Review Committee; (c) clinical ~~unit, or standing or ad hoc — that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.~~

~~**9.1-2 Appointment of Members**~~

~~a. Unless otherwise specified, the Chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Medical Executive~~Department/Program specific committees; (d) and if needed, the Ethics Committee. ~~Medical Staff committees shall be responsible to the Medical Executive Committee.~~

~~b. A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; Allied Health Professionals; representatives from~~ The PSMC ~~departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with votes~~ Medical Staff has no other committees unless ~~the statement of committee composition designates the position as nonvoting.~~formed pursuant to Medical Staff policy (as such policies are approved by MEC and the Governing Board).

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~~**c. The Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-**~~**9.1-2 Members of Medical Staff Committees**

a. MEC members are as set forth in Section 9.3;

b. PRC members are set forth in Section 9.2;

c. Clinical Department/Program committees shall include the Medical Director, the Medical Staff members ~~who serve in non-ex officio capacities.~~

~~d. The Committee Chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.~~

~~e. Each Committee Chair shall appoint a Vice Chair to fulfill the duties of the Chair in his or her absence and to assist as requested by the Chair. Each Committee Chair or other authorized~~

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~~person chairing a meeting has the right to discuss and to vote on issues presented to the committee.~~

~~**9.1-3 Representation on PSMC Committees and Participation in PSMC Deliberations**~~

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

~~**9.1-4 Ex Officio Members**~~

~~The Chief of Staff and the Chief Executive Officer, or their respective designees and the Chief Medical Officer are~~ of the department, ex officio members ~~of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.~~, and the Medical Director invitees who are employed by PSMC and subject to confidentiality.

d. Ethics committee members are set from time to time by Medical Staff policy (as such policies are approved by MEC).

9.1-~~5~~3 Action Through Subcommittees

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

~~**9.1-6 Terms and Removal of Committee Members**~~

~~Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official. Except as provided in the immediately preceding sentence, any committee member may be removed by a majority vote of the Medical Executive Committee.~~

~~**9.1-7 Vacancies**~~

~~Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.~~

~~9.1-8~~9.1-4 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Bylaws, Article 11, Meetings.

9.1-~~9~~5 Attendance of Nonmembers

Any Medical Staff member who is in good standing may ask the Chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner~~.~~, APP, or BHP. The Committee Chair shall have the discretion to grant or

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deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and ~~Rules~~Policies applicable to that committee.

9.1-~~10~~6 Conflict of Interest

a. In any instance where a Medical Staff member has or reasonably could be perceived to have a conflict of interest, as defined below, such individual shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual with a conflict may be asked, and may answer, any questions concerning the matter before leaving. Any dispute over the existence of a conflict of interest shall be resolved by the chairperson of the committee, or, if it cannot be resolved at that level, by the Chief of Staff.

b. A conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The fact that ~~a committee member or~~any Medical Staff ~~leader~~member chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

9.1-~~11~~7 Accountability

All committees shall be accountable to the Medical Executive Committee.

9.2 Professional Review Committee

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9.2-1 Composition

There shall be a Professional Review Committee ("PRC") as described in this Section 9.2 and the definition section of these Bylaws. ~~Unless a specific~~ The Professional Review Committee ~~is created, the Medical Executive Committee (together with PSMC's Quality Officer/Director as an ex officio member) will fulfill the obligations of the Professional Review Committee. The number of members on the Professional Committee and the qualifications~~ shall be the ~~same as applicable~~Chief of Staff, Vice Chief of Staff, Medical Directors, and CMO notwithstanding that the Trauma Program has program specific peer review that may or may not be sent to ~~the Medical Executive Committee.~~ PRC.

9.2-2 Duties and Meeting Frequency

a. This committee shall serve as a focal point for furthering professional review, credentialing and quality improvement obligations as well as furthering an understanding of the roles, relationships, and responsibilities of the Governing Body, administration, and the Medical Staff with respect to the same. It may also serve as a forum for discussing any PSMC matters regarding the provision of patient care. It shall meet ~~at least quarterly or~~ as often as necessary to fulfill its responsibilities. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

~~b. The committee may also serve as the initial forum for exercise of the meet and confer provisions contemplated by Bylaws, Section 15.7; provided, however, that upon request of at~~

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~~least four committee members (which four must be comprised of at least three Medical Staff representatives and one Governing Body representative, or of at least three Governing Body representatives and one Medical Staff representative), a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.~~

9.2-3 Accountability

The Professional Review Committee is directly accountable to the Medical Executive Committee and directly accountable to the Governing Body.

9.3 Medical Executive Committee

9.3-1 Composition

The Medical Executive Committee ("MEC") shall be composed of (a) the Elected Medical Staff officers (Chief of Staff~~,~~ and Vice Chief of Staff~~, and ~~,); (b) the other Medical Staff officers described in Section 8.1-1 (the Medical Staff's department~~ chairs)~~,~~/program Medical Directors; and (c) at least one at-large representative selected ~~by the other voting members of the MEC, and the Trauma Medical Director~~per approved Medical Staff Policy. In addition, the Chief Medical Officer and the Chief Executive Officer of PSMC sit on the committee as ex officio members without vote. The Chief of Staff shall chair the Medical Executive Committee. ~~AHPs~~Advanced Practice Providers and Behavioral Health Providers are permitted on the Medical Executive Committee, but a majority of the committee must be physicians.

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9.3-2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below.

a. Supervise the performance of all Medical Staff functions, which shall include:

1. ~~Requiring regular reports and recommendations from the departments, committees and officers~~Issuing such directives as appropriate to ensure effective performance of ~~the~~all Medical Staff ~~concerning discharge of assigned~~ functions; and
2. ~~Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and~~

~~3.~~ Following up to ~~assure~~ensure implementation of all directives.

b. Coordinate the activities of the committees and departments.

c. ~~Assure~~Ensure that the Medical Staff adopts Bylaws and ~~Rules~~Policies establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.

d. Based on input and reports from the departments and applicable committees (if any), ~~assure~~ensure that the Medical Staff adopts Bylaws, ~~Rules~~Policies or regulations establishing criteria and standards, consistent with Colorado law, for Medical Staff membership and

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privileges (including, but not limited to, any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.

e. ~~Assure~~Ensure that the Medical Staff ~~adopt~~adopts Bylaws, ~~Rules~~Policies or regulations establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

f. Evaluate the performance of practitioners, APPs, or BHPs exercising clinical privileges whenever there is doubt about the ability to perform requested privileges by the an applicant~~,~~ or member~~, or Allied Health Professional~~.

g. Based upon input from the departments and applicable committees (if any), make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.

h. When indicated, initiate Focused Professional Practice Evaluations and/or pursue disciplinary or corrective actions affecting Medical Staff members.

i. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

1. The Medical Staff Bylaws~~, Rules,~~ and ~~policies~~Policies;
2. PSMC's Bylaws~~, Rules,~~ and ~~policies~~Policies;
3. State and federal laws and regulations; and
4. Accreditation requirements, as applicable.

j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.

k. Implement, as it relates to the Medical Staff, the approved policies of PSMC.

l. With input from departments and applicable committees (if any), set objectives for establishing, maintaining and enforcing professional standards within PSMC and for the continuing improvement of the quality of care rendered at PSMC; assist in developing programs to achieve these objectives including, but not limited to, Ongoing Professional Practice Evaluations, as further described at Bylaws, Article 7, Performance Evaluation and Monitoring.

m. ~~Regularly report to~~At the request of the Governing Body report through the Chief of Staff ~~and the Chief Executive Officer~~ on ~~at least~~ the following:

1. ~~The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Body that~~That quality of care is consistent with professional standards; and
2. The *general* status of any Medical Staff disciplinary or corrective actions in progress.

n. ~~Review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall assist PSMC in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in~~

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~~evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to notice and comment proceedings or other mechanisms that may be implemented by PSMC administration in making exclusive contracting decisions.~~

~~o.~~ Prioritize and ~~assure~~ensure that PSMC-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

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

~~q~~p. Establish the date, place, time and program of the regular meetings of the Medical Staff.

~~r~~q. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

~~s~~r. Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and PSMC.

The authority delegated pursuant to this Section 9.3-2 may be removed by amendment of these Bylaws. An amendment may be proposed by resolution of the Medical Staff, approved by a 2/3 vote of the eligible voting Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee. All amendments are subject to approval of the Governing Body.

9.3-3 Meetings

The Medical Executive Committee should be scheduled to meet on a monthly basis and shall meet at least ten times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

Article 10 Departments

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10.1 Organization of Clinical Departments of Pagosa Springs Medical Center

Upper San Juan Health Service District doing business as Pagosa Springs Medical Center encompasses different types of services including, without limitation, hospital services, clinic services, EMS and ambulance services. For purposes of these Bylaws, the clinic shall be referred to as a "department". Each department shall be organized as an integral unit of the Medical Staff and shall have a ~~Chair who will be selected and shall have the authority, duties, and responsibilities specified in the Rules. Additionally, each department may appoint a Department Committee and such other standing or Ad Hoc Committees as it deems appropriate to perform its required functions. The composition and responsibilities of each standing Department Committee shall be specified in the Rules. Departments may also form sections as described below.~~Medical Director as described in this Article 10.

10.2 Designation

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10.2-1 ~~Current~~ Designation of Departments/Programs with MEC representation

The ~~current~~designated clinical departments/programs of PSMC that have Department Medical Director representation on MEC are:

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- Acute Care (inpatient care) and other Medical Subspecialties (including Telemedicine);
- Primary Care (which means the rural health clinic for primary care):

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- Emergency Department~~, the Acute Care Department (inpatient care), the~~ ;
- Surgery Department~~,~~; and ~~as set forth~~
- Trauma Program.
- Any department subsequently added in accordance with Section 10.~~1, for purposes of these Bylaws, the Clinic shall be referred to as the Clinic Department~~2-2.

10.2-2 ~~Future~~Other Departments

~~The Medical Executive Committee will periodically restudy the designation of the departments and recommend to the Governing Body (including to its designee, the Chief Executive Officer) what action is desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Medical Executive Committee and the Governing Body.~~

There are many other clinical departments of PSMC as determined from time to time by PSMC administration. Such clinical departments do not have representation on MEC unless approved by amendment to these Bylaws.

10.3 Assignment to Departments

Each member shall be assigned membership in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with the practice privileges granted.

10.4 Functions of Departments

The departments shall fulfill the clinical, administrative, quality improvement/risk management/utilization management, and collegial and education functions described in ~~the Rules.~~PSMC policies and/or the Medical Staff Policies. When the department or any of its committees meets to carry out the duties described below, the meeting body shall ~~constitute a peer review committee, which is subject to the standards and~~be entitled to the protections and immunities afforded by federal ~~and state law~~law and Colorado Revised Statutes Sections 25-3-109 (Quality Improvement Matters) AND 12-36.5-104 (Peer Review) for peer review committees. Each department or its committees, if any, must meet regularly to carry out its duties.

