BYLAWS OF THE MEDICAL STAFF

Medical Staff Services
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Banner
Behavioral Health
Hospital – Scottsdale

BANNER BEHAVIORAL HEALTH HOSPITAL

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MEDICAL STAFF BYLAWS

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Behavioral Health Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of those purposes. These Bylaws provide the legal structure for Medical Staff operation and describe the relationship between the organized Medical Staff and its members and applicants. These Bylaws along with the Bylaws of Banner Health provide a recognized structure for Medical Staff activities and document the relationship between the Medical Staff and the Board of Directors.

ARTICLE ONE: NAME

1.1 The organizational component of Banner Health to which these Bylaws are addressed is called "The Medical Staff of Banner Behavioral Health Hospital."

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 **PURPOSES**

The purposes of this Medical Staff are:

2.1-1 To provide oversight for the quality of care, treatment, and services provided by practitioners with privileges, and to approve and amend medical staff bylaws.

2.1-2 To continually seek to provide quality and efficient care for all patients admitted to, or treated in, any facilities, departments, or service of the Hospital.

2.1-3 To discharge those duties and responsibilities delegated by the Board of Directors and to provide a mechanism for accountability to the Board, through defined organizational structures, for the review of the appropriateness of patient care services, professional and ethical conduct, and teaching and research activities of each practitioner appointed to the Medical Staff, so that patient care provided at the Hospital facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

2.1-4 To evaluate clinical processes and outcomes and identify and implement opportunities for professional performance improvement.

2.1-5 To maintain the highest scientific and educational standards for continuing medical education programs for members of the Medical Staff.

2.1-6 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Hospital and through which they fulfill the obligations of staff appointment.

2.1-7 To provide an orderly and systematic means by which staff members can advise the Board and CEO on medical staff matters and on Hospital policy-making and planning processes.

2.1-8 To participate in education of patients and families.

2.2-9 To take action, as necessary to enforce the Medical Staff Bylaws, rules and regulations and policies.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff through its committees and officers include:

2.2-1 To participate in the performance improvement, patient safety and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided in the Hospital, including:

(a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria;
(b) Engaging in the ongoing monitoring of patient care practices;
(c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges;
(d) Promoting the appropriate use of Hospital resources; and
(e) Complying with the applicable Banner Care Management Initiatives.

2.2-2 To make recommendations to the Board concerning appointments and reappointments to the staff, including category, clinical privileges, corrective action, and termination of membership and privileges.

2.2-3 To participate in the development, conduct, and monitoring of medical education programs and clinical research activities.

2.2-4 To develop and maintain Bylaws and policies consistent with sound professional practices, and to take action, as necessary, to enforce compliance with the Medical Staff Bylaws, rules and regulations, and policies.

2.2-5 To participate in the Hospital's long range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2-6 To exercise through its officers, committees, and other defined components, the authority granted by these Bylaws, to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.

ARTICLE THREE: MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

Every physician, advanced practice professional or other practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws or in rules and regulations:

3.1-1 ELIGIBLE HEALTHCARE PROVIDERS

3.1-1.1 Medical Doctors (MD)

3.1-1.2 Osteopathic Medicine (DO)
3.1-1.3 Psychologists
3.1-1.4 Advanced Practice Registered Nurses (APRNs)
3.1-1.5 Physician Assistants

3.1-2 **LICENSURE**

Evidence of a currently valid license issued by the State of Arizona to their profession.

3.1-3 **PROFESSIONAL EDUCATION AND TRAINING**

a) Graduation from an approved medical or osteopathic school or attainment of doctorate degree in psychology from an accredited university; or certification by the Educational Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in Medical Sciences. For purposes of this section, an “approved” or “accredited” school or university is one fully accredited during the time of practitioner’s attendance by the Accreditation Council for Graduate Medical Education (ACGME), by the American Osteopathic Association (AOA), by the Royal College of Physicians and Surgeons of Canada or by the American Psychological Association (APA), or by a successor agency to any of the foregoing or by an accrediting agency on file with the U.S. Secretary of Education or a school equivalent to one accredited by the ACGME.

b) Satisfactory completion of an approved postgraduate training program. An "approved" postgraduate training program is one fully accredited throughout the time of the practitioner's training by the ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or APA, or by a successor agency to any of the foregoing, or a program equivalent to one accredited by the ACGME. Postgraduate training must be in a field of specialty appropriate and acceptable to the Executive Committee.

c) Advanced Practice Professionals. Advanced Practice Professionals must have successfully completed a training program required for licensure or certification, or an equivalent program approved by the Medical Executive Committee and the Governing Body.

3.1-4 **BOARD CERTIFICATION**

(a) Board certified or qualified for Board certification - Where membership and privileges are granted on the basis of Board qualification, certification must be obtained within five years of completion of training. Failure to become certified within the time allowed under these Bylaws, as required by the appropriate Board shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges. This Board certification requirement shall not apply to Staff members with privileges prior to September 20, 2002.

For purposes of this section, “Board certification” or “Board certified” means has been/is certified by a board approved by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists or by a board determined by the Medical Executive Committee to be equivalent. For purposes of this section, “Board qualification” or “Board qualified” means the applicant has completed the training and other requirements necessary to be accepted as an active candidate for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed qualified during this time period if the director of his/her training program

certifies that he/she has met all training requirements for qualification by the appropriate board.

(b) Exceptions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:
   a. where a particular field or specialty does not have a Board certification:
   b. to applicants/members where there is a shortage of qualified Medical Staff members in the practitioner's specialty necessary to meet the Hospital's demand for services where the Medical Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board certification.

Members are required to remain board certified. Recertification must be obtained within three years from the expiration of Board certification or recertification. Failure to maintain board certification shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

(c) The Medical Executive Committee may consider extending membership within the current appointment term, under the following circumstances for initial certification or maintenance of certification:
   a. a practitioner has taken the exam, and is awaiting results or has exam scheduled and provides evidence of this; or
   b. a practitioner has submitted evidence of a particular medical, physical, family, or financial hardship in which they were unable to become certified or recertified within the required time frame. In this instance, the practitioner must sit for the next available board exam to become certified or recertified.
   c. Advanced Practice Professionals. Advanced Practice Professionals must have successfully completed a training program required for licensure or certification, or an equivalent program approved by the Medical Executive Committee and the Governing Body.

In the event the practitioner fails to certify or does not take the exam, it shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

3.1-5 **CLINICAL PERFORMANCE**

Current experience, clinical results, and utilization patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

3.1-6 **COOPERATIVENESS**

Demonstrated ability to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care and patient and employee satisfaction. It is the policy of Banner Behavioral Health Hospital and this Medical Staff, that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, all Medical Staff members, and other practitioners must conduct themselves in a professional and cooperative manner consistent with the Medical Staff's policy on professional conduct. Failure to do so may constitute disruptive behavior. Disruptive behavior by any practitioner against any individual (e.g., against another Medical Staff member, hospital employee, patient or visitor) shall not be tolerated. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken.

3.1-7 **TEAMWORK**
Demonstrated ability to work as a member of the healthcare team, exhibiting the skills, communication practices and behaviors of a team leader.

3.1-8 **SATISFACTION OF MEMBERSHIP OBLIGATIONS**
Satisfactory compliance with the basic obligations accompanying appointment to the staff and equitable participation, as determined by Medical Staff and Board authorities, in the discharge of staff obligations specific to staff category.

3.1-9 **PROFESSIONAL ETHICS AND CONDUCT**
Demonstrated high moral character and adherence to generally recognized standards of medical and professional ethics which include refraining from: paying or accepting commissions or referral fees for professional services; delegating the responsibility for diagnosis or care to a practitioner or allied health professional not qualified to undertake that responsibility; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and failing to obtain appropriate informed patient consent for treatment.

3.1-10 **PARTICIPATION IN GOVERNMENT PROGRAMS**
Ability to participate in Medicare/AHCCCS and other federally funded health programs.

3.1-11 **HEALTH STATUS**
Freedom from or adequate control of any significant physical or mental health impairment and freedom from abuse of any type of substance or chemical that may affect cognitive, motor, or communication ability in a manner that interferes with the ability to provide quality patient care or the other qualifications for membership, and freedom from infectious tuberculosis.

3.1-12 **VERBAL AND WRITTEN COMMUNICATION SKILLS**
Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-13 **PROFESSIONAL LIABILITY INSURANCE**
Evidence of professional liability insurance of a kind and in an amount satisfactory to the Board.

3.1-14 **FINGERPRINT CLEARANCE**
Evidence of current fingerprint clearance pursuant to ARS 36-425.03. for all members of the Active, Associate and APP Staff.

3.1-15 **FELONY CHARGES**
A practitioner must never have been convicted of, or entered a plea of guilty to or a plea of no contest to any felony related to the practice of medicine.

3.1-16 **EFFECTS OF OTHER AFFILIATIONS**
No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:
(a) Licensure to practice;
(b) Completion of a postgraduate training program at any Banner facility;

(c) Certification by any clinical board;
(d) Membership on a medical school faculty;
(e) Staff appointment or privileges at another health care facility or in another practice setting; or
(f) Prior staff appointment or any particular privileges at Hospital.

3.1-17 **NONDISCRIMINATION**

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the delivery of quality and efficient patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, or to community need.

3.1-18 **EXEMPTIONS FROM QUALIFICATIONS**

Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the Honorary Staff or Resident Staff and as otherwise provided in these Bylaws.

3.2 RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP

Each staff member, regardless of assigned staff category, shall have the following rights:

(a) The right to meet with the Medical Executive Committee in the event he/she is unable to resolve a difficulty. The member must submit written notice to the Chief of Staff at least two weeks in advance of the regular meeting;
(b) The right to initiate a recall election of a Medical Staff Officer and/or a committee chairman by following the procedures set forth in Section 7.5;
(c) The right to initiate the scheduling of a general staff meeting by following the procedures set forth in Section 9.1-2;
(d) The right to challenge any rule or policy established by the Medical Executive Committee by presentation to the Medical Executive Committee of a petition signed by 40% of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will provide information clarifying the intent of the rule or policy or schedule a meeting to discuss the issue;
(e) The right to request conflict resolution of any issue by presentation to the Medical Executive Committee of a petition signed by one third of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will schedule a meeting to discuss the issue.
(f) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken.
(g) The right to request review by the Medical Executive Committee in the event that nonreviewable corrective action is taken.
(h) The right to request that the Medical Executive Committee request a Joint Conference Committee meeting with the Board to resolve concerns regarding medical staff bylaws, credentialing recommendations, policies or other issues which such medical staff has been unable to resolve through informal processes with the CEO, senior management, the Medical Staff Subcommittee, the Care Management and Quality Committee, or the Board of Directors.

3.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

Each staff member, regardless of assigned staff category, and each practitioner exercising temporary privileges under these Bylaws, shall:

(a) Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate;
(b) Abide by the Banner Health Bylaws, these Bylaws, rules and regulations, and all other standards and policies of the Board, the Medical Staff and Hospital;

(c) Discharge such staff, committee, and Hospital functions for which he or she is responsible, including review and supervise the performance of other practitioners;
(d) Serve on the on-call roster for charity, unassigned, and emergency patients as determined by the Medical Executive Committee and the CEO;
(e) Prepare and complete in timely fashion, according to these Bylaws and to Hospital policies, the electronic medical record and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, services, or departments;
(f) Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and obtain consultation when necessary for the health or safety of those patients;
(g) Participate in continuing education programs;
(h) Use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and Banner Health's business information designated as confidential by Banner Health or its representatives prior to disclosure;
(i) Refrain from disclosing confidential information to anyone unless authorized to do so;
(j) Protect access codes and computer passwords and to ensure confidential information is not disclosed;
(k) Disclose to the Medical Staff when requested any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or the Hospital;
(l) Refrain from making treatment recommendations/decisions for economic benefit of the practitioner and unrelated to needs of the patient;
(m) Comply with all applicable state and federal law in disclosing to a patient any direct financial interest that the practitioner, his/her group or his/her employer has in a separate diagnostic or treatment facility prior to transferring the patient to such facility.
(n) Participate in Banner training program for the electronic medical record (EMR) prior to exercising clinical privileges and to remain current with regard to relevant changes, upgrades and enhancements to the EMR.
(o) Participate in the Hospital Orientation Program as required by the Medical Executive Committee.

3.4 TERM OF APPOINTMENT

Appointments to the Medical Staff and grants of clinical privileges are for a period not to exceed two years. The Board, after considering the recommendations of the Medical Executive Committee, may establish a shorter appointment period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability, has been the subject of disciplinary action, or is under investigation or where further evaluation is pending.

3.4-1 EXPIRATION

The appointment of each staff member shall expire every two years on the last day of the birth month of the practitioner, except as provided in this Section. An interim reappointment may be necessary to align the practitioner with the birth month reappointment cycle.

3.5 EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every applicant to and member of the Medical Staff agrees that when corrective action is initiated or taken or when a recommendation is made by any committee or any person acting on its behalf, the effect of which is to deny, revoke, or otherwise limit the privileges or membership of the applicant or staff member, such applicant or member shall exhaust the administrative remedies afforded in these Bylaws and Fair Hearing Plan prior to initiating litigation.

3.6 LIMITATION OF DAMAGES

Every applicant to and member of the Medical Staff agrees that his or her sole remedy for any adverse or corrective action for failure to comply with these Bylaws shall be the right to seek injunctive relief pursuant to ARS 36-445 et. seq. An alleged breach of any provision of these Bylaws and/or Fair Hearing Plan shall provide no right to monetary relief from the Medical Staff, the Hospital or any third party, including any employee, agent or member of the Medical Staff or the Hospital and any person engaged in peer review activities.

3.7 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.7-1 QUALIFICATIONS

A practitioner, who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Hospital, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as any other staff member.

(a) Practitioners rendering professional services pursuant to employment or contracts with the Hospital shall be required to maintain Medical Staff membership and privileges.

(b) Unless otherwise provided in the contract for professional services or in an exclusive contract, termination of such employment or contracts shall not result in automatic termination of Medical Staff membership and privileges.

3.8 EXCLUSIVE CONTRACTS

The Hospital may enter into an Exclusive Agreement with members of the Medical Staff which limit the rights of other practitioners to exercise clinical privileges and/or the rights and prerogatives of Medical Staff membership. Such Agreements may only be entered into after a determination by the CEO that expected improvements to the quality of care, coverage, cost-efficiency and/or service excellence will outweigh the anticompetitive effect of the Agreement as required by the Board's Physician Exclusive Agreements policy. No reporting is required under federal or state law when privileges or membership is limited because an Exclusive Agreement is entered into, and no such reports shall be made.

3.8-1 REVIEW OF POSITIONS

(a) Prior to entering into or transferring an Exclusive Agreement for a program or service not previously covered by an Exclusive Agreement, the CEO shall explain to the Medical Executive Committee the need for, and expected benefits of, the Exclusive Agreement.

(b) The Medical Executive Committee shall give Medical Staff members whose privileges may be adversely affected by the establishment or modification of the Agreement an opportunity to submit written information to the Medical Executive Committee regarding the impact the establishment of the Agreement would have on the quality of patient care to be provided and/or why the Agreement is not necessary to establish the expected benefits.

(c) The Medical Executive Committee shall be given an opportunity to report its findings to the CEO before the Exclusive Agreement is entered into or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care and whether the Agreement is necessary to establish the expected benefits. The CEO is ultimately responsible for determining, in his/her discretion, whether to enter into the Agreement.

(d) In the event the Medical Executive Committee disagrees with the decision of the CEO to enter into an exclusive contract, the Medical Executive Committee may request a Joint Conference Committee as set forth in Section 13.6. The request must be made, if at all, within ten calendar days of notification by the CEO's decision.

3.9 **MEDICAL DIRECTORS**

3.9-1 **ROLE**

A medical director is a practitioner engaged by the hospital either full or part-time in an administrative capacity. Where provided for by contract, a medical director's responsibilities shall include assisting the Medical Staff and/or the Care Management Council to carry out peer review and quality improvement activities. Medical Directors shall serve as ex officio appointee with vote on all committees of the Medical Staff consistent with the scope of their responsibilities. Medical Directors must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1.

3.9-2 **CHIEF MEDICAL OFFICER**

The Chief Medical Officer, may be employed by the Hospital to perform duties determined by the Chief Executive Officer and as required by law. The Chief Medical Officer shall automatically be granted Active Staff membership without privileges. For the Chief Medical Officer to exercise privileges at the Facility, s/he must apply for membership and privileges in the manner described in these Bylaws. Although it is preferred, the Chief Medical Officer need not be a psychiatrist. The Chief Medical Officer need not remain in the active practice of medicine, and need not comply with the applicable requirements in Section 3.1. The Chief Medical Officer shall have Medical Staff leadership and peer review responsibilities as delegated by the Medical Executive Committee including, but not limited to, responsibility for reviewing care, conducting investigations, identifying trends and resolving issues, and serve as an ex-officio member on all Medical Staff Committees.

3.10 **CREDENTIALING PROCESS**

Applicants for appointment and reappointment will be processed in accordance with the Credentialing Procedures Manual.

ARTICLE FOUR: MEDICAL STAFF CATEGORIES/AFFILIATIONS

4.1 **CATEGORIES**

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories: active, associate, consulting, psychology, telemedicine and honorary.

4.2 **ACTIVE STAFF**

4.2-1 **QUALIFICATIONS FOR ACTIVE STAFF**

The Active Staff shall consist of physicians who have completed training deemed equivalent to that required by the American Board of Psychiatry and Neurology or the American Board of Addiction Medicine, and have maintained at least twenty-five (25) patient contacts per reappointment cycle.

Physicians must demonstrate a genuine concern, interest, and activity in the Hospital through substantial involvement in the affairs of the Medical Staff or Hospital and/or regularly admit patients to the Hospital. The involvement in the affairs of the Medical Staff or Hospital necessary to achieve and maintain active staff shall be established by the Medical Executive Committee.