10.5 Department ~~Chair~~Medical Director

10.5-1 Qualifications

Each Department ~~Chair~~Medical Director shall be an ~~active~~Active Medical Staff member and a practitioner, shall have demonstrated ability in at least one of the clinical areas covered by the department, ~~shall be Board certified,~~ and shall be willing and able to faithfully discharge the functions of his or her office. If there will be specific qualifications, the same shall be set forth in ~~the Rules~~PSMC policies and/or the Medical Staff Policies.

10.5-2 Selection

Department ~~officers~~Medical Directors shall be appointed by the Chief Executive Officer of PSMC.

10.5-3 Term of Office and Termination

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Each Department ~~Chair~~Medical Director shall serve a ~~two-year~~ term~~, the expiration of which coincides~~ set forth by contract with ~~the Medical Staff year or until their successors are chosen,~~PSMC unless ~~they shall sooner resign, be removed from office, or lose their~~the Medical Director's term is earlier terminated due to contract termination, resignation, loss of Medical Staff membership or privileges in that department. Department ~~officers~~Medical Directors are eligible to succeed themselves.

10.5-4 ~~Removal~~

~~A department officer may be removed for failure to cooperatively and effectively perform the responsibilities of his or her office. Removal may be initiated by the Medical Executive Committee or by written request from 20 percent of the members of the department who are eligible to vote on department matters. Such removal may be effected by a 66 2/3 percent vote of the Medical Executive Committee members or by a 66 2/3 percent vote of the department members eligible to vote on department matters. The procedures for effecting removal shall be as described in the Rules.~~

~~10.5-5~~ Roles and Responsibilities of Department ~~Officers~~Medical Directors

Specific roles and responsibilities of ~~department officers~~Department Medical Directors shall be as set forth in the ~~Rules~~contract, PSMC policies and Medical Staff Policies. These roles and responsibilities include at least the following:

a. Clinically related activities of the department.

b. ~~Administratively related activities of the department, unless otherwise provided by PSMC.~~

~~c.~~ Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

~~d~~c. Recommending to the ~~medical staff~~Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.

~~e~~d. Recommending clinical privileges for each member of the department.

~~f~~e. Assessing and recommending to the relevant PSMC authority off-site ~~sources for~~ resources which are needed for patient care, treatment, and services and are currently not provided by the department or the organization.

~~g~~f. Integration of the department or service into the primary functions of the organization.

~~h~~g. Coordination and integration of interdepartmental and intradepartmental services.

~~i~~h. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

~~j~~i. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

~~k. 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.~~

~~l~~j. Continuous assessment and improvement of the quality of care, treatment, and services.

~~m~~k. Maintenance of quality ~~control programs~~assurance, as appropriate.

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~~n~~l. Orientation and continuing education of all ~~persons~~Medical Staff in the department.

Article 11 Meetings

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11.1 Medical Staff Meetings

11.1-1 Medical Staff Meetings

There shall be at least two meetings of the Medical Staff during each Medical Staff year, but the Chief of Staff may, in his/her discretion, require more Medical Staff meetings. The date, place and time of the meeting(s) shall be determined by the Chief of Staff. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

11.1-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Body, or upon the written request of 10 percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.1-3 Combined or Joint Medical Staff Meetings

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

11.2 Department and Committee Meetings

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11.2-1 Regular Meetings

Departments and committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. Each department shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.

11.2-2 Special Meetings

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

11.2-3 Combined or Joint Department or Committee Meetings

The departments or committees may participate in combined or joint department or committee meetings with staff members from other hospitals, health care entities or ~~the County~~ Medical ~~Society~~Societies; however, precautions shall be taken to ~~assure~~ensure that confidential Medical Staff information is not inappropriately disclosed, and to ~~assure~~ensure that this Medical Staff

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(through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

11.3 Notice of Meetings

Written notice stating the place, day and hour of any regular or special Medical Staff meeting or of any regular or special department or committee meeting not held pursuant to resolution shall be delivered either personally or by email to each person entitled to be present not fewer than two calendar days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.4 Quorum

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11.4-1 Medical Staff Meetings

The presence of *25* percent of the voting Medical Staff department members at any regular or special meeting shall constitute a quorum.

11.4-2 Committee Meetings

The presence of *50* percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of *30* percent of the voting members of a committee but in no event less than three voting committee members.

11.4-3 Department Meetings

~~The presence of *25* percent of the voting Medical Staff members at any regular or special department meeting shall constitute a quorum.~~

The procedures for specific department meetings are established as set forth by Section 15.1-3.

11.5 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting, at which a quorum is present at the start of the meeting, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business despite the subsequent departure/withdrawal of members from the meeting unless alternate specific requirement by these Bylaws ~~a transaction of business.~~exists. Committee action may be conducted by telephone or internet conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone or internet conference. Valid action may be taken without a meeting if at least *five* days notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved in writing setting forth the action so taken, which is signed by at least *66-2/3* percent of the members entitled to vote~~. The meeting chair shall refrain from voting except when necessary to break a tie, except that the Compliance and Accreditation Committee Chair may vote.~~

11.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the ~~presiding officer~~applicable medical director or his or her designee and ~~forwarded~~made available to ~~the~~ Medical ~~Executive Committee~~Staff members or ~~other designated committee and~~ the Governing Body upon request. Each committee shall maintain a permanent file of the minutes of each meeting. Care should be taken to be sure minutes consider privacy and confidentiality obligations as minutes may be, except as otherwise limited by law.

11.7 Attendance Requirements

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11.7-1 Regular Attendance Requirements

Each ~~active member~~Active Member of ~~a~~the Medical Staff ~~category~~is required to attend not less than fifty percent (50%) of the staff meetings called during ~~each year of~~ his/her 24-month appointment period. Attendance at Department Meetings and Medical Staff Meetings shall be counted to determine the fifty percent attendance requirement.

11.7-2 Failure to Meet Attendance Requirements

It shall be the individual responsibility of each Medical Staff member to fulfill his/her ~~-~~attendance requirements. Practitioners who have not met meeting attendance requirements before the end of the appointment/reappointment period ~~will~~may be reappointed for a maximum of twenty-four months, to the day, but on an administrative probationary status~~.~~ (not reportable to the NPDB). Depending upon the facts and circumstances, Practitioners who do not meet the meeting attendance requirements during the reappointment period might not be reappointed.

11.7-3 Special Appearance

A professional review committee~~,~~ (for purposes of this section, shall be comprised of all members of the Medical Executive Committee), at its discretion, may require the appearance of a practitioner, APP, or BHP during a review of the clinical course of treatment regarding a patient. If possible, the Chair of the meeting should give the practitioner, APP, or BHP at least five days advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the ~~practitioner's~~practitioner, APP, or BHP's appearance is mandatory. Failure of a practitioner, APP, or BHP to appear at any meeting with respect to which he or she was given special notice shall (unless excused by the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the ~~practitioner's~~practitioner, APP, or BHP's privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. ~~The practitioner shall be entitled to the procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews.~~

Commented [KS1]: Removed because conflicts with 14.12-3 (b)

11.8 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to ~~an approved~~a parliamentary procedure~~;~~ (record of agenda, minutes, affirming/opposing votes); however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

Article 12 Confidentiality, Immunity, Releases and Indemnification

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12.1 General

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Except as limited by applicable laws, the Medical Staff, department and/or committee minutes, files and records — including information regarding any member or applicant to this Medical Staff — shall be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general PSMC records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

12.2 Breach of Confidentiality

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

12.3 Access to and Release of Confidential Information

12.3-1 Access for Official Purposes

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

a. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.

b. Medical Staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

c. The Chief Executive Officer, the Governing Body, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.

12.3-2 Member's Access

a. A Medical Staff member shall be granted access to ~~PSMC's~~their individual PSMC credential file ~~for such member~~, subject to the following provisions:

1. Anything within the file that pertains to ~~quality~~peer review, peer references, affiliation verifications, and the National Practitioners Data Report will be removed from the file by the Medical Staff ~~Coordinator~~Office Manager prior to access by the Medical Staff Member.
2. Notice of a request to review the file shall be given by the member to the Chief of Staff (or his or her designee) at least three days before the requested date for review.
3. The member may review and receive a copy of only those documents, provided by or addressed personally to the member. If requested by a member, a summary of all other information, including peer review committee findings, letter of reference, proctoring reports, complaints, etc., may be provided to the member, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized. If the member requests documents and/or summaries as described in this subparagraph, such release could undermine the confidentiality of the content of PSMC's professional review files and PSMC shall not be liable to member or otherwise for breaches in confidentiality.
4. The review by the member shall take place in the Medical Staff office (or conference room), during normal work hours, with an officer or designee of the Chief of Staff present.

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5. In the event a Notice of Charges, as referenced in these Bylaws, Section 14.5-3, is filed against a member, access to that member's credentials file shall be governed by Bylaws, Section 14.~~6~~5-9.

b. A member may be permitted to request correction of information as follows:

1. After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.

2. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Professional Review Committee and/or Medical Executive Committee whether to make the correction as requested, and the Professional Review Committee and/or Medical Executive Committee shall make the final determination.

3. The member shall be notified promptly, in writing, of the decision of the Professional Review Committee and/or Medical Executive Committee.

4. In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Committee, and shall be placed in the credentials file immediately following review by the Medical Executive Committee.

12.4 Immunity and Releases

12.4-1 Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical Staff and PSMC and all third parties shall be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, PSMC, or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at PSMC or by reason of otherwise participating in a Medical Staff or PSMC credentialing, quality improvement, or peer review activities.

12.4-2 Activities and Information Covered

a. **Activities**

The immunity provided by this Bylaws, Article 12, shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment, privileges, or specified services;
2. Periodic reappraisals for reappointment, privileges, or specified services;
3. Corrective action;
4. Hearings and appellate reviews;
5. Quality improvement review, including patient care audit;
6. Peer review;
7. Utilization reviews;

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8. Morbidity and mortality conferences; and
9. Other PSMC, department or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

b. **Information**

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Bylaws, Article 12, may relate to a ~~practitioner's~~practitioner, APP, or BHP's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

12.5 Releases

Each practitioner, APP, and BHP shall, upon request of PSMC, execute general and specific releases in accordance with the tenor and import of these Bylaws, Article 12; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of these Bylaws, Article 12.

12.6 Cumulative Effect

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

~~**12.7 Indemnification**~~

~~PSMC shall indemnify, defend, and hold harmless the Medical Staff and its individual members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:~~

~~a. As a member of or witness for a Medical Staff, department, committee, or hearing committee;~~

~~b. As a member of or witness for PSMC's Governing Body or any PSMC task force, group or committee; and~~

~~c. As a person providing information to any Medical Staff or PSMC group, officer, Governing Body member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.~~

~~PSMC shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will PSMC indemnify~~

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~~an Indemnitee for acts or omissions taken as a part of a crime, or in bad faith, or in pursuit of the Indemnitee's private economic interests.~~

Article 13 Performance Improvement and Formal Corrective Action

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13.1 Peer Review Philosophy

13.1-1 Role of Medical Staff in Organization-wide Quality Improvement Activities

The Medical Staff is responsible to oversee the quality of medical care, treatment and services delivered at PSMC. An important component of that responsibility is the oversight of care rendered by members ~~and Allied Health Professionals~~ practicing at PSMC. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on ~~informal corrective~~performance improvement measures and/or corrective action as necessary to achieve and ~~assure~~ensure quality of care, treatment and services. Toward these ends:

a. Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess and improve performance of their ~~peersat~~peers at PSMC.

b. The initial goals of the peer review processes are to prevent, detect and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, corrective measures, which may or may not include formal investigation and/or discipline, must be implemented and monitored for effectiveness.

c. Peers in the departments and committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful and ongoing. The term "peers" generally requires that a majority of the peer reviewers be ~~members holding the same license as the practitioner being reviewed, including~~physicians and, where possible, at least one member practicing the same specialty as the member being reviewed. Notwithstanding the foregoing, DOs and MDs shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

d. The departments and committees may be assisted by the Chief Medical Officer.