4.2-2 **PREROGATIVES**

An Active Staff member may:
(a) Admit patients.
(b) Exercise such clinical privileges as are granted by the Board.
(c) Vote on all matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a member; and
(d) Hold office at any level in the staff organization and be chairman or a member of a committee provided the specific qualifications for the position involved are met and except as otherwise provided in these Bylaws or by resolution of the Medical Executive Committee.

4.2-3 **OBLIGATIONS**

An Active Staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:
(a) Contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff, and faithfully perform the duties of any office or position to which elected or appointed;
(b) Pay all staff dues and assessments.

4.2-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure of an Active Staff member to satisfy the qualifications or obligations of the active staff category for any reappointment cycle may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been removed from the Active Staff category may request reconsideration of the change by the Medical Executive Committee.

4.3 **ASSOCIATE STAFF**

4.3-1 **QUALIFICATIONS FOR ASSOCIATE STAFF**

The Associate Staff shall consist of physicians who have completed training deemed equivalent to that required by the American Board of Psychiatry and Neurology or the American Board of Addiction Medicine and who admit patients to the Hospital only on an occasional basis or are only occasionally involved in the affairs of the Medical Staff or Hospital.

4.3-2 **PREROGATIVES**

An Associate Staff member may:
(a) Admit patients, except as set forth in rules and regulations; privilege criteria and Hospital admission policies;
(b) Exercise such clinical privileges as are granted by the Board;
(c) Be appointed to hospital or medical staff committees, except the MEC as in (e) below, and serve as chairman, unless otherwise provided by these Bylaws;
(d) Demonstrate his/her continued clinical competency to provide care to patients treated at the Hospital by providing information regarding current experience, clinical results and utilization practice patterns at either the Hospital or other hospitals; and
(e) Vote on matters presented at committees to which he or she has been appointed unless otherwise limited by these Bylaws. Associate members may not vote on matters presented at general or special meetings of the Medical Staff, hold membership on the MEC, or hold office at any level of the staff organization.

4.3-3 **OBLIGATIONS**

An Associate Staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:
(a) Participate when requested in quality review program activities and in discharging such other functions as may be required;

(b) Satisfy the special appearance requirements of the Medical Staff; and
(c) Pay all staff dues and assessments.

4.3-4 **CHANGE IN STAFF CATEGORY**

Associate members will be advanced to the active staff category at the time of reappointment or sooner, upon request, and if the qualifications set forth in 4.2-1 are satisfied. Failure to utilize the Hospital during an entire reappointment cycle may result in a practitioner being dropped from the Medical Staff.

4.4 CONSULTING STAFF

4.4-1 **QUALIFICATIONS FOR CONSULTING STAFF**

The Consulting Staff shall consist of physicians (other than psychiatrists and physicians who practice addiction medicine) who consult or otherwise provide service to patients in the Hospital.

4.4-2 **PREROGATIVES**

A Consulting Staff member may:

(a) Exercise such clinical privileges, excluding the privilege to admit, as are granted by the Board;
(b) Be appointed to committees unless otherwise provided by these Bylaws; and
(c) Vote on matters presented at committees to which he or she has been appointed unless otherwise limited by these Bylaws. Consulting members with more than 25 patient contacts within a reappointment cycle may vote on matters presented at general or special meetings of the Medical Staff and hold office at any level of the staff organization except Chief of Staff.

4.4-3 **OBLIGATIONS**

A Consulting Staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

(a) Participate when requested in quality review program activities and in discharging such other functions as may be required;
(b) Satisfy the special appearance requirements of the Medical Staff; and
(c) Pay all staff dues and assessments.

4.4-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure of a Consulting Staff member to satisfy the qualifications or obligations of the Consulting Staff category for any reappointment period may result in a practitioner being dropped from the Medical Staff.

4.5 HONORARY STAFF

4.5-1 **QUALIFICATIONS FOR HONORARY STAFF**

Membership on the honorary staff is by invitation and is restricted to staff members for whom the Medical Executive Committee recommends and the Board approves this status in recognition of longstanding service to the Hospital or other noteworthy contributions to its activities.

4.5-2 **PREROGATIVES**

Honorary Staff members shall not be eligible to vote on matters presented to the staff nor to hold elected office; are not required to have malpractice insurance or a license to practice; and are not required to pay dues or assessments. Honorary Staff members may serve on committees and may vote on matters presented at committees of which they are members. Honorary Staff members are not allowed to admit or treat patients.

4.6 PSYCHOLOGY STAFF

4.6-1 QUALIFICATIONS FOR PSYCHOLOGY STAFF

The Psychology Staff shall consist of psychologists who:

(a) Are currently licensed by the State of Arizona Board of Psychologist Examiners at the practice level of psychology; and
(b) Meet at least one of the following:
    a. Possess a doctorate degree in psychology from an American Psychological Associate approved program, or
    b. Possess certification by the American Board of Professional Psychologists, or
    c. Be currently listed in the National Register of Health Services Providers of Psychology, or
    d. Meet the educational requirements as outlined in ARS 32-2071
(c) Documents a minimum of one (1) full year full-time experience (or its equivalent) in either:
    a. a psychiatric inpatient setting either pre- or post-doctoral. This requirement may be fulfilled as part of the above criteria, or
    b. a mental health care setting where experience included the assessment and treatment of patients with a level of pathology requiring inpatient treatment (e.g., community mental health center which evaluated patient for hospitalization or provided assessment and treatment whether pre- or post-hospitalization.)

4.6-2 PREROGATIVES

A Psychology Staff member may:

(a) Pursuant to a physician order, exercise such clinical privileges as have been granted by the Board;
(b) Be appointed to committees unless otherwise provided by these Bylaws; and
(c) Vote on matters presented at committees to which he or she has been appointed and serve as chairman. Psychology Staff members may not vote on matters presented at general or special meetings of the Medical Staff or hold office at any level of the staff organization.

4.6-3 OBLIGATIONS

A Psychology Staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

(a) Participate when requested in quality review program activities and in discharging such other functions as may be required;
(b) Satisfy the special appearance requirements of the Medical Staff; and
(c) Pay all staff dues and assessments.

4.7 RESIDENT STAFF

4.7-1 QUALIFICATIONS FOR RESIDENT STAFF

The Resident Staff shall consist of psychiatry residents who provide:

(a) a letter from Residency Program Director indicating (1) approval to engage in moonlighting activity and (2) current clinical competency to perform the privileges requested;
(b) evidence of a currently valid license issued by the State of Arizona to practice medicine, independent of his/her residency license;
(c) evidence of a DEA registration separate from the training program's DEA registration;
(d) evidence of professional liability insurance of a kind and in an amount satisfactory to the Banner Board;
(e) evidence of freedom from infectious tuberculosis per Banner policy;
(f) evidence of flu vaccination or an approved exemption per Banner policy; and
(g) evidence of current fingerprint clearance pursuant to ARS 36-425.03.

4.7-2 **PREROGATIVES**

A Resident Staff member may:

(a) exercise such clinical privileges as are granted by the Board; and
(b) attend meetings or serve on committees with no vote, if invited by the organized medical staff.

4.7-3 **OBLIGATIONS**

A Resident Staff member must:

(d) adhere to Medical Staff Bylaws, Rules and Regulations and Banner policies;
(e) adhere to any policies of his/her Psychiatry Residency Program regarding moonlighting and agree to fully follow its requirements;
(f) be responsible for reporting all hours worked at BBHH to the Residency Program Director;
(g) Successfully complete, prior to exercising privileges at the Hospital:
- Banner's electronic medical record/computerized physician order entry (CPOE) training; and
- Banner's electronic New Provider Orientation.

(h) satisfy any special appearance requirements imposed by the Medical Staff; and
(i) prior to practicing at Hospital, obtain a Banner Health photo identification badge. The resident is required to present legible Federal/State government issued photo identification (i.e. driver's license, passport, etc.) in order to receive the identification badge.

Resident Staff membership and clinical privileges automatically expire upon completion/termination of residency. To maintain privileges, practitioners must apply for medical staff membership and privileges.

4.8 TELEMEDICINE STAFF

4.8-1 **QUALIFICATIONS FOR TELEMEDICINE STAFF**

The telemedicine staff shall consist of physicians providing care, treatment and services of patients only via an electronic communication link. These physicians are subject to the credentialing and privileges process of the Hospital.

4.8-2 **PEROGITIVES**

A telemedicine staff member may:

a) Treat patients via electronic communication link, except as set forth in privilege criteria and Hospital policies.
b) Exercise such clinical privileges as are granted by the Board.
c) Be appointed to committees unless otherwise provided by these Bylaws.
d) Vote on matters presented at committees to which he or she has been appointed unless otherwise limited by these Bylaws or by department rules and regulations.

A telemedicine member may not vote on matters presented at general and special meetings of the Medical Staff or of the department of which he or she is a member; nor hold office at any level in the staff organization.

4.8-3 **OBLIGATIONS**

A Telemedicine Staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

a) Participate when requested in quality review program activities and in discharging such other functions as may be required;
b) Satisfy the special appearance requirements of the Medical Staff; and

c) Pay all staff dues and assessments.

4.8-4 **CHANGE IN STAFF CATEGORY**
Members of the Telemedicine Staff will be placed in other staff categories if they provide patient care services while physically located at the Medical Center and if the qualifications set forth in 4.2-1 are satisfied.

4.8-5 **AUTOMATIC EXPIRATION OF MEMBERSHIP AND PRIVILEGES**.
The membership and privileges of members of the Telemedicine Staff will automatically expire if their relationship terminates with the group with which Medical Center contracts, if their privileges terminate at their distant primary site. A physician who believes his or her telemedicine privileges were wrongly denied, terminated or limited may submit information to the Medical Executive Committee demonstrating why the denial, limitation or termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Executive Committee's decision.

4.8-6 **FAILURE TO SATISFY QUALIFICATIONS**
Failure of a telemedicine staff member to satisfy the qualifications or obligations of the telemedicine staff category for any reappointment period may result in a practitioner being dropped from the medical Staff.

4.9 **ADVANCED PRACTICE PROVIDERS**

a. The term, "Advanced Practice Provider" (APP) refers to APRNs and PAs, who provide direct patient care services in the Medical Center under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Banner Board and shall be credentialed through the same processes as a Medical Staff member and shall be granted clinical privileges as defined in State laws and in these Bylaws. They may provide patient care services only to the extent of the clinical privileges that have been granted.
b. Other categories of dependent healthcare professionals, known as Allied Health Professionals, who provide patient care services in support of, or under the direction of a Medical Staff member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Medical Staff as defined in the Allied Health Rules and Regulations.

4.9-1 **REQUIREMENTS FOR ADVANCED PRACTICE PROVIDERS**
APP providers shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision of a member of the Medical Staff. In addition to a complete application, as defined in these Bylaws, the supervising Physician will sign the agreement of supervision included on the APP provider's privilege form and/or reference form.

4.9-2 **PREROGATIVES OF ADVANCED PRACTICE PROVIDERS**
(a) Exercise such clinical privileges as are granted by the Banner Board.
(b) Perform such teaching activities as are authorized.
(c) Serve on committees to which they have been appointed.
(d) Vote on all matters presented at department and committees of which he or she is a member.

4.9-3 **OBLIGATIONS OF ADVANCED PRACTICE PROVIDERS**

Each APP provider shall discharge the basic obligations as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Medical Center, as applicable to his/her activities in association with the Medical Center.

4.9-4 **ADVERSE ACTION AND APPELLATE PROCESS**

a. **INITIATION OF ADVERSE ACTION REVIEW AND APPEAL PROCESS**
APPs subject to Adverse Action (other than Non-reviewable Actions defined in Section 6.8 of the Medical Staff Bylaws) shall be afforded an Adverse Action Review and appeal process in accordance with this policy. Adverse Action includes: denial of a request to provide any patient care services within the applicable scope of practice or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable scope of practice. APPs are not entitled to due process rights set forth in the Medical Staff Bylaws and Fair Hearing Plan, and none of the procedural rules set forth therein shall apply.

b. **NOTICE OF ADVERSE RECOMMENDATION OR ACTION**
Within fifteen (15) days after Adverse Action is taken against an APP, the APP shall be notified in writing of the specific reasons for the Adverse Action and the APPs rights per this policy.

c. **REQUEST FOR REVIEW OF ADVERSE RECOMMENDATION OR ACTION**
The APP may request an Adverse Action Review following the procedure set forth in this policy. If the APP does not deliver a written request for an Adverse Action Review to the Chief of Staff within ten (10) days following the date of the written notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

d. **COMPOSITION OF THE REVIEW COMMITTEE**
The Chief of Staff will appoint up to three (3) members of the Medical Staff and if applicable, the Chief Nursing Officer to serve as the Review Committee.

e. **NOTICE OF TIME AND PLACE FOR REVIEW**
The APP shall be notified ten (10) days prior via written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any that will be called to support the Adverse Action.

f. **STATEMENTS IN SUPPORT**
A Representative acting on behalf of the Medical Staff (Medical Staff Representative) as appointed by the Chief of Staff, and the APP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Chief of Staff at least five (5) days prior to the review.

g. **RIGHTS OF PARTIES**
During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. None of the APP, the Hospital or the Medical Staff Representative shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

h. **BURDEN OF PROOF**
The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the APP has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

i. **ACTION ON COMMITTEE REVIEW**
Upon completion of the review, the Review Committee shall consider the information and evidence presented and make a recommendation, which shall include the basis

therefore, and forward it to the Chief of Staff. The APP and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

j. **DUTY TO NOTIFY OF NONCOMPLIANCE**
If the APP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the APP must promptly notify the Chief of Staff of such deviation, including this policy or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

k. **REQUEST FOR APPELLATE REVIEW**
If the APP is dissatisfied with the Committee's recommendation, such party may submit a written request for an Appellate Review, provided that the Chief of Staff receives such request within ten (10) days following the APP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with the identified process or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable.

l. **INTERVIEW WITH MEDICAL EXECUTIVE COMMITTEE**
Upon a proper and timely request for an Appellate Review, the APP shall be given an interview with the MEC. The APP shall be given at least five (5) days prior written notice of the time, place and date of the Appellate Review. At the appeal, the parties shall be allowed to present written and/or oral arguments as to why the Committee's recommendation should be reversed or modified.

m. **FINAL DETERMINATION BY THE MEDICAL EXECUTIVE COMMITTEE**
The MEC shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the MEC shall not be subject to further appeal. The final decision will be submitted to the Banner Health Board of Directors.

n. **CONFIDENTIALITY**
The Medical Staff will strive to maintain the confidentiality of all matters reviewed to the extent appropriate under the circumstances and as permitted by law.

4.9-5 **AUTOMATIC SUSPENSION OR LIMITATION**
Automatic suspension shall be immediately imposed under the conditions contained in section 6.7 of the Medical Staff Bylaws.

4.9-6 **NON-REVIEWABLE ACTIONS**
Not every action entitles the APP to rights pursuant to Article 4. Non-Reviewable actions are defined in Section 6.8 of the Medical Staff Bylaws.

Where an action that is not reviewable (automatic or non-reviewable action) has been taken against an APP, the affected APP may request that the action be reviewed and may submit information demonstrating why the action is unwarranted. The MEC, in its sole discretion, shall decide whether to review the submission and whether to take or recommend any action. The affected APP shall have no appeal or other rights in connection with the MEC's decision.

ARTICLE FIVE: DELINEATION OF PRACTICE PRIVILEGES

5.1 PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES

Completed applications for membership and privileges are submitted at the time of initial appointment to the Medical Executive Committee and are subject to final approval by the Board. Completed applications for reappointment are submitted to the Medical Executive Committee and are subject to final approval by the Board. The process for appointment and reappointment to the Medical Staff is set forth in further detail in further detail in the Credentialing Procedures Manual.

5.2 PROCESS FOR CREDENTIALING AND PRIVILEGING ALLIED HEALTH PROFESSIONALS

Completed applications for allied health membership for initial appointment and privileges are submitted to the Medical Executive Committee for review and action prior to submission to the Board. Completed applications for reappointment are submitted to the Medical Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Allied Health Rules and Regulations.

5.3 PROCESS FOR "DISTANT SITE" CREDENTIALING OF TELEMEDICINE PROVIDERS

Where the Medical Center ("Originating Site") has a contract with a Joint Commission accredited facility ("Distant Site") approved by the Medical Executive Committee, the Medical Center will accept the credentialing and privileging decision of the Distant Site for applicants who provide telemedicine services and are credentialed at the Distant Site. Privileges at the Originating Site shall be identical to those granted at the Distant Site, except for services which the Medical Center does not perform. Privileges shall be granted and renewed for the same period as have been granted by the Distant Site. Board approval of privileges at the Distant Site qualifies as Board approval at the Medical Center.

5.3 PROFESSIONAL PRACTICE EVALUATION

The Medical Staff conducts Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with Joint Commission requirements and Banner policy.

5.4 FOCUSED PROFESSIONAL PERFORMANCE EVALUATION (FPPE)

All clinical privileges are granted under a period of Focused Professional Performance Evaluation (FPPE) to assure and assess the practitioner's ability and competency to perform the privileges granted by the Board. The FPPE requirements are established by the Medical Staff Executive Committee. Results of FPPE are reviewed and acted on by the Chair of the Peer Review Sub-Committee or designee in accordance with the Banner System FPPE Policy and the Medical Staff Rules and Regulations.

5.4-1 A retrospective review of the practitioner's clinical activity will be performed at Banner Behavioral Health Hospital must be completed.

(a) Three months after a practitioner's initial appointment or initial granting of privileges, the Medical Staff Office will obtain a list of the practitioner's activity and quality outcome data in the hospital. An evaluation form will be generated for three (3) randomly selected cases which will be reviewed and/or assigned for review by the Peer Review Chair as needed. Results of the review will be reported to the Medical Executive Committee for review and action.

(b) The reviewer's report is confidential and for use of the Medical Executive Committee only. The report, however, may be released to other hospitals if requested in writing, by the reviewed physician for privileges at other hospitals.