13.1-2 ~~Informal Corrective Activities~~Performance Improvement Plans

The Medical Staff ~~officers, departments and~~Officers, CMO, or Medical Staff committees may counsel, educate, issue letters of warning or censure, or focused professional practice evaluation in accordance with ~~Bylaws, Section 7.4(a)(2)~~Medical Staff Policy in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The practitioner, APP, or BHP shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Professional Review Committee or its designee(s). Any ~~informal actions~~performance improvement plans, monitoring, Level I and Level II proctoring, required training or counseling shall be documented in the member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute an adverse restriction of privileges and as such ~~*informal corrective action is*~~*performance*

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improvement plans are not grounds for any formal hearing or appeal rights under Bylaws, Article 14, Hearings and Appellate Reviews.

13.1-3 Criteria for Initiation of Formal Corrective Action Investigation

A formal corrective action investigation may be initiated whenever reliable information indicates a member or APP or BHP may have exhibited acts, demeanor or conduct, either within or outside of PSMC, that is reasonably likely to be:

a. Detrimental to patient safety or to the delivery of quality patient care within PSMC;

b. Unethical;

c. Contrary to the Medical Staff Bylaws or ~~Rules~~Policies;

d. Below applicable professional standards;

e. Disruptive of Medical Staff or PSMC operations; or

f. An improper use of PSMC resources.

Generally, reasonable attempts for ~~informal correction~~performance improvement will precede *formal* corrective action; however, ~~informal~~ attempts at performance improvement (e.g., Variance reporting, peer review, performance improvement plan) are not required or in any way a mandatory condition prior to formal corrective action. Formal corrective action will be initiated whenever circumstances reasonably appear to warrant it. Any recommendation of formal corrective action must ~~be based on evaluation of applicant-specific information~~set forth the facts and be provided to the Medical Executive Committee for determination.

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~~**13.1-4 Initiation**~~

13.1-4 Medical Executive Committee Determination of Formal Corrective Action

a. ~~Any person who believes that formal corrective action may be warranted may provide information to the~~ The Professional Review Committee, the Chief of Staff, any other Medical Staff officer, any Department ~~Chair, any Medical Staff committee, the chair of any Medical Staff Committee,~~Medical Director, the Governing Body or the Chief Executive Officer.

~~b. If~~ may provide facts to the ~~Professional Review~~Medical Executive Committee~~,~~ with a request for formal corrective action. Only the Medical Executive Committee~~, the Chief of Staff, any other Medical Staff officer, any Department Chair, , the Governing Body or the Chief Executive Officer~~ determines ~~that~~ whether to proceed with further investigation and/or formal corrective action ~~may be warranted under Bylaws, Section 13.1-3, above, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Professional Review Committee orally or in writing~~.

~~c~~b. The Chief of Staff shall notify the Chief Executive Officer, or his or her designee in his or her absence, and the Professional Review Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the ~~Professional Review~~Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee pursuant to Bylaws, Section 13.1-~~6~~4(d), below, or otherwise.

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~~13.1-5 Expedited Initial Review~~

~~a. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee and/or the Chief Medical Officer may, on behalf of the Professional Review Committee, immediately investigate and conduct (or cause to conduct) whatever interviews may be indicated; such process is deemed an informal investigation/review. The information developed during this initial informal review shall be presented to the Professional Review Committee, which shall decide whether to initiate a formal investigation.~~

~~b. In cases of complaints of harassment or discrimination involving a patient, etc., an expedited initial review shall be conducted on behalf of the Professional Review Committee by the Chief of Staff, the Chief of Staff's designee, or the Chief Medical Officer, together with representatives of administration, or by an attorney for PSMC. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient, an expedited initial informal review shall be conducted by the Chief Medical Officer and PSMC's human resources director (or his/her designee), or by an attorney for PSMC, who shall use best efforts to complete the expedited initial review within the time frame set out at Bylaws, Section 13.1-8, below. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial informal review shall be referred to the Professional Review Committee if it is determined that corrective action may be indicated against a Medical Staff member.~~

~~13.1-6 Formal Investigation~~

~~a. If the Professional Review~~c. If the Medical Executive Committee concludes action is indicated but that no formal investigation is necessary, it may proceed to take action without a formal investigation.

~~b~~d. If the ~~Professional Review~~Medical Executive Committee concludes a further formal investigation is warranted, it shall direct a formal investigation to be undertaken. The ~~Professional Review~~Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include persons with a conflict of interest (e.g., business partners, or relatives) of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances. If the investigation is delegated to an officer or committee other than the ~~Professional Review~~Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner, using best efforts to complete the expedited initial review within the time frame set out for formal investigation in the Bylaws, Section 13.1-~~8~~6, below, and shall forward a written report of the investigation to the ~~Professional Review~~Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. If the ~~Professional Review~~Medical Executive Committee delegates any portion of an investigation, such delegation shall be deemed a part of the work of the ~~Professional Review~~Medical Executive Committee and will be afforded the greatest confidentiality permitted by law.

~~c.~~e. The Medical Executive Committee will provide written notice to the member being investigated at the time the investigation is initiated in the form of return receipt certified mail

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or overnight courier service. Prior to any adverse action being approved, the ~~Professional Review~~Medical Executive Committee shall ~~assure~~ensure that the member being investigated was given an opportunity to provide information in a manner and upon such terms as the ~~Professional Review~~Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in Bylaws, Article 14, Hearings and Appellate Reviews, nor shall the hearings or appeals ~~Rules~~Policies apply.

~~d~~f. Despite the status of any investigation, at all times the ~~Professional Review~~Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

13.1-~~7 Professional Review~~5 Medical Executive Committee Action

a. As soon as practicable after the conclusion of the investigation, the ~~Professional Review~~Medical Executive Committee shall take action including, without limitation, the following:

1. Determining no corrective action should be taken and, if the ~~Professional Review~~Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file;
2. Deferring action for a reasonable time;
3. Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude department or -Committee Chairs from issuing informal ~~written or oral warnings~~performance improvement plans outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in PSMC's confidential professional review file for the member;

~~4. Recommending the imposition~~4. Imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring;

5. ~~Recommending reduction~~Reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;
6. ~~Recommending reductions~~Reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
7. ~~Recommending suspension~~Suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated;
8. Referring the member for evaluation and follow-up as appropriate; and
9. Taking other actions deemed appropriate under the circumstances.

b. If the ~~Professional Review~~Medical Executive Committee takes any action that would give rise to a hearing pursuant to Bylaws, Section 14.2, it shall also make a determination whether the

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action is a "medical disciplinary" action or an "administrative disciplinary" action. A medical disciplinary action is one taken for cause or reason that involves that aspect of a ~~practitioner's~~practitioner, APP, or BHP's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 14, Hearings and Appellate Reviews, hearing purposes.

c. And, if the ~~Professional Review~~Medical Executive Committee makes a determination that the action is medical disciplinary, it shall also determine whether the action is taken for any of the reasons required to be reported to the Colorado Medical Board, the National Practitioners Data Bank or otherwise.

13.1-~~8~~6 Time Frames

Insofar as feasible under the circumstances, formal ~~and informal~~ investigations and reviews should be conducted ~~expeditiously, as follows:~~

~~a. Informal investigations should be~~ and completed ~~and the results should be reported within 60 days.~~

~~b. Expedited initial (informal) reviews should be completed and the results should be reported within 30 days.~~

~~c. From~~, from the commencement of a formal investigation, ~~the investigation should be completed and the results should be reported~~ within 90 days.

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13.1-~~9~~7 Procedural Rights

a. If, after receipt of a request for formal corrective action pursuant to Bylaws, Section 13.1-4, above, the ~~Professional Review~~Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Body, or upon request of the Governing Body to the CEO. The Governing Body (or CEO, as applicable) may affirm, reject or modify the action. The Governing Body (or CEO, as applicable) shall give great weight to the ~~Professional Review~~Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the ~~Professional Review~~Medical Executive Committee and the ~~Professional Review~~Medical Executive Committee still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within 70 days after receiving the notice of decision.

b. If the ~~Professional Review~~Medical Executive Committee recommends an action that is a ground for a hearing under Bylaws, Section 14.2, the Chief of Staff shall give the practitioner, APP, or BHP special notice of the adverse recommendation and of the right to request a hearing. The Governing Body may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

13.1-~~10~~8 Initiation by Governing Body

a. The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible

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governance of PSMC in the event that the Medical Staff fails in any of its substantive duties or responsibilities.

b. Accordingly, if the ~~Professional Review~~Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Governing Body (on its own or by and through the CEO) may direct the ~~Professional Review~~Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the ~~Professional Review~~Medical Executive Committee. If the ~~Professional Review~~Medical Executive Committee fails to act in response to that Governing Body direction, the Governing Body may, in furtherance of the Governing Body's ultimate responsibilities and fiduciary duties, engage consultant(s) to investigate and may initiate corrective action, but must comply with applicable provisions of Bylaws, Article 13, Performance Improvement and Formal Corrective Action, and Article 14, Hearings and Appellate Reviews. The Governing Body shall inform the ~~Professional Review~~Medical Executive Committee in writing of what it has done.

13.2 Summary Restriction or Suspension

13.2-1 Criteria for Initiation

a. Whenever a ~~practitioner's~~practitioner, APP, or BHP's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff, the Medical Executive Committee, the Professional Review Committee, the Department ~~Chair~~Medical Director in which the member holds privileges, or the Chief Executive Officer may summarily restrict or suspend the Medical Staff membership or privileges of such member.

b. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give special notice to the member and written notice to the Governing Body, the ~~Professional Review~~ Medical Executive Committee, ~~and~~ the Chief Executive Officer, and the Medical Staff Office. The special notice shall fully comply with the requirements of Bylaws, Section 13.2-1(d), below.

c. The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the member's patients shall be promptly assigned to another member by the ~~Department Chair~~department Medical Director or by the Chief of Staff considering, where feasible, the wishes of the patient and the affected ~~practitioner~~member in the choice of a substitute member.

d. Within one working day of imposition of a summary suspension, PSMC shall provide verbal notice (or reasonable attempts of verbal notice) to the affected Medical Staff member ~~shall be provided with verbal notice of such~~ of suspension; ~~followed,~~ PSMC shall mail written notice within three ~~working~~calendar days of imposition~~, by written notice of such~~ of suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was reasonable and warranted because failure to suspend or restrict the member's privileges summarily could reasonably result in an imminent danger to the health of any individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Bylaws, Section 14.3-1 (which applies in all cases where the ~~Professional Review~~Medical Executive Committee does not

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immediately terminate the summary suspension). ~~The notice under Bylaws, Section 14.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.~~

e. The notice of the summary action given to the ~~Professional Review~~Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Bylaws, Section 13.1~~-3~~, shall be followed.

13.2-2 ~~Professional Review~~Medical Executive Committee Action

Within one week after such summary action has been imposed, a meeting of the ~~Professional Review~~Medical Executive Committee or an ad hoc committee appointed by the Chief of Staff shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the ~~Professional Review~~Medical Executive Committee may impose, although in no event shall any meeting of the ~~Professional Review~~Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Bylaws, Article 14, Hearings and Appellate Reviews, nor shall any procedural ~~Rules~~Policies apply. The ~~Professional Review~~Medical Executive Committee may thereafter continue, modify or terminate the terms of the summary action. It shall give the practitioner, APP, or BHP special notice of its decision, within ~~two working~~three calendar days of the meeting, which shall include the information specified in Bylaws, Section 14.3-1 if the action is adverse.

13.2-3 Procedural Rights

~~Unless the Professional Review Committee promptly terminates the summary action, and if~~If the summary action constitutes a suspension or restriction of clinical privileges required to be reported to the Colorado Medical Board or National Practitioner Data Bank, or if the suspension lasts for more than 14 (fourteen) days, the member shall be entitled to the procedural rights afforded by Bylaws, Article 14, Hearings and Appellate Reviews ~~including, but not limited to, a right to a preliminary hearing as described at Bylaws, Section 14.5~~.

13.2-4 Initiation by Governing Body

a. If no one authorized under Bylaws, Section 13.2-1(a), above, to take a summary action is available to summarily restrict or suspend a member's membership or privileges, the Governing Body (or its designee) may immediately suspend or restrict a member's privileges if a failure to act immediately may result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) made reasonable attempts to contact the Chief of Staff and the Chair of the department to which the member is assigned before acting.

b. Such summary action is subject to ratification by the ~~Professional Review~~Medical Executive Committee. If the ~~Professional Review~~Medical Executive Committee does not ratify such summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

13.3 Automatic Administrative Suspension or Limitation

In the following instances, the member's privileges or membership shall be automatically suspended or limited as described and all such suspensions shall be subject to Section 13.3-8 hereof:

13.3-1 Licensure

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a. **Revocation, Suspension or Expiration.** Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended or expired without an application pending for renewal, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.

b. **Restriction.** Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation.** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

d. **Obligation to Immediately Notify PSMC**. Every member of the Medical Staff agrees, as a condition of appointment, to notify PSMC's CEO and the Medical Staff ~~Coordinator~~Office Manager within twenty-four (24) hours of the effective date of any revocation, restrictions, suspension, probation or otherwise.

13.3-2 Drug Enforcement Administration Certificate

a. **Revocation, Suspension, and Expiration.** Whenever a member's Drug Enforcement Administration certificate is revoked, limited, suspended or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

b. **Probation.** Whenever a member's Drug Enforcement Administration certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

c. **Obligation to Immediately Notify PSMC**. Every member of the Medical Staff agrees, as a condition of appointment, to notify PSMC's CEO and the Medical Staff ~~Coordinator~~Office Manager within twenty-four (24) hours of the effective date of any revocation, restrictions, suspension, probation or otherwise.

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13.3-3 Failure to Satisfy Special Appearance Requirement

A member who fails without good cause to appear and satisfy the requirements of Bylaws, Section 11.7-3 shall automatically be suspended from exercising all or such portion of privileges as the ~~Professional Review~~Medical Executive Committee specifies.

13.3-4 Medical Records

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Medical Staff members are required to complete medical records ~~within the time~~in a timely fashion as prescribed by the Professional Review Committee. Failure to timely complete medical records ~~shall~~may result in an ~~automatic~~administrative suspension after notice is given ~~as provided in the Rules~~. Such suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients in PSMC, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating; provided, however, members whose privileges have been suspended for delinquent records may admit and treat new

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patients in life-threatening situations. The suspension shall continue until the medical records are completed. In addition to the provisions of Section 13.3-8, the Medical Executive Committee, may impose monetary fine(s) for delinquent medical records.

13.3-5 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

Every member of the Medical Staff agrees, as a condition of appointment, to notify PSMC's CEO and the Medical Staff ~~Coordinator~~Office Manager within twenty-four (24) hours of the effective date of any termination, cancellation, reduction or limitation of professional liability insurance coverage.

13.3-6 Failure to Pay Dues or Fines

If the member fails to pay required dues or fines within 30 days after written warning of delinquency, a ~~practitioner's~~practitioner, APP, or BHP's Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the practitioner, APP, or BHP pays the delinquent dues.

13.3-7 Exclusion from Federally Funded Health Care Programs

Exclusion from federally funded health care programs including Medicare and Medicaid will result in the member's medical staff appointment and clinical privileges being automatically suspended. By accepting medical staff appointment, each member agrees to notify the PSMC's CEO and Medical Staff ~~Coordinator~~Office Manager, within twenty-four (24) hours of the effective date of any exclusion from federally funded programs. Each staff member further agrees to notify the PSMC's CEO and Medical Staff ~~Coordinator~~Office Manager, with seven (7) calendar days of any investigation undertaken by appropriate authority for potential exclusion from any federally funded programs.

13.3-8 Correction of Deficiencies or Deemed Voluntary Resignation with Automatic Termination

If within ninety (90) days of the automatic ~~suspension,~~administrative suspension per sections 13.3-1 through 13.3-7 (administrative suspension is not reportable), the member is unable to (or does not) provide sufficient documented proof of the correction of the deficiencies, occurrences, or problems that lead/resulted in the ~~automatic~~ suspension, such lack of correction will be deemed a voluntary resignation from the Medical Staff and membership shall automatically terminate (or partially terminate, if the suspension was a partial suspension). Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to initial applicants.

13.3-9 ~~Executive Committee Deliberation and Procedural Rights~~

~~a. As soon as practicable after action is taken or warranted as described in Bylaws, Section 13.3-1, Section 13.3-2, or Section 13.3-3, the Professional Review Committee shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Bylaws, Section~~

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~~13.1-6, Formal Investigation. The Professional Review Committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or Drug Enforcement Administration action, but instead shall address what, if any, additional action should be taken by PSMC. There is no need for the Professional Review Committee to act on automatic suspensions for failures to complete medical records (Bylaws, Section 13.3-4), maintain professional liability insurance (Bylaws, Section 13.3-5), to pay dues (Bylaws, Section 13.3-6, above) or comply with government and other third party payor Rules and policies (Bylaws, Section 13.3-7, above).~~

~~b. Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing *only if* the suspension is reportable to the Colorado Medical Board or the federal National Practitioner Data Bank.~~

~~13.3-10~~ Notice of Automatic Suspension or Action

~~Special~~PSMC shall provide notice of an automatic suspension or action ~~shall be given~~ to the affected individual, and regular notice of the suspension shall be given to the ~~Professional Review~~Medical Executive Committee, Chief Executive Officer and Governing Body, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the Department ~~Chair~~Medical Director or Chief of Staff. The wishes of the patient and affected practitioner, APP, or BHP shall be considered, where feasible, in choosing a substitute member.

13.3-~~11 Automatic~~10 Action Based upon Actions Taken by Another Peer Review Body after a Hearing

a. The ~~Professional Review~~Medical Executive Committee shall be empowered to ~~automatically~~investigate and potentially impose any adverse action that has been taken by another peer review body after a hearing at/by that other peer review body that meets applicable legal requirements for a Medical Staff hearing. Such an adverse action may be any action taken by the other peer review body, including, but not limited to, denying membership and/or privileges, restricting privileges or terminating membership and/or privileges. ~~The action may be taken automatically only if the other peer review body took action based upon standards that were essentially the same as those in effect at PSMC at the time the automatic action will be taken.~~ Also, the action that will be the basis of the ~~automatic~~ action must have become final within the past 36 months. The ~~automatic~~ action may be taken only after ~~the practitioner~~ PSMC has completed ~~the hearing and any appeal at that other peer review body; however,~~its own investigation; it is not necessary to await a final disposition in any judicial proceeding that may be brought challenging that other peer review body's action.

b. The practitioner, APP, or BHP shall not be entitled to any hearing or appeal at PSMC unless the ~~Professional Review~~Medical Executive Committee takes an action that is more restrictive than the final action taken by the other peer review body. Any hearing and appeal that is requested by the practitioner, APP, or BHP shall not address the merits of the action taken by the original peer review body, which were already reviewed at the other peer review body's hearing, and shall be limited to only the question of whether the ~~automatic~~ action is more restrictive than the other peer review body's action. The practitioner, APP, or BHP shall not be

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entitled to challenge the ~~automatic~~ peer review action unless he or she successfully overturns the other peer review action in court.

c. Nothing in this Section shall preclude the Medical Staff or Governing Body from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

13.4 Interview

~~Interviews~~Any interviews conducted under Article 13 shall neither constitute nor be deemed a hearing as described in Bylaws, Article 14, Hearings and Appellate Reviews, shall be preliminary in nature, and shall not be conducted according to the procedural ~~Rules~~Policies applicable with respect to hearings. ~~The Professional Review Committee shall be required, at the practitioner's request, to grant an interview only when so specified in these Bylaws, Article 13. In the event an interview is granted, the practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto.~~ A record of the matters discussed and the findings resulting from an interview shall be ~~made~~kept.

13.5 Confidentiality

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline.

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14.1 General Provisions

14.1-1 Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners, APPs, and BHPs (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review.

Accordingly, discretion is granted to the Medical Staff and Governing Body to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret these Bylaws in that light. The Medical Staff, the Governing Body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and claim all privileges and immunities afforded by the federal and state laws.

14.1-2 Exhaustion of Remedies

If an adverse action as described in Bylaws, Section 14.2 is taken or recommended, the practitioner, APP, or BHP must exhaust the remedies afforded by these Bylaws before resorting to legal action.

14.1-3 Intra-Organizational Remedies

The hearing and appeal rights established in the Bylaws are strictly adjudicative rather than legislative in structure and function. The hearing committees have no authority to adopt or modify ~~Rules~~Policies and standards or to decide questions about the merits or substantive validity of Bylaws, ~~Rules~~ or ~~policies~~Policies. However, the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws~~, Rules~~ or ~~policies~~Policies and decide those questions. If the only issue in a case is whether a Bylaw~~, Rule~~ or policy is lawful or meritorious, the practitioner, APP, or BHP is not entitled to a hearing or appellate review. In such cases, the practitioner, APP, or BHP must submit his challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

14.1-4 Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

a. Body whose decision prompted the hearing refers to the ~~Professional Review~~Medical Executive Committee in all cases where the Professional Review Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. Practitioner, as used in this Article, refers to the practitioner who has requested a hearing pursuant to Bylaws, Section 14.3-2 of this Article.

c. APP or BHP, as used in this Article, refers to the APP or BHP who has requested a hearing pursuant to Bylaws, Section 14.3-2 of this Article.