(c) Active staff members of the Medical Staff are eligible to serve as reviewers for the retrospective review process.
(d) The reviewer shall give a candid opinion on the report to the Medical Executive Committee. The reviewer shall immediately notify the Peer Review Chair or Chief of Staff should any questions arise concerning a provider's competency or management of a particular case.
(e) Following review of the completed review forms, additional cases may be required if deemed necessary by the Medical Executive Committee Chairman.
(f) For those practitioners with minimal activity during the initial FPPE period (practitioners who only provide occasional coverage at the hospital or BPC) during the initial period 100% of his/her cases may be reviewed and/or peer references attesting to the provider's competency, at the time of reappointment, may be accepted as FPPE.

5.5 EXERCISE OF PRIVILEGES

5.5.1 IN GENERAL

(a) For new applicants, the following must be successfully completed, as applicable, prior to exercising privileges at the Hospital:
- Banner's electronic medical record/computerized physician order entry (CPOE) training; and
- Banner's electronic New Provider Orientation.

Exceptions may be made for practitioners granted temporary or disaster privileges.
(b) Except in an emergency, a practitioner providing clinical services at the Hospital may exercise only those clinical privileges specifically granted.

5.5.2 PRIVILEGES IN EMERGENCY SITUATIONS

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to the degree permitted by the practitioner's license, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of staff category or privileges. A practitioner providing such emergency services outside the scope of granted privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

5.5-3 TELEMEDICINE PRIVILEGES

5.5-3.1 The Medical Executive Committee shall continually evaluate the performance of the telemedicine services by practitioners at reappointment, renewal, or revision of clinical privileges. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine services may also be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand.

5.5-3.2 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of BBHH.

5.6 PROCEDURE FOR DELINEATING PRIVILEGES

5.6.1 REQUESTS

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. Specific requests must also be submitted for modifications of privileges in the interim between reappointment periods.

All requests for clinical privileges will be processed in accordance with the procedures set forth in the Credentialing Procedures Manual and according to relevant privilege criteria.

Requests for Additional Privileges - When requesting additional privileges, the practitioner shall submit the request in writing and submit any documentation as required by privilege criteria. Medical Staff Services shall query the NPDB and AZ licensure, verify current competency and provide all relevant documents to the Medical Executive Committee for review. If the practitioner satisfies all requirements for the additional privilege(s), recommendation for granting the privilege(s) shall be forwarded to the Board.

5.6.2 **SUPERVISION**

Whenever a practitioner is required by the Medical Staff to be supervised, the practitioner must arrange for the number and types of cases to be reviewed or observed as required by the Medical Executive Committee. Supervision must be completed within one year of date privilege is granted. Otherwise, supervised privileges will be voluntarily withdrawn. Request for extension to supervision time frame may be submitted in writing prior to expiration of the supervision period for consideration by the Medical Executive Committee and must include reason for request.

5.6.3 **ADVANCEMENT FROM SUPERVISION**

Whenever a practitioner completes supervisory requirements, the supervisory reports and other required documentation will be submitted to the Medical Executive Committee for review. Where the practitioner has successfully completed the requirements, the Medical Executive Committee may recommend unsupervised privileges to the Board.

5.7 **BASIS FOR PRIVILEGE DETERMINATIONS**

Clinical privileges shall be granted in accordance with education and training, experience, utilization practice patterns, current health status, and demonstrated current competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Additional factors that may be used in determining privileges include those qualifications set forth in Section 3.1. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determination(s). In reappointment determinations, results of quality and performance improvement and utilization review, peer review, supervised cases (if applicable), and where appropriate, practice at other hospitals will also be considered. In review of requests for changes in privileges, evidence of appropriate training and experience and current clinical competence must be documented.

5.8 **PRIVILEGE DECISION NOTIFICATION**

The decision to grant, limit or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within three (3) weeks of the Board's action. In case of privilege denial, the applicant is informed of the reason for denial. The decision to grant, deny, revise or revoke privilege(s) is disseminated and made available to all appropriate internal and/or external persons or entities.

5.9 **HISTORIES AND PHYSICALS**

A history and physical examination ("H&P") in all cases shall be completed by a physician or Allied Health Professional who is approved by the medical staff to perform admission H&Ps within 24 hours after admission. The completed H&P must be on the medical record prior to any procedure in which anesthesia or conscious sedation will be administered or the case will be cancelled unless the responsible practitioner documents in writing that such delay would constitute a hazard to the patient. A legible H&P performed within 30 days prior to admission is

acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The content of complete H&P is delineated in the Rules and Regulations.

5.10 **DEVELOPMENT OF NEW PRIVILEGE CRITERIA**

Prior to developing new criteria for privileges not previously established, the Medical Staff will work with hospital staff to determine whether sufficient space, equipment, staffing, and financial resources will be in place or available to support the new privilege.

5.11 **TEMPORARY PRIVILEGES**

5.11-1 **CONDITIONS**

Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has satisfied the professional liability insurance requirement of these Bylaws. Special requirements of supervision and reporting may be imposed by the Chief of Staff. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws and the policies of the Medical Staff and Hospital.

5.11-2 **CIRCUMSTANCES**

Upon the recommendation of the Chief of Staff, the CEO or designee may grant temporary privileges in the following circumstances:

(a) Pendency of Application: Temporary privileges may be granted to an applicant who has submitted a complete application that has been verified and raises no concerns, has been approved by the Chief of Staff and another physician member of the MEC and is awaiting review and approval of the MEC and the Board.

Temporary privileges may be granted to an applicant for an initial period not to exceed 60 calendar days upon completion of CPOE/EMR training and new physician orientation. One extension may be granted for an additional period not to exceed 60 calendar days. Any such renewal shall be made by the CEO when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges.

Under no circumstances may such privileges be granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Specific Patient Care Need:

1. One Time Request:

Temporary privileges may be granted to a practitioner for the care of a specific patient but only after receipt of a request for the specific privileges desired and confirmation of appropriate licensure, adequate professional liability insurance coverage, current DEA registration (if applicable) and favorable results of the National Practitioner Data Bank query. Such temporary privileges will be granted for the duration of the specific patient's admission and may not exceed 60 calendar days. Such temporary privileges may not be granted in more than two (2) instances in any 12 month period after which the practitioner must apply for staff appointment, and are restricted to the care of specific patients for which they are granted.

2. Coverage of Service:
Where a service is not adequately covered to meet patient care needs, temporary privileges may be granted upon receipt of application, signed criminal background check release and verification of the following information: appropriate licensure, certification (if applicable) adequate professional liability insurance, DEA registration (if applicable), current clinical competency, education and training, and NPDB query response. Privilege criteria for the requested privilege(s) must be met. Temporary privileges granted under these circumstances constitute the exception rather than the norm, and cannot be utilized for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 90 calendar days upon completion of CPOE/EMR training and new provider orientation. One extension may be granted for an additional period not to exceed 90 calendar days.

5.11-3 **ADDITIONAL PROCEDURES**

Temporary privileges to obtain additional specific procedures approved to be performed at BBHH may be granted, but only after the member has applied for the privileges and has provided documentation of appropriate training and recent experience as required by approved criteria.

5.11-4 **TERMINATION**

The CEO, CMO or Chief of Staff may terminate any or all of a practitioner's temporary privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

5.11-5 **RIGHTS OF THE PRACTITIONER**

A practitioner is not entitled to the procedural rights afforded by these Bylaws because a request for temporary privileges is refused in whole or in part or because all or any portion of the temporary privileges are terminated, not renewed, restricted, suspended, or limited in any way.

5.12 **DISASTER PRIVILEGES**

5.12-1 **GRANTING TEMPORARY DISASTER PRIVILEGES**

In the event of an officially declared emergency or disaster, any physician, nurse practitioner, or physician assistant may be granted temporary disaster privileges upon recommendation of the CEO, Chief Medical Officer, Chief of Staff or incident commander handling the disaster or their respective designee provided that the care, treatment, and services provided are within the scope of the individual’s license.

Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group.

- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.
- Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.
- Where the practitioner is not a member of an Arizona hospital's Medical Staff, a current Hospital employee or Medical Staff member must recommend the granting of such privileges.

Such privileges expire within thirty (30) calendar days or upon the termination of the disaster or upon completion of inpatient care, whichever occurs first, and may be terminated in accordance with Section 5.9-4. A practitioner is not entitled the procedural rights afforded by these Bylaws because a request for disaster privileges is refused or because such privileges are terminated or otherwise limited.

5.12-2 **PRIMARY SOURCE VERIFICATION**

Primary source verification of licensure will begin as soon as the immediate situation is under control, and must be completed within 72 hours (or as soon as possible) from the time the volunteer begins working at the hospital. If not verified within 72 hours, the reason must be documented.

5.12-3 **OVERSIGHT**

Oversight of the professional performance of volunteer practitioners who receive disaster privileges (e.g. direct observation, mentoring, clinical record review) will be the responsibility of the Chief of Staff or designee.

5.1-4 **CONTINUATION OR RENEWAL OF PRIVILEGES**

The CEO or designee will decide within 72 hours whether continuation or renewal of the disaster privileges is indicated. This decision is based upon information regarding the professional practice of the volunteer. The CEO, CMO or Chief of Staff may terminate any or all of a practitioner's disaster privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner.

5.12-5 **IDENTIFICATION**

Volunteer practitioners functioning under disaster privileges will be identified as such by wearing an identification badge provided upon the granting of privileges.