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14.1-5 Substantial Compliance

Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

14.2 Grounds for Hearing

Except as otherwise specified in these Bylaws (including those Exceptions to Hearing Rights specified in Bylaws, Section 14.~~13~~12, of this Article), ~~any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse~~ a formal corrective action *that is reportable to the National Practitioner Data Bank and ~~constitute~~/or the Colorado Medical Board* constitutes grounds for a hearing including, without limitation, the following:

14.2-1 Denial of Medical Staff applications for membership and/or privileges (denial of pre-applications do ~~no~~not constitute grounds for a hearing).

14.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

14.2-3 ~~Revocation~~Reportable revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or privileges.

14.2-4 Involuntary imposition of significant consultation or Level III proctoring requirements, as described ~~at Bylaws, Section 7.4-4(a)(3),~~in the Medical Staff Proctoring Policy, that cannot be completed prior to the time frame required for obligatory reporting to the Colorado Medical Board (i.e., Level I and Level II proctoring requirements, as well as transitory restrictions that do not require reporting to the Colorado Medical Board ~~of~~for the National Practitioner Data Bank do not entitle the practitioner, APP, or BHP to a hearing).

14.2-5 Summary suspension of Medical Staff membership and/or privileges for more than fourteen days during the pendency of corrective action and hearings and appeals procedures.

14.2-6 Any other "medical disciplinary" action or recommendation that must be reported to the Colorado Medical Board or to the National Practitioner Data Bank.

14.3 Requests for Hearing

14.3-1 Notice of Action or Proposed Action

a. In all cases in which action has been taken or a recommendation made as set forth in Bylaws, Section 14.2, the practitioner, APP, or BHP shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to Bylaws, Section 14.3-2, below. The notice must state:

1. What action has been proposed against the practitioner, APP, or BHP;
2. Whether the action, if adopted, must be reported under applicable law or regulation;
3. A brief indication of the reasons for the action or proposed action;
4. That the practitioner, APP, or BHP may request a hearing;
5. That a hearing must be requested within 30 days; and
6. That the practitioner, APP, or BHP has the hearing rights described in the Medical Staff Bylaws, including those specified in Bylaws, Section 14.~~6~~5, Hearing Procedure.

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b. The notice shall also advise the practitioner, APP, or BHP that he or she may request mediation of the dispute pursuant to Bylaws, Section 14.4, of these Bylaws and that mediation must be requested, in writing, within 10 days of the date of receipt of the notice sent.

14.3-2 Request for Hearing

a. The practitioner, APP, or BHP shall have 30 days following receipt of special notice of such action to request a hearing ~~(and, if applicable, a preliminary hearing, as further described in Bylaws, Section 14.5).~~ The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. If the practitioner, APP, or BHP does not request a hearing within the time and in the manner described, the practitioner, APP, or BHP shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Body within 70 days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.

b. The practitioner, APP, or BHP shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the practitioner, APP, or BHP elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

c. Any time attorneys will be allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

~~d. Any request for mediation must be received within 10 days of the date of receipt of the notice sent pursuant to Bylaws, Section 14.3-1(b).~~

14.4 Mediation of Peer Review Disputes

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14.4-1 Mediation is a process in which a neutral person facilitates communication between the Professional Review Committee or Medical Executive Committee and a practitioner, APP, or BHP to assist them in reaching a mutually acceptable resolution of a peer review controversy in a manner that is consistent with the best interests of patient care.

14.4-2 The parties are encouraged to consider mediation when it would be productive in resolving the dispute.

14.4-3 In order to obtain consideration of mediation, the practitioner, APP, or BHP must request mediation in writing, as defined herein, within 10 days of his/her receipt of a notice of action or proposed action that would give rise to a hearing pursuant to Bylaws, Section 14.2.

14.4-4 If the practitioner, APP, or BHP and the Professional Review Committee or Medical Executive Committee agree to mediation, all deadlines and time frames relating to the fair hearing process shall be tolled while the mediation is in process, and the practitioner, APP, or BHP agrees that no damages may accrue as the result of any delays attributable to the mediation.

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14.4-5 Mediation cannot be used by either the Medical Staff or the practitioner, APP, or BHP as a way of unduly delaying the corrective action/fair hearing process. Accordingly, unless both the Medical Staff and the practitioner, APP, or BHP agree otherwise, mediation must commence within 30 days of the ~~practitioner's~~practitioner, APP, or BHP's request and must conclude within 30 days of its commencement. If the mediation does not resolve the dispute, the fair hearing process will promptly resume upon completion of the mediation.

14.4-6 The parties shall cooperate in the selection of a mediator (or mediators). Mediators should be both familiar with the mediation process and knowledgeable regarding the issues in dispute. The mediator may also serve as the Hearing Officer at any subsequent hearing, subject to the agreement of the parties which may be given prior to the mediation or after, with the parties to decide when they will agree on this issue. The costs of mediation shall be shared fifty percent by the Medical Staff and fifty percent by the practitioner~~.~~, APP, or BHP. The inability of the Medical Staff and the practitioner, APP, or BHP to agree upon a mediator within the required time limits shall result in the termination of the mediation process and the resumption of the fair hearing process.

14.4-7 Once selected, the mediator and the parties, working together, shall determine the procedures to be followed during the mediation. Either party has the right to be represented by legal counsel in the mediation process.

14.4-8 All mediation proceedings shall be confidential except that communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented. Except as otherwise permitted in this Section, no other evidence of anything said at, or any writing prepared for or as the result of, the mediation shall be used in any subsequent fair hearing process that takes place if the mediation is not successful.

14.5 ~~[SECTION INTENTIONALLY OMITTED.]~~

~~14.6~~ Hearing Procedure

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14.~~6~~5-1 Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the chair of the Governing Body shall fulfill the functions assigned in this Section to the Chief of Staff, and the Governing Body shall assume the role of the ~~Professional Review~~Medical Executive Committee. The Governing Body may, but need not, grant appellate review of decisions resulting from such hearings.

14.~~6~~5-2 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the practitioner, APP, or BHP of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing.

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14.~~6~~5-3 Notice of Charges

Together with the special notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the practitioner, APP, or BHP is charged and a list of the charts in question, where applicable. A supplemental notice may be issued at any time, provided the practitioner, APP, or BHP is given sufficient time to prepare to respond.

14.~~6~~5-4 Hearing Committee

a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three members who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners, APPs, or BHPs who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one member who has the same healing arts licensure as the practitioner, APP, or BHP and who practices the same specialty as the practitioner, APP, or BHP. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

b. Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner~~.~~, APP, or BHP. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.

c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

14.~~6~~5-5 The Hearing Officer

a. The use of a Hearing Officer to preside at a hearing is mandatory. The appointment of a Hearing Officer shall be by the Chief Executive Officer, as a representative of the ~~Professional Review~~Medical Executive Committee, as follows:

1. Together with the notice of a hearing, the practitioner, APP, or BHP shall be provided a list of at least three but no more than five potential Hearing Officers meeting the criteria set forth in Bylaws, Section 14.~~6~~5-5(b), below.
2. The practitioner, APP, or BHP shall have five work days to accept any of the listed potential Hearing Officers, or to propose at least three but no more than five other names of potential Hearing Officers meeting the criteria set forth in Bylaws, Section 14.~~6~~5-5(b), below.
3. If the practitioner, APP, or BHP is represented by counsel, the parties' counsel may meet and confer in an attempt to reach accord in the selection of a Hearing Officer from the two parties' lists.

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4. If the parties are not able to reach agreement on the selection of a Hearing Officer within five working days of receipt of the ~~practitioner's~~practitioner, APP, or BHP's proposed list, PSMC's Chief Executive Officer shall select an individual from the composite list.
5. Unless a Hearing Officer is selected pursuant to stipulation of the parties, he/she shall be subject to reasonable voir dire (questioning regarding the suitability and qualifications to be the Hearing Officer).

b. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by PSMC, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer. While the Hearing Officer may be paid for his/her services, the Hearing Officer shall gain no direct financial benefit from the outcome. Further, the Hearing Officer must not act as a prosecuting officer or as an advocate.

c. The Hearing Officer shall preside over the voir dire process and may question ~~panel~~Hearing Committee members directly, and shall make all rulings regarding service by the proposed hearing committee members or the Hearing Officer. The Hearing Officer shall endeavor to ~~assure~~ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.

d. The Hearing Officer's authority shall include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.

e. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case. Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the effect of terminating the hearing (a "termination order") at the direction of the Hearing Committee. The terminating order shall be in writing and shall include documentation of the reasons therefore. If a terminating order is against the ~~Professional Review~~Medical Executive Committee, the charges against the practitioner, APP, or BHP will be deemed to have been dropped. If, instead, the terminating order is against the practitioner, APP, or BHP, the practitioner, APP, or BHP will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the terminating order to PSMC's Governing Body. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal shall be conducted in general accordance with the provisions of Bylaws, Section 14.~~7~~6. If the order is

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found to be unwarranted, the Hearing Committee shall reconvene and resume the hearing. If the Governing Body determines that the terminating order should not have been issued, the matter will be remanded to the Hearing Committee for completion of the hearing.

f. Upon adjournment of the evidentiary portion of the hearing, the Hearing Officer shall meet with the members of the ~~hearing committee~~Hearing Committee to assist them with the process for their review of the evidence and preparation of the report of their decision. Upon request from the ~~hearing committee~~Hearing Committee members, the Hearing Officer may remain during the ~~hearing committee's~~Hearing Committee's full deliberations. During the deliberative process, the Hearing Officer shall act as legal advisor to the ~~hearing committee~~Hearing Committee, but shall not be entitled to vote.

g. In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

h. To the extent that any provision in this Section of these Bylaws may conflict with any other provision of the Bylaws (e.g. granting certain duties and authority to the Chair of the Hearing Committee), this provision shall preempt and control.

14.~~6~~5-6 Representation

The practitioner, APP, or BHP shall have the right, at his or her expense, to attorney representation at the hearing. If the practitioner, APP, or BHP elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the practitioner, APP, or BHP elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not present, the practitioner, APP, or BHP and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed to practice in the State of Colorado who is not also an attorney.

14.~~6~~5-7 Failure to Appear or Proceed

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Failure without good cause of the practitioner, APP, or BHP to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

14.~~6~~5-8 Postponements and Extensions

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Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted upon a showing of good cause, as follows:

a. Until such time as a Hearing Officer has been appointed, by the Hearing Committee or its Chair acting upon its behalf; or

b. Once appointed, by the Hearing Officer.

14.~~6~~5-9 Discovery

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a. **Rights of Inspection and Copying.** The practitioner, APP, or BHP may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the practitioner, APP, or BHP has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.

b. **Limits on Discovery.** The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners, APPs, or BHPs other than the practitioner, APP, or BHP under review nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

c. **Ruling on Discovery Disputes.** In ruling on discovery disputes, the factors that may be considered include:

1. Whether the information sought may be introduced to support or defend the charges;
2. Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;
3. The burden on the party of producing the requested information; and
4. What other discovery requests the party has previously made.

d. **Objections to Introduction of Evidence Previously Not Produced for the Medical Staff.** The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the practitioner, APP, or BHP can prove he or she previously acted diligently and could not have submitted the information.

14.~~6~~5-10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least 10 days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

14.~~6~~5-11 Witness Lists

Not less than 15 days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name

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of any witness at least 10 days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

14.~~6~~5-12 Procedural Disputes

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

b. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses and rulings thereon shall be entered into the hearing record by the Hearing Officer.

14.~~6~~5-13 Record of the Hearing

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the court reporter shall be borne by PSMC, but the cost of the transcript, if any, shall be borne by the party requesting it. The practitioner, APP, or BHP is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

14.~~6~~5-14 Rights of the Parties

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions which are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Hearing Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The practitioner, APP, or BHP may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

14.~~6~~5-15 Rules of Evidence

Judicial Rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these Bylaws, Article 14. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

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14.~~6~~5-16 Burdens of Presenting Evidence and Proof

a. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner, APP, or BHP shall be obligated to present evidence in response.

b. An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied privileges. The practitioner, APP, or BHP must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges.

c. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

14.~~6~~5-17 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.

14.~~6~~5-18 Basis for Decision

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

14.~~6~~5-19 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

14.~~6~~5-20 Decision of the Hearing Committee

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the ~~Professional Review~~Medical Executive Committee, the Governing Body, the Medical Staff Office Manager and by special notice to the practitioner, APP, or BHP. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the practitioner, APP, or BHP and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

14.~~7~~6 Appeal

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14.~~7~~6-1 Time for Appeal

Within 40 days after receiving the decision of the Hearing Committee, either the practitioner, APP, or BHP or the ~~Professional Review~~Medical Executive Committee may request an appellate review~~. A written request for such~~; any party requesting appellate review shall make the request in writing and cause it to be delivered to the Chief of Staff, the Chief Executive Officer and the other side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. ~~The Governing Body shall consider the decision within 70 days, and shall give it great weight.~~

14.~~7~~6-2 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a request for appeal, schedule a review date and cause each side to be given notice (with special notice to the practitioner, APP, or BHP) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date of such notice provided~~; however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received if the Appeal Board is conducting an appeal of the results of a preliminary hearing.~~. The time for appellate review may be extended by the Appeal Board for good cause.

14.~~7~~6-3 Appeal Board

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an appellate Hearing Officer and shall have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article 14. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

14.~~7~~6-4 Appeal Procedure

The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record of the hearing before the Hearing Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her or its position on appeal. The appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

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14.~~7~~6-5 Decision

a. Within 30 days after the adjournment of the appellate review proceeding ~~(10 days if the Appeal Board is conducting an appeal of the results of a preliminary hearing),~~, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

b. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.

c. The Appeal Board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. Unless the Appeal Board elects to conduct a de novo review, the Appeal Board shall sustain the factual findings of the Hearing Committee if they are supported by substantial evidence. The Appeal Board may, however, exercise its independent judgment in determining whether a practitioner, APP, or BHP was afforded a fair hearing, whether the decision is reasonable and warranted in light of the supported findings, and whether any bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such reasons, findings and conclusions differ from those of the Hearing Committee.

d. The Appeal Board shall forward copies of the decision to each side involved in the hearing.

e. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days ~~(15 days if the remand is in the context of an appeal from a preliminary hearing)~~ unless the parties agree otherwise or for good cause as determined by the Appeal Board.

14.~~8~~7 Administrative Action Hearings

The following modifications to the hearing process apply when the ~~Professional Review~~Medical Executive Committee (or Governing Body) has taken or recommended an action described in Bylaws, Section 14.2 for a non-medical disciplinary cause or reason. Such actions shall be deemed administrative disciplinary actions.

14.~~8~~7-1 Administrative Action Hearing

The affected practitioner, APP, or BHP shall be entitled to an administrative action hearing, conducted in accordance with Bylaws, Section 14.~~6~~5, except as follows:

a. At the election of the body whose decision prompted the hearing, the hearing shall be conducted by an arbitrator, meeting the qualifications of Bylaws, Section 14.~~6~~5-4(b), and selected by mutual agreement of the parties, if agreement can be reached within 10 days, failing which the arbitrator shall be selected by the body whose decision prompted the hearing.

b. The arbitrator shall have all of the rights and responsibilities of a Hearing Officer and a Hearing Committee, as described in Bylaws, Section 14.~~6~~5.

c. At the election of the body whose decision prompted the hearing, both parties shall have the right to be represented by an attorney, whether or not the other party elects to be represented by an attorney. The parties shall be notified of this election at the time the practitioner, APP,

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or BHP is notified of his/her right to a hearing. If attorney representation is permitted, the parties shall promptly notify each other of their elections regarding attorney representation, together with the name and contact information of their attorneys.

14.~~8~~7-2 Nonreportability of Administrative Actions

Administrative disciplinary actions are not reportable to the Colorado Medical Board or the National Practitioner Data Bank.

14.~~8~~7-3 Nonwaiver of Protections

Notwithstanding the foregoing, it is understood that circumstances precipitating administrative disciplinary actions may nonetheless involve or affect quality of care at PSMC (e.g., conduct that does or may impair the ability of others to render quality care, or that affects patients' perceptions of the quality of care rendered at PSMC). Processing a matter as ~~and~~an administrative disciplinary action does not waive any protections that may be available under Colorado or federal law for peer review actions taken in furtherance of quality of care or services provided at PSMC.

14.~~9~~8 Right to One Hearing

No practitioner, APP, or BHP shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

14.~~10~~9 Confidentiality

All proceedings conducted under Article 14 of these Bylaws will be private unless otherwise provided by law. To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

14.~~11~~10 Release

By requesting a hearing or appellate review under these Bylaws, a practitioner, APP, or BHP agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

14.~~12~~11 Governing Body Committees

In the event the Governing Body should delegate some or all of its responsibilities described in these Bylaws, Article 14 to its committees (including a committee serving as an Appeal Board), the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee.

14.~~13~~12 Exceptions to Hearing Rights

14.~~13~~12-1 Exclusive Use, PSMC Contract Practitioners, APPs, or BHPs

a. **Exclusive Use**

The procedural rights of Bylaws, Article 14 do not apply to a practitioner, APP, or BHP whose application for Medical Staff membership and privileges was denied or whose privileges were terminated on the basis that the privileges he or she seeks are granted only pursuant to an exclusive use policy. Such practitioners, APPs, or BHPs shall have the right, however, to request that the Governing Body review the denial, and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner, APP, or BHP may personally

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appear before and/or submit a statement in support of his or her position to the Governing Body.

b. **PSMC Contracts With Practitioners, APPs, or BHPs**

The hearing rights of Bylaws, Article 14 do not apply to practitioners, APPs, or BHPs who have contracts with PSMC to provide clinical services. Removal of these practitioners, APPs or BHPs from office and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with PSMC. The hearing rights of Bylaws, Article 14 shall apply if an action is taken which must be reported (to the Colorado Medical Board and/or to the National Practitioner Data Bank) and/or if the ~~practitioner's~~practitioner, APP, or BHP's Medical Staff membership status or privileges that are independent of the ~~practitioner's~~practitioner, APP, or BHP's contract are removed or suspended.

14.~~13~~12-2 Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners, APPs, or BHPs shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current Colorado license to practice medicine, dentistry, or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the ~~Rules~~Policies); to maintain professional liability insurance as required by the ~~Rules~~Policies; or to meet any of the other basic standards specified in Bylaws, Section 2.2-2 or to file a complete application.

14.~~13~~12-3 Automatic Suspension or Limitation of Privileges

a. No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Bylaws, Section 13.3-1. In other cases described in Bylaws, Section 13.3-1 and Section 13.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the Drug Enforcement Administration was unwarranted, but only whether the member may continue to practice at PSMC with those limitations imposed.

b. Practitioners, APPs, or BHPs whose privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Bylaws, Section 13.3-3), failing to complete medical records (Bylaws, Section 13.3-4), failing to maintain malpractice insurance (Bylaws, Section 13.3-5), failing to pay dues (Bylaws, Section 13.3-6), or failing to comply with particular government or other third party payor ~~Rules or policies~~ Policies(Bylaws, Section 13.3-7) are not entitled ~~under Bylaws, Section 13.3-9~~ to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and it must be reported to the Colorado Medical Board or National Practitioner Data Bank.

~~**14.13-4 Failure to Meet Minimum Activity Requirements**~~

~~Practitioners shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their Medical Staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the only review shall be provided by the Professional Review Committee through a subcommittee consisting of at least three Professional Review Committee members. The subcommittee shall give the practitioner notice of the reasons~~

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~~for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than 30 days and no more than 100 days after the date the notice was given. At this interview, the practitioner may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the practitioner, Professional Review Committee and Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the Professional Review Committee within 45 days after the decision was rendered, or the Governing Body within 90 days after the decision was rendered.~~

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15.1 ~~Rules and~~ Policies

15.1-1 Overview and Relation to Bylaws

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff ~~Rules~~Policies, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such ~~Rules and policies~~Policies shall be deemed an ~~integral part of~~addendum to the Medical Staff Bylaws.

15.1-2 General Medical Staff ~~Rules~~Policies

Medical Staff Policies must be approved by the MEC and accepted or approved by the Governing Board.~~-~~ New policies may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least fifty-one percent of the voting members of the Medical Staff. The Medical Staff shall initiate and adopt such ~~Rules~~Policies as it may deem necessary and shall periodically review and revise its ~~Rules~~Policies to comply with current Medical Staff practice. ~~New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least fifty-one percent of the voting members of the Medical Staff. Additionally, PSMC administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on PSMC operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:~~

~~a. Except as provided at Section 15.1-2(d), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. This review and comment opportunity may be accomplished by mailing (either by U.S. postal service or email) or alternatively, in the discretion of the MEC, by posting proposed Rules on a portal of the PSMC website at least 15 days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments in the 15 days prior to the Medical Executive Committee meeting. The Chief of Staff (or his/her designee) will summarize all comments for the Medical Executive Committee.~~

~~b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least fifty-one percent of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall~~

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~~notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6:~~

~~1. If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-2(b)(3), the proposed Rule shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed Rule.~~

~~2. If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Governing Body.~~

~~3. With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least twenty-five percent of return votes have been cast.~~

~~c. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body.~~

~~d. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Governing Body for approval and immediate implementation, subject to the following provisions of this Section 15.1-2(d). If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 15.1-2(a)) the Medical Staff shall be notified of the provisionally adopted and approved Rule, and may, by petition signed by at least thirty three and 1/3 of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1-2.~~

If there is a conflict between the Bylaws and the ~~Rules~~Policies, the Bylaws shall prevail.

15.1-3 Department ~~Rules~~Procedures

~~Subject to the approval of the Medical Executive Committee and Governing Body, each department shall~~ Each department may formulate its own ~~Rules~~Procedures for conducting its affairs and discharging its responsibilities. Additionally, PSMC administration may develop and recommend proposed department ~~Rules~~Procedures, and in any case should be consulted as to the impact of any proposed department ~~Rules~~Procedures on PSMC operations and feasibility. Such ~~Rules~~Procedures shall not be inconsistent with the Medical Staff or PSMC Bylaws, ~~Rules~~Procedures or other policies.