ARTICLE 6: INVESTIGATIONS AND CORRECTIVE ACTION

6.1 **CRITERIA FOR INITIATING INVESTIGATIONS AND/OR CORRECTIVE ACTION**

An investigation or corrective action may be initiated against a practitioner if it appears that the practitioner does not meet the standards required by these Bylaws or any applicable Medical Staff policies, or if the practitioner is or may be engaged in a course of conduct, either within or outside the Hospital, that is detrimental to patient care or lower than the standards or aims of the Medical Staff.

6.2 **PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION**

(a) A request for an investigation and/or corrective action may be submitted to the Chief of Staff by any member of the Medical Staff, the CEO, or the Board. The request must be in writing

and must be supported by reference to the specific activities or conduct forming the basis for the request.

(b) Within 60 calendar days of the Chief of Staff's receipt of a request for corrective action, an ad-hoc committee of the Medical Executive Committee appointed by the Chief of Staff shall consider the request and determine if an investigation is warranted. The ad-hoc committee may use one or more "evaluation tools" described below to determine if an investigation is warranted or, where an investigation is found to be warranted, to determine whether corrective action is necessary. Evaluation tools include but are not limited to an interview with the practitioner, concurrent or retrospective chart review, concurrent observation, consultation requirements, or other means of evaluating a practitioner's competency or performance. A practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension pursuant to Section 6.6-10 of these Bylaws. The practitioner has the right to an interview if he/she believes the ad-hoc committee should reconsider the use of any such evaluation tool. However, the practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such tools. The Medical Executive Committee will be kept informed of the status of such investigations.

(c) Certain matters that may lead to corrective action are routinely considered by the Medical Executive Committee as a part of ongoing quality and performance improvement, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the Medical Executive Committee, the Medical Executive Committee shall conduct a review as set forth herein, and no request for an investigation and/or corrective action is required.

6.3 PROCEDURE FOR PROFESSIONAL REVIEW

(a) Within 60 calendar days of the determination by the ad-hoc committee that an investigation or corrective action may be warranted, the ad-hoc committee shall conclude an investigation and document its findings. If the findings warrant that corrective action be taken, the affected practitioner shall have an opportunity for an interview with the ad-hoc committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. A record of such interview shall be made by the ad-hoc committee and included with its report. In certain instances, the ad-hoc committee investigation may not be concluded within 60 calendar days. In such instances, the investigation shall be concluded as soon as reasonably practicable. The affected practitioner shall have no procedural rights arising out of such delay. After its deliberations, the ad-hoc committee will make its recommendation, and if adverse, shall forward it to the Medical Executive Committee.

(b) If the ad-hoc committee recommends that corrective action be taken, the Medical Executive Committee shall review the recommendation to determine whether it is supported by substantial evidence and whether the Bylaws were followed. If the Medical Executive Committee recommends corrective action that is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws.

6.4 SUMMARY SUPERVISION

6.4-1 INITIATION

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with or following the initiation of professional review activities and until such time as a final determination is made regarding his or her privileges. Any two of the following individuals in concert shall have the right to impose supervision:

(a) Chief of Staff or designee, acting as a member of and on behalf of the Medical Executive Committee;

(b) Chief Medical Officer;

(c) Chief Executive Officer or designee;
(d) Chairman of the Banner Board of Directors

6.4-2 **REVIEW BY THE MEDICAL EXECUTIVE COMMITTEE**

A practitioner whose clinical privileges have been placed under summary supervision by any two individuals identified in Section 6.4-1 shall be entitled to request a review of the summary supervision by the Medical Executive Committee or subcommittee thereof, having no less than three (3) members. The review must be requested, if at all, within 10 business days of the practitioner's receipt of notice of the supervision. Such review shall take place within 10 business days of the request for review. Upon deliberation, the Medical Executive Committee or subcommittee thereof may direct that summary supervision be terminated or continued.

6.5 **SUMMARY SUSPENSION**

6.5-1 **INITIATION**

Whenever immediate action must be taken in the best interest of patient care in the Hospital or to prevent imminent danger to the health of any individual, any two of the following individuals shall have the right to summarily suspend membership and all or any portion of the clinical privileges of a practitioner:

(a) Chief of Staff or designee, acting as a member of and on behalf of the Medical Executive Committee;
(b) Chief Medical Officer;
(c) Chief Executive Officer or designee;
(d) Chairman of the Banner Board of Directors

A summary suspension is effective immediately upon imposition and until such time as a final decision is made regarding the practitioner's privileges. Summary suspension shall be followed promptly by special notice to the affected practitioner.

6.5-2 **REVIEW BY THE MEDICAL EXECUTIVE COMMITTEE**

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Medical Executive Committee or a subcommittee thereof having no less than three (3) members who shall be appointed by the Chief of Staff. The review must be requested within 10 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 10 business days of the request for review. Upon deliberation, the Medical Executive Committee or subcommittee thereof may direct that summary suspension be terminated or continued.

6.5-3 **EXPEDITED HEARING RIGHTS**

In the event summary suspension is continued, special notice of the decision shall be sent to the affected practitioner who may request a hearing pursuant to the Fair Hearing Plan.

6.5-4 **ALTERNATIVE COVERAGE**

Immediately upon imposition of summary suspension, the Chief of Staff, Chief Medical Officer, CEO, or their respective designees shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the Hospital. Patients' wishes shall be considered in the selection of an alternative practitioner.

6.6 AUTOMATIC SUSPENSION OR LIMITATION

When grounds exist for automatic suspension, the privileges of the practitioner will be automatically suspended without prior action by the Medical Executive Committee or the Board. Alternative medical coverage will be provided for patients as set forth in Section 6.5-4. The Chief of Staff will notify the practitioner of the suspension. In addition, further corrective action may be recommended in accordance with the provisions contained within these Bylaws whenever any of the following actions occur:

6.6-1 LICENSE

(a) Revocation: Whenever a practitioner's license to practice in this State is revoked, Medical Staff appointment and clinical privileges are immediately and automatically revoked.

(b) Restriction: Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that are within the scope of the limitation or restriction are similarly immediately and automatically restricted.

(c) Suspension: Whenever a practitioner's license is suspended, Medical Staff appointment and clinical privileges are automatically suspended for the term of the licensure suspension.

(d) Probation: Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.

(e) Expiration: Whenever a practitioner's license becomes expired.

6.6-2 CONTROLLED SUBSTANCE REGISTRATION

Whenever a practitioner's DEA or other controlled substance registration is revoked, restricted, suspended, or has expired**,** the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

6.6-3 MEDICAL RECORDS

A temporary suspension of privileges to admit patients or to schedule new procedures shall be imposed for failure to complete medical records within the time periods established by the Medical Executive Committee and designated in the Medical Staff Rules and Regulations. Such suspension shall not apply to patients admitted or already scheduled at the time of the suspension. Physicians will not be scheduled for shifts if suspended. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension shall become automatic permanent suspension for failure to complete delinquent records within 60 cumulative days within any consecutive 12 month period. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if the delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.6-4 PROFESSIONAL LIABILITY INSURANCE

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under Section 3.1-13 of these Bylaws. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.6-5 **FREEDOM FROM INFECTIOUS TUBERCULOSIS**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious tuberculosis whenever such evidence is requested. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension upon presentation of evidence of freedom from TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.6-6 **EXCLUSION FROM MEDICARE/STATE PROGRAMS**

The CEO with notice to the Chief of Staff will immediately and automatically suspend the Medical Staff privileges of an Excluded Practitioner. An "Excluded Practitioner" is a practitioner whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or Tricare (formerly CHAMPUS) program. The CEO may restore limited privileges to an Excluded Practitioner upon his/her signing an agreement whereby he/she agrees (a) not to provide items or services to patients enrolled in Medicare/State Programs and (b) to indemnify the hospital and the Medical Staff for any liability they might have solely incurred as a result of a breach of this agreement as set forth in the Board's Excluded Staff Practitioners Policy.

6.6-7 **FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT**

A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, in accordance with Section 10.3-3, shall automatically be suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Failure to appear within 90 calendar days of the request to appear shall result in revocation of staff membership and privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.6-8 **FAILURE TO PAY STAFF DUES**

A practitioner who fails to pay staff dues as set forth in Section 12.2 shall automatically be suspended from the Medical Staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-9 **FAILURE TO EXECUTE RELEASES AND/OR PROVIDE DOCUMENTS**

A practitioner who fails to execute a general or specific release and/or provide documents, including but not limited to assessment reports, stipulation agreements, correspondence to/from regulatory boards or other facilities when requested by the Chief of Staff or designee or a medical staff committee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-10 **FAILURE TO PARTICIPATE IN AN EVALUATION**

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges shall automatically be suspended. If, within 30 calendar days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated.

Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-11 **FAILURE TO COMPLETE ASSESSMENTS AND PROVIDE RESULTS**
A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings without good cause, shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-12 **FAILURE TO BECOME/REMAIN BOARD CERTIFIED**
Whenever a practitioner's time period in which to become/remain board certified expires, the practitioner is deemed to have immediately and voluntarily relinquished his/her Medical Staff appointment and clinical privileges.

6.6-13 **FAILURE TO MAINTAIN FINGERPRINT CLEARANCE**
A practitioner who fails to maintain current fingerprint clearance pursuant to ARS 36-425.03 shall automatically be suspended. If a copy of the Application for Fingerprint Clearance Card and Criminal History Affidavit, if applicable, are provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-14 **FAILURE TO OBTAIN INFLUENZA VACCINATION**
A practitioner who fails to provide evidence of annual influenza vaccination or, if granted an exemption, to wear a protective mask as required by Banner policy shall automatically be suspended. Privileges shall be reinstated when evidence of vaccination is provided or when flu season is deemed to have ended.

6.6-15 **MISREPRESENTATION**
If it is discovered that an individual willfully misrepresented or omitted answers to questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, and the misrepresentation or omission is an intentional material or substantive misrepresentation, as determined by the Medical Executive Committee, the individual's membership and clinical privileges shall be automatically terminated.

6.6-16 **AUTOMATIC LIMITATIONS**
When a practitioner's privileges are restricted or terminated at any Banner facility, such practitioner's privileges will be automatically restricted or terminated, as the case may be, at the Medical Center. When a practitioner has been asked to refrain from exercising all or a portion of privileges at any Banner facility, the practitioner shall be required to refrain from exercising such restricted privileges at the Medical Center. The practitioner has no due process rights arising out of restrictions taken at the Medical Center because of restrictions taken at another Banner facility, including a request to refrain. If the practitioner is reinstated at the Banner facility that restricted or terminated such practitioner's privileges or from which such practitioner refrained, such practitioner's privileges remain restricted or terminated at the Medical Center until Medical Center lifts the restriction. If the Medical Center decides not to reinstate the practitioner's privileges, the practitioner is entitled to due process rights as outlined in these Bylaws.

6.7 HEARING AND APPEAL RIGHTS

6.7-1 HEARINGS AND APPEALS

The hearing will be conducted in accordance with Fair Hearing Plan. The appeal will be conducted in accordance with the Board's Appellate Review Policy.

6.7-2 FAIR HEARING PLAN

When hearing rights are triggered, the practitioner is notified of the grounds for the adverse action or recommendation and his/her right to request a hearing by submitting a written request to the CEO within calendar 30 days.

6.7-3 HEARING PANEL

When a hearing is requested, the hearing will be conducted by a committee composed of at least three members. No person in direct economic competition with the practitioner or who has participated in the adverse recommendation shall participate. Members of the hearing committee shall be physicians and may, but need not, be members of the medical staff.

6.7-4 SCHEDULING THE HEARING

Except when the practitioner has the right to request an expedited hearing and has requested such a hearing, the CEO shall send the practitioner notice of the date, time, and place of the hearing at least 30 calendar days prior to the hearing. Efforts will be made to schedule the meeting to commence not less than 30 calendar days nor more than 90 calendar days after the CEO sends special notice to the practitioner. Upon receipt of a written request by a practitioner for an expedited hearing, the hearing must be held as soon as the arrangements may reasonably be made. The above stated time periods may be modified upon the mutual agreement of the practitioner and the Chief of Staff.

6.7-5 HEARING PROCESS

The Medical Executive Committee has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the practitioner has the right to submit evidence and testimony to challenge the adverse recommendation or action provided that the procedures set forth in the Fair Hearing Plan have been followed.

6.7-6 SCHEDULING THE APPEAL

Upon receipt of a timely and proper request for appellate review, as defined in the Appellate Review policy the General Counsel of Banner shall schedule the appellate review as soon as practicable. The General Counsel will attempt to schedule the review at a date and time acceptable to the practitioner, representatives of the Medical Staff and members of the Appeals Subcommittee.

6.7-7 APPEAL PROCESS

The practitioner has the burden of demonstrating, by preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, or applicable law, and created demonstrable prejudice; or the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record. Thereafter, the Medical Executive Committee may present evidence in support of the reconsidered recommendation or action.

6.8 **NONREVIEWABLE ACTION**

Not every action entitles the practitioner to rights pursuant to the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension as set forth in Section 6.6 are not reviewable under the Fair Hearing Plan. In addition, the following occurrences are also nonreviewable under the Fair Hearing Plan:

(a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(b) Issuance of a warning or a letter of admonition or reprimand.
(c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
(d) Termination or limitation of temporary privileges or disaster privileges.
(e) Supervision and other requirements imposed as a condition of granting privileges.
(f) Termination of any contract with or employment by the Hospital.
(g) Any recommendation voluntarily imposed or accepted by a practitioner.
(h) Denial of membership and privileges for failure to complete an application for membership or privileges.
(i) Removal of membership and privileges for failure to complete supervision within the time period granted by these Bylaws.
(j) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
(k) Reduction or change in staff category.
(l) Refusal of the Medical Executive Committee to consider a request for appointment, reappointment, staff category, or privileges within one year of a final adverse decision regarding such request.
(m) Removal or limitation of call obligations.
(n) Any requirement to complete an educational assessment or training program.
(o) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(p) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
(q) Retrospective chart review.
(r) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the CEO to enter into, terminate or modify an exclusive contract for certain clinical services; or (2) the termination or modification of the practitioner's relationship with the exclusive provider.
(s) Grant of conditional appointment/reappointment or appointment/reappointment for a limited duration.
(t) Failure to maintain Board Certification as specified by these Bylaws.

6.9 **REPORTING REQUIREMENT**

The Medical Center shall comply with any applicable reporting requirements. In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual's privileges for more than thirty (30) days.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 **GENERAL OFFICERS OF THE MEDICAL STAFF**

7.1-1 **IDENTIFICATION**

The general officers of the staff are:

(a) Chief of Staff

(b) Vice Chief of Staff
(c) Immediate Past Chief of Staff (ex officio)
(d) Secretary/Treasurer

7.1-2 **QUALIFICATIONS**

(a) Each general officer must:
   a. Be a member of the active staff at the time of nomination and election and remain a member in good standing during his or her term of office.
   b. Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
   c. Have demonstrated a high degree of interest in and support of the Medical Staff and the Hospital.
   d. Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general officers of the Medical Staff, the CEO, and the Board.
   e. Not have a disabling conflict of interest with the Medical Staff or Hospital as determined by the Medical Executive Committee.

(b) Candidates for the Chief of Staff and Vice Chief of Staff must meet the qualifications for general officers, meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry. A practitioner may not hold simultaneously two or more general staff offices.

7.2 **TERM OF OFFICE**

The term of office of general staff officers is two years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office.

7.3 **ELIGIBILITY FOR RE-ELECTION**

A general staff officer is eligible for nomination and reelection in succeeding terms.

7.4 **NOMINATIONS**

7.4-1 **NOMINATING COMMITTEE**

(a) The General Officers of the Staff shall serve as the nominating committee. During the final year of the General Officers' term of office, the Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each office. Nominees must disclose interests that potentially compete with the interests of the Medical Staff and/or the Hospital, including ownership and financial interests in competing facilities or employment or contractual relationships with the Hospital or with competing facilities. At the September meeting of the Medical Executive Committee, the Nominating Committee shall present for information the list of nominations to the Medical Executive Committee and the CEO. The Secretary shall give written notice of the nominations to all active staff members of the Medical Staff.

(b) Nominations may also be made in writing before the September Medical Executive Committee meeting by any voting member of the Medical Staff if evidence is presented that the potential nominee meets the qualifications for office and consents to the nomination. Such nominees must also disclose potential conflicts of interest.

7.5 **ELECTIONS, VACANCIES, AND REMOVALS**

7.5-1 **ELECTION PROCESS**

The Medical Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.
(a) If there is a solo candidate on the slate of nominations, that candidate will be deemed approved; a formal written ballot will not be sent.
(b) If there is more than one candidate on the slate of nominations, the ballots will be sent electronically within 14 days after September's MEC meeting.
(c) The candidate receiving the highest number of votes via electronic and/or mail ballot vote of members of the Active Staff is elected. In the case of a tie, a majority vote of the Medical Executive Committee shall decide the election.

7.5-2 VACANCIES IN ELECTED OFFICES

In the event of a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve for the remainder of the unexpired term. A vacancy in any other general staff office shall be filled by appointment by the Chief of Staff with the approval of the Medical Executive Committee.

7.5-3 RESIGNATIONS AND REMOVAL FROM OFFICE

(a) Resignations: any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified in the notice.
(b) Removals: removal from office may be initiated only by the Medical Executive Committee or by petition signed by at least one-third of the active staff members, for failure to maintain qualifications of the office as outlined in Bylaws Section 7.1-2 and/or uphold the duties of the office as outlined in Bylaws Section 7.6 or for any other reason. Such removal shall be considered at a special meeting of the Medical Staff as provided in Section 10.1-2, for the purpose of considering and acting upon the request for removal. Removal shall require a two-thirds vote of the voting members present at the special meeting and shall be effective immediately upon tabulation of the vote by the Secretary or his/her designee.

7.6 DUTIES OF OFFICERS

7.6-1 CHIEF OF STAFF

The chief of staff is ultimately responsible for the medical and psychiatric care provided to patients in the Hospital. S/he shall be responsible for the quality and appropriateness of inpatient and outpatient psychiatric services and treatment provided by the Medical Staff and for ensuring that such services and treatment are in accordance with acceptable standards of practice.