15.1-4 ~~Medical Staff Policies~~

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~~a. Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. New or revised policies (proposed policies) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least fifty percent (50%) of the voting members of the Medical Staff. Proposed policies shall not be inconsistent with the Medical Staff Bylaws, Medical Staff Rules or PSMC bylaws, policies, and procedures; upon adoption shall have the force and effect of Medical Staff Bylaws.~~

~~b. Medical Executive Committee approval is required, unless the proposed policy is one generated by petition of at least fifty-one percent of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed policy, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6.~~

~~1. If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-5(b)(3), the proposed policy shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed policy.~~

~~2. If conflict management is invoked, the proposed policy shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the Governing Body.~~

~~3. Approval of the Medical Staff shall require the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed policy, has been given and at least twenty-five percent of the votes have been cast.~~

~~c. Following approval by the Medical Executive Committee or the voting Medical Staff as described above, a proposed Policy shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body.~~

~~15.1-6~~ Conflict Management

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least thirty-three and 1/3 of the voting members of the Medical Staff) regarding a proposed or adopted ~~Rule or~~ policy, or other issue of significance to the Medical Staff, the ~~President~~Chief of ~~the Medical~~ Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of three to five members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership

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responsibilities of the Medical Executive Committee, and the safety and quality of patient care at PSMC. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Governing Body for its consideration in making its final decision with respect to the proposed ~~Rule,~~ policy, or issue.

15.2 Forms

Application forms and any other prescribed forms required by these Bylaws or approved Medical Staff policies for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Executive Committee and the Governing Body. Upon adoption, they shall be deemed part of the Medical Staff ~~Rules. They~~Policies. All Forms may be amended by approval of the Medical Executive Committee and the Governing Body.

15.3 Dues

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~~The~~By approved policy, the Medical Executive Committee shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff.

15.4 Medical Screening Exams

15.4-1 All patients who present to PSMC, including the Emergency Department, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition or, where applicable, active labor. This screening examination may be performed ~~by the following persons:~~in accordance with PSMC approved policies and procedures.

~~a. **In the Emergency Department:** by a registered nurse who has been determined by the ER Nurse Manager to be qualified and experienced in emergency nursing and who is required to follow standardized procedures approved by the Medical Staff.~~

~~b. **For labor and delivery:** by a registered nurse who has been determined to be qualified and experienced in obstetrical nursing and who is required to follow standardized procedures approved by the Medical Staff.~~

~~c. **In all circumstances:** in the event the registered nurse performing the screening examination is uncertain about the nature of the patient's condition or the existence of an emergency or active labor, a physician from either the Emergency Department or for labor and delivery shall be required to examine the patient and make the determination of the existence of an emergency or active labor.~~

15.4-2 Medical screening examinations and emergency services shall be provided in compliance with all applicable provisions of state and federal law, and PSMC policies and procedures respecting Emergency Medical Services.

~~**15.4-3** Informed Consent. Based upon input from the departments, the Medical Staff shall develop a list of procedures and informed consent "form" requiring informed consent of the patients. This list and form may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval by the Governing Body. Upon adoption shall have the force and~~

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~~effect of Medical Staff Bylaws. All Medical Staff shall obtain informed consents consistent with such adopted procedures and form.~~

15.5 Legal Counsel

The Medical Staff may, at its expense, retain and be represented by independent legal counsel. Further, by mutual agreement with PSMC administration, the Medical Staff may work cooperatively with PSMC's legal counsel.

15.6 Authority to Act

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

15.7 Disputes with the Governing Body

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In the event of a dispute between the Medical Staff and the Governing Body relating to the independent rights of the Medical Staff, the following procedures shall apply.

a. **Invoking the Dispute Resolution Process**

1. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25 percent of the members of the active staff.

2. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50 percent of the members of the active staff.

b. **Dispute Resolution Forum**

1. ~~Ordinarily, the~~ The initial forum for dispute resolution shall be two representatives of the MEC determined by the ~~Compliance~~Chief of Staff and ~~Accreditation Committee~~two representatives of the Governing Board determined by the Board Chair, which shall meet and confer~~ as further described in Bylaws, Section 9.2(b).~~.

~~2.~~ However, upon request of at least 2/3 of the members of the Medical Executive Committee and 2/3 of the members of the Governing Board, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body~~.~~ (such event would require notice of a public meeting of the Governing Board).

2. A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of:

i. At least a majority of the Medical Executive Committee plus two members of the Governing Body; or

ii. At least a majority of the Governing Body plus two members of the Medical Executive Committee.

c. The parties' representatives shall convene as early as possible, shall gather and share relevant information, and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute the Governing Body shall make its final determination ~~giving great weight to~~upon consideration of relevant PSMC governance, the ~~actions and~~fiduciary duties of the Governing Board, and the recommendations of the Medical Executive Committee. ~~Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical~~

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~~care provided and the competency of the Medical Staff, and to ensure the responsible governance of PSMC.~~

15.8 No Retaliation

Neither the Medical Staff, its members, committees or department heads, the Governing Body, its ~~chief~~ administrative ~~officer~~officers, or any other employee or agent of PSMC or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, PSMC employee, member of the Medical Staff, or any other health care worker of the health facility because that person has done either of the following:

a. Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the Medical Staff of the facility, or to any other governmental entity.

b. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Medical Staff, or governmental entity.

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16.1 Medical Staff Responsibility and Authority

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16.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Body~~, which approval shall not be unreasonably withheld.~~. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body. Amendments may be proposed as set forth in Sections 16.1-2 and 16.1-3 . Additionally, PSMC administration may develop and recommend proposed Bylaws, amendments or policies (generally by taking such proposals to the MEC for consideration), and in any case should be consulted as to the impact of any proposed Bylaws on PSMC operations, compliance with laws and feasibility.

16.1-~~3~~2~~2~~ Amendments to the Bylaws may be proposed by the MEC using the following process:

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1. A vote of a majority of the MEC approves the amendments proposed by the MEC.
2. The MEC issues the proposed amendments to the eligible voting Active Medical Staff for a comment period of at least 30 days with a stated deadline (the MEC may, in its discretion, include a report or commentary about the proposed amendments and the process).

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3. Following the expiration of the Medical Staff comment period, the MEC reviews the comments of Medical Staff and determines, by majority vote, whether to make any further proposed amendments to the Bylaws (any further amendments by the MEC does not trigger an additional comment period).
4. The MEC (through the Clerk to the Board) submits the proposed amendments ~~Proposed amendments shall be submitted~~ to the Governing Body for a comment period of ~~comments~~ at least 30 days with a stated deadline. Each Board member will provide written comment (affirming assent, objection, questions, concerns or "no comment") to the Clerk of the Board; nothing herein precludes the Governing Body from discussing such comments at a duly noticed meeting of the Governing Body.

The Medical Staff Office Manager shall compile all comments of the Board members in an efficient order (which may be by Board member and/or may be by section if several members have comment on a particular section). ~~before they are distributed to the Medical Staff for a vote. The Governing Body has the right to have its comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.~~

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6. Following the expiration of the Governing Body comment period, the MEC reviews the comments of the Governing Body and determines, by majority vote, whether to make any further proposed amendments to the Bylaws (any further amendments by the MEC does not trigger an additional comment period).

7. The Medical Staff Office Manager shall commence the time period to vote via email to each eligible Active Medical Staff member who shall each have fifteen days to provide his/her vote to the Medical Staff Office Manager. The MSO Manager's email shall distribute the following: (a) the ballot; (b) the proposed Bylaw amendments; (c) the MEC's report or commentary regarding the proposed amendments; (d) the compiled comments of the Board members regarding the proposed amendments; and (e) information on the process and the deadline for voting. The eligible Active Medical Staff members may request from the MSO a hard copy of the emailed documents.

8. Following the 15-day voting period (or sooner if all votes are earlier received), if the Medical Staff Office Manager confirms an affirmative approval of a majority of the actually voting eligible Active Medical Staff members, then such proposed amendments shall by submitted (through the Clerk to the Board) for a vote by the Governing Body at a duly noticed meeting. If there is not approval of a majority of the actually voting eligible Active Medical Staff members, then the proposed amendments fail.

9. Such proposed amendments are approved only upon the affirmative vote of a majority of the members of the Governing Body actually voting on the matter at a duly noticed public meeting of the Governing Body.

16.1-~~23~~3 Amendments to the Bylaws may be proposed by signed petition of 33.33% of the eligible voting Active Medical Staff using the following process:

1. A signed petition of 33.33% of the eligible voting Active Medical Staff (hereinafter the "Petitioning Medical Staff") proposes amendments and provides a written statement of the proposed amendments to the MEC.

2. The Petitioning Medical Staff shall provide the MEC with a comment period of at least 30 days with a stated deadline (the Petitioning Medical Staff may, in its discretion, include a report or commentary about the proposed amendments and the process).

3. Following the expiration of the Medical Staff comment period, the Petitioning Medical Staff reviews the comments of MEC and determines, by majority vote, whether to make any further proposed amendments to the Bylaws (any further amendments by the Petitioning Medical Staff does not trigger an additional comment period).

4. The Petitioning Medical Staff (through the Clerk to the Board) submits the proposed amendments and comments of the MEC to the Governing Body for a comment period of at least 30 days with a stated deadline. Each Board member will provide written comment (affirming assent, objection, questions, concerns or "no comment") to the Clerk of the Board; nothing herein precludes the Governing Body from discussing such comments at a duly noticed meeting of the Governing Body.

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5. The Medical Staff Office Manager shall compile all comments of the Board members in an efficient order (which may be by Board member and/or may be by section if several members have comment on a particular section).

6. Following the expiration of the Governing Body comment period, the Petitioning Medical Staff reviews the comments of the Governing Body and determines, by majority vote, whether to make any further proposed amendments to the Bylaws (any further amendments by the Petitioning Medical Staff does not trigger an additional comment period).

7. The Medical Staff Office Manager shall commence the time period to vote via email to each eligible Active Medical Staff member who shall each have fifteen days to provide his/her vote to the Medical Staff Office Manager. The MSO Manager's email shall distribute the following: (a) the ballot; (b) the proposed Bylaw amendments; (c) the Petitioning Medical Staff's report or commentary regarding the proposed amendments; (d) the commentary of the MEC; (e) the compiled comments of the Board members regarding the proposed amendments; and (f) information on the process and the deadline for voting. The eligible Active Medical Staff members may request from the MSO a hard copy of the emailed documents.

8. Following the 15-day voting period (or sooner if all votes are earlier received), if the Medical Staff Office Manager confirms an affirmative approval of a majority of the actually voting eligible Active Medical Staff members, then such proposed amendments shall by submitted (through the Clerk to the Board) for a vote by the Governing Body at a duly noticed meeting. If there is not approval of a majority of the actually voting eligible Active Medical Staff members, then the proposed amendments fail.

9. Such proposed amendments are approved only upon the affirmative vote of a majority of the members of the Governing Body actually voting on the matter at a duly noticed public meeting of the Governing Body.

~~Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least thirty-three and 1/3 percent of the voting Medical Staff members. If Aamendments are submitted upon petition of the voting Medical Staff members, then the proposed amendments shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Governing Body for review and comment as described in Section 16.1-3. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Governing Body when the proposed amendments are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for a vote.~~

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16.2 ~~Methodology~~Governing Body May Impose Conditions For Failure of Medical Staff to Exercise Its Duty

~~**16.2-1** Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:~~

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~~a. The affirmative vote of a majority of the eligible voting Medical Staff members actually voting on the matter by emailed secret ballot returned within 15 days from the start of the vote, provided at least 7 days advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and~~

~~b. TheIf the approval of the Governing Body, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff, and the Medical Executive Committee and the Bylaws Committee.~~

~~16.2 2~~ In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

16.3 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Governing Body. Such corrections are effective upon adoption by the Medical Executive Committee; provided however, they may be rescinded by vote of the Medical Staff or the Governing Body within 120 days of the date of adoption by the Medical Executive Committee. (For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the eligible votes actually cast, provided at least 10 percent of the eligible voting members of the Medical Staff cast ballots.)

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UPPER SAN JUAN HEALTH SERVICES DISTRICT
D/B/A PAGOSA SPRINGS MEDICAL CENTER

Formal Written Resolution 2020-09
March 24, 2020

WHEREAS, PSMC administration proposes that PSMC purchase air-evacuation insurance for all benefit-eligible employees and their families. Benefit to these employees includes saving the employee, and their family members, the out-of pocket cost for air evacuation. Benefit to PSMC includes reasonable expense (approximately $25.00 per year for the benefit-eligible employees, which is approximately 200) to assure all benefit-eligible employees have this coverage; however, this does not result in any elimination of cost to PSMC.

NOW, THEREFORE, BE IT RESOLVED by the USJHSD Board of Directors to approve the the proposed purchase of air-evacuation insurance for all benefit-eligible employee and their families.

EFFECTIVE and ADOPTED this 24th day of March, 2020.

UPPER SAN JUAN HEALTH SERVICE DISTRICT

_____
Gregory J. Schulte, Chairman

Attest:

_____
Heather Thomas, Clerk to the Board

MINUTES OF REGULAR BOARD MEETING
Tuesday, February 25, 2020
5:30 PM
The Board Room
95 South Pagosa Blvd., Pagosa Springs, CO 81147

The Board of Directors of the Upper San Juan Health Service District (the *"Board"*) held its regular board meeting on February 25, 2020, at Pagosa Springs Medical Center, The Board Room, 95 South Pagosa Blvd., Pagosa Springs, Colorado.

Directors Present: Chair Greg Schulte, Treasurer-Secretary Dr. King Campbell, Director Kate Alfred, Director Jason Cox, and Director Karen Daniels.

Present by Phone: Director Dr. Jim Pruitt

Director(s) Absent: Vice-Chair Matt Mees. (The noted absence was excused due to prior notification.)

1) CALL TO ORDER

a) Call for quorum: Chair Schulte called the meeting to order at 5:33 p.m. MST and Clerk of the Board, Heather Thomas, recorded the minutes. A quorum of directors was present and acknowledged.

b) Board member self-disclosure of actual, potential or perceived conflicts of interest: Per advisement by Chair Schulte, Director Dr. Pruitt acknowledged a conflict of interest and, therefore, requested to separate voting on the Provider Privileges Consent Agenda item as Director Dr. Pruitt is included as a decision item with respect to the Medical Executive Committee recommending a Medical Board reappointment.

c) Approval of the Agenda: The Board noted approval of the agenda.

2) PUBLIC COMMENT

There was none.

3) PRESENTATION

Item intentionally struck from agenda. There was no presentation.

4) REPORTS

a) **Oral Report**

i) Chair Report

Chair Schulte gave an update regarding the Archuleta County Combined Dispatch IGA, the proposed 9-1-1 surcharge, and the Town's URA (Urban Renewal Authority) noting that a meeting was held last Thursday, where the Town Council appointed J.R. Ford as representative for the Special District and Chair Schulte was appointed as Mayoral Designee. The first meeting of the URA is scheduled for April 15.

ii) Contracts

Item intentionally struck from agenda. There was no report.

iii) Strategic Planning

Item intentionally struck from agenda. There was no report.

iv) CEO Report

CEO, Dr. Rhonda Webb, announced to the Board that there will be a Chamber of Commerce After-hours event, hosted by PSMC, on March 18, at 5:00 p.m., held in the Board Room and overflowing in the Cancer Center. Members of the Chamber, and their invited guests, are invited to attend.

CEO Dr. Webb then discussed rising healthcare costs, stating that she is proud that PSMC is improving, not declining, as reported of other rural healthcare systems across the nation. CEO Dr. Webb then noted in 2018 the entire team and the Board managed to make a small margin profit, in spite of a system that is considered quite young and having a lot of debt. CEO Dr. Webb noted in 2019 the team and the Board managed to double the previous margin of 2018 by continuing the changes put in place to help PSMC maximize revenue and decrease expenses. CEO Dr. Webb stated that PSMC was able to manage all of these improvements, while having the lowest prices, per the RAND report, of any Colorado hospital within a 2-hour drive of PSMC. CEO Dr. Webb noted that PSMC desires to work together with community members to make healthcare affordable and offer the right services at the right time.

CEO Dr. Webb announced that PSMC will begin hosting Town-Hall Meetings around the community to help give community members an opportunity to meet with the organization and help people understand the nuances of where hospitals are today with the ever-changing healthcare environment.

v) HVAC Project, status report

Chair Schulte noted to the Board that he had requested a verbal report by COO-CNO, Kathee Douglas, on the year-to-date report as submitted within the board packet and instructed COO-CNO Douglas to begin with the HVAC project status report.

COO-CNO Douglas advised the Board that the contract with contractor GE Johnson has been fully executed and GE Johnson has proceeded to order necessary equipment. PSMC staff is continuing weekly status meetings with GE Johnson every Wednesday.

COO-CNO Douglas advised the OR is scheduled to be down June 10th through the 23rd.

Comparison pricing for fixtures and furniture required to get the second OR operational are being conducted at this time.

There were no questions.

vi) Finance Report

CFO, Chelle Keplinger, presented and discussed the attached PowerPoint financial presentation and advised that auditors will be onsite the week of March 16.

Director Cox noted observations of the Finance Committee, stating budget was spot on though expenses were slightly higher due to additional interest expenses.

Chair Schulte inquired of the statement within the Finance Report which states, "At the request of the Finance Committee, administration will provide to the Finance Committee on a quarterly basis a service line analysis of an existing service." CFO Keplinger answered advising the Finance Committee requested administration to give an overall picture of how a specific service line is performing. Due to the complexity and involvement of many other aspects regarding the service line, administration will then compile all information and present a report and analysis to the Finance Committee of a specific service line once a quarter.

b) **Written Reports**

i) Operations Report

COO-CNO Douglas presented and discussed the Yearly Comparison Report noting key points:

- PSMC is no longer in a 20 percent growth spurt and has begun to plateau.
- Inpatient services have been affected due to changing many inpatient services to outpatient services.
- An anticipated decline in ER visits due to opening walk-in clinic.
- Transfer numbers were a little higher due to uncontrollable situations.
- Diagnostic imaging fell flat, though cardiology is still growing due to Dr. Lambert increasing his days and services here.
- Regarding surgery: ENT, as new service line, drew many cases; others saw some decrease. CEO Dr. Webb noted that, in comparison, 2018 saw a record number of orthopedic surgeries in December, more than have ever been done before.

Questions were asked and answered.

ii) Medical Staff Report

There were no questions.

5) EXECUTIVE SESSION

Chair Schulte gave a brief overview of the reason for the need of an executive session.

Treasurer-Secretary Dr. Campbell motioned to enter into executive session. Upon motion seconded by Director Daniels, the Board entered into executive session at 6:08 p.m. MST, regarding matters to remain confidential pursuant to other federal or state statute – specifically confidential quality and peer review stats that are confidential per state statutes C.R.S. Section 25-3-109, et seq.

and C.R.S. Section 12-36.5-101 et seq.

Directors present in executive session were: Chair Schulte, Treasurer/Secretary Dr. Campbell, Director Alfred, Director Daniels, and Director Cox.

Also present in executive session were: CEO Dr. Webb, CAO Bruzzese, CNO/COO Douglas, CFO Keplinger, COS Dr. Ralph Battels, Manager of the Medical Staff Office, Krista Starr, and Clerk of the Board, Heather Thomas.

Present by phone was Director Dr. Pruitt.

Chair Schulte adjourned the executive session at 6:22 p.m. MST.

6) DECISION AGENDA

The confidential annual report of PSMC's 2019 peer review activities was presented in executive session by the Manager of the Medical Staff Office, Krista Starr, as such report is to be used and remain confidential in accordance with the Quality Management Act, C.R.S. Section 25-3-109, et seq. and the Professional Review Act, C.R.S. Section 12-36.5-101 et seq.

Director Alfred motioned to accept Resolution 2020-06, regarding acceptance of PSMC's annual report of PSMC's 2019 peer review activities. It was noted that the attached resolution was mistitled as 2019-06 and should have been titled 2020-06. The resolution was amended as stated. Upon motion seconded by Director Daniels, the Board unanimously accepted said resolution, as amended.

7) CONSENT AGENDA

Due to Director Dr. Pruitt's noted conflict of interest regarding approval of Medical Staff report recommendations for new or renewal of provider privileges, Chair Schulte reminded the Board that the Consent Agenda items are to be separated for discussion.

Director Daniels motioned to approve the noted Board Member absence and the minutes of the regular meeting of 01/21/2020. Upon motion seconded by Treasurer-Secretary Dr. Campbell, the Board unanimously approved said consent agenda items.

Treasurer-Secretary Dr. Campbell motioned to approve the Medical Staff report recommendations for new or renewal of provider privileges. Due to previously advised conflict of interest, Director Dr. Pruitt noted abstention from approval of noted consent agenda item. Upon motion seconded by Director Alfred, the Board unanimously approved said consent agenda item with noted abstention by Director Dr. Pruitt.

8) OTHER BUSINESS

CAO Bruzzese advised the Board that comments of the Board regarding proposed amendments to the Medical Staff Bylaws is only step two of four. The Board noted the following:

- Director Mees: In writing affirmed no issues with the proposed amendments.
- Treasurer-Secretary Dr. Campbell: No comment.
- Director Alfred: No comment.
- Director Daniels: No comment.
- Director Cox: No comment.
- Chair Schulte: No comment.

- Director Dr. Pruitt: Reiterated written comments as previously submitted in writing and included within the Board Packet.

The MEC provided within the Board Packet a written response regarding Director Dr. Pruitt's written comments.

9) ADJOURN

There being no further business, Chair Schulte adjourned the regular meeting at 7:02 p.m. MST.

Respectfully submitted by:
Heather Thomas, serving as Clerk of the Board