The chief of staff shall serve as the highest elected officer of the Medical Staff to:
(a) enforce the Bylaws and implement sanctions where indicated;
(b) call, preside at, and be responsible for the agenda of all general staff meetings, meetings of the Medical Executive Committee;
(c) serve as an ex officio member of all other staff committees without vote. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;
(d) appoint, with the consultation of the Medical Executive Committee, members for all standing and special Medical Staff or multidisciplinary committees, and designate the chairman of these committees;
(e) interact with the CEO and Chief Medical Officer in all matters of mutual concern within the Hospital;
(f) represent the views and policies of the Medical Staff to the CEO;
(g) be a spokesman for the Medical Staff in external professional affairs;

(h) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Medical Executive Committee;
(i) receive and act upon requests of the Board to the Medical Staff; and
(j) report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated functions to promote quality patient care;
(k) serve on the Banner Peer Review Council;
(l) meet and discuss with the Board Medical Staff Subcommittee any matters of concern to the Medical Staff.

7.6-2 **VICE CHIEF OF STAFF**

The vice chief of staff shall assume all duties and authority of the Chief of Staff in his or her absence if the Vice Chief of Staff meets the qualifications to assume the position of Chief of Staff. If s/he does not meet the qualifications for Chief of Staff, the Secretary/Treasurer will assume the position if qualified. If neither the Vice Chief of Staff nor the Secretary/Treasurer is eligible, the Member-at-Large would assume the position. The vice chief of staff shall be a member of the Medical Executive Committee, shall provide review of all applications and re-applications to the Medical Staff and present these to the MEC for recommendation to the Board, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

7.6-3 **IMMEDIATE PAST CHIEF OF STAFF**

The immediate past chief of staff shall be an ex officio member of the Medical Executive Committee and shall perform such duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee.

7.6-4 **SECRETARY/TREASURER**

The secretary/treasurer shall be a member of the Medical Executive Committee. As secretary, he/she shall assure that accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings are maintained. As treasurer, he/she shall safeguard all funds of the Medical Staff. The secretary/treasurer shall perform all such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Medical Executive Committee.

ARTICLE EIGHT: COMMITTEES

8.1 **DESIGNATION**

The committees described in this Article or in the Medical Staff Rules and Regulations shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, the descriptions of which will be contained in the Medical Staff Rules and Regulations. When appropriate, the Medical Executive Committee may recommend the creation, elimination, modification, or combination of committees. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws. In addition, special or ad hoc committees may be appointed for specific purposes by the Chief of Staff; such appointment will cease upon the accomplishment of the purpose of the committee. Such special or ad hoc committees shall report to the Medical Executive Committee.

8.2 **GENERAL PROVISIONS**

8.2-1 **EX OFFICIO MEMBERS**

The Chief of Staff, Chief Medical Officer, and the CEO or their respective designees are ex officio members of all standing and special committees of the Medical Staff.

8.2-2 **SUBCOMMITTEES**

Any standing committee may elect to perform any of its specifically designated functions by appointing a subcommittee which reports its recommendations to the parent committee. Any such subcommittee may include individuals appointed by the committee chairman who are not members of the standing committee.

8.2-3 **APPOINTMENT OF MEMBERS AND CHAIRMEN**

Except as otherwise provided, the Chief of Staff shall appoint, in consultation with the Medical Executive Committee, the members and chairman of any Medical Staff committee formed to accomplish Medical Staff functions.

8.2-4 **TERM, PRIOR REMOVAL AND VACANCIES**

(a) Except as otherwise provided, committee members and chairmen shall be appointed by the Chief of Staff for a term of one year or until the member's successor is appointed, unless such member or chairman sooner resigns or is removed from the committee. There is no limitation in the number of terms they may serve.
(b) A Medical Staff member serving on a committee, except one serving ex officio, may be removed by the Chief of Staff from the committee for failure to remain as a member of the staff in good standing, for failure to satisfy the attendance requirements specified in Section 10.3, or by action of the Medical Executive Committee. A committee member removed by the Chief of Staff or the Medical Executive Committee action shall have the right to an appearance before the Medical Executive Committee to request reconsideration of the removal.
(c) A vacancy in any committee may be filled for the unexpired portion of the term in the same manner in which the original appointment was made.

8.2-5 **VOTING RIGHTS**

Each Medical Staff committee member shall be entitled to one vote on committee matters unless disallowed by staff category. Hospital personnel assisting the Medical Staff in performance of the functions of the committee shall have no voting rights.

8.3 **MEDICAL EXECUTIVE COMMITTEE**

The Medical Executive Committee acts as the organizational body which oversees the functions and duties of the Medical Staff. It is empowered by the organized medical staff to act for the Staff, to coordinate all activities and policies of the Staff and its Committees and is actively involved in ensuring excellent patient care.

8.3-1 **COMPOSITION**

The Medical Executive Committee includes physicians and may include other licensed independent practitioners. Membership shall consist of:

(a) Chief of Staff, as chairman
(b) Vice-Chief of Staff
(c) Secretary/Treasurer
(d) Immediate Past Chief of Staff (ex officio, with vote)
(e) One Member-at-Large
(f) Chief Medical Officer (ex officio with vote)
(g) Chief Executive Officer (ex officio without vote)
(h) Chief Nursing Officer (ex officio without vote)
(i) Other representation as necessary, may be appointed by the Chief of Staff and approved by majority vote of the Medical Executive Committee (ex officio, without vote)

8.3-2 **ELECTIONS, TERMS, VACANCIES, AND REMOVALS**

(a) **ELECTIONS**

The Medical Staff officers and Members-at-Large shall be elected in the manner prescribed in Section 7.5.

(b) **TERMS OF OFFICE**

With the exception of ex officio members, all members of the Medical Executive Committee shall serve a two year term.

(c) **REMOVALS AND VACANCIES**

Removals and vacancies of general staff officers, committee chairmen and other Medical Executive Committee members, will be handled in the manners prescribed in Section 7.5, respectively. Vacancies among at-large members may be filled by appointment by the Chief of Staff with approval of the Medical Executive Committee.

8.3-3 **DUTIES**

The duties and authority of the Medical Executive Committee are to:

(a) Act on all matters of Medical Staff business, except for the election or removal of general staff officers and for the approval of Medical Staff Bylaws. The Medical Executive Committee may act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its authority as set forth herein;
(b) Receive and act upon reports and recommendations from Medical Staff committees, and other assigned activity groups;
(c) Make recommendations to the Board of Directors regarding the organized medical staff structure, and the process used to review credentials and delineate privileges;
(d) Coordinate and implement the professional and organizational activities and policies of the Medical Staff, including but not limited to the review of committee policies and procedures, the review of committee reports, the determination of dues and assessments of members; responsibility for the investment and expenditure of Medical Staff funds which shall be exclusively for purposes permitted by the IRS and consistent with the responsibilities of the Medical Staff;
(e) Review aggregate quality performance data and make recommendations for quality improvement;
(f) Recommends the adoption or assists in the formulation of policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to medications in both the hospital and any associated ambulatory department;
(g) Review quality parameters and indicators, including those recommended by Care Management and/or Banner;
(h) Account to the Board for the quality and efficiency of medical care provided to patients in the Hospital, including a summary of specific findings, actions, and results and including an assessment of the quality of services rendered pursuant to contract; and for the other responsibilities delegated by the Board to the Staff;
(i) Make recommendations to the CEO and to the Board on Hospital medico-administrative matters;
(j) Review the qualifications, credentials, performance, delineation of privileges and professional competence and character of Medical Staff and Allied Health Professional applicants and members and make recommendations to the Board regarding such matters;
(k) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;

(l) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees;
(m) Assist in obtaining and maintaining regulatory compliance of the Hospital.
(n) Review and act on information derived from Risk Management, incident reports, and trend analysis, concurrent and retrospective, to effectively maintain a safe patient environment and reduce liability;
(o) Declare a medical record complete for purposes of filing after reasonable attempts to contact the responsible physician have failed;
(p) Provide oversight for the Utilization Review process;
(q) Develop and maintain infrastructure, policies and procedures for conducting research studies and review requests and make recommendations for such research projects;
(r) Make recommendations regarding educational conferences.
(s) Enforce the Bylaws, rules and regulations, and policies of the Hospital;
(t) Review sentinel events, near misses, and complex clinical issues;
(u) Review potential conflicts of interest and recommend actions to address actual conflicts;
(v) Investigate, review and resolve complaints of disruptive conduct by any of member of the Medical and Allied Health Professional Staff;
(w) Serve as a resource for moral and ethical issues;
(x) Monitor and evaluate the quality and appropriateness of patient care and professional performance;
(y) Seek peer review assistance from external sources if and when the Medical Executive Committee determines that such assistance is appropriate and/or necessary;
(z) Review aggregate quality performance data of individual physicians and make recommendations for quality improvement in the context of peer review;
(aa) Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative and educational functions as well as issues referred from a Medical Director or Chief Medical Officer;
(bb) Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, consultation and suspension as warranted; and
(cc) Recommend to the Board the limitation, revocation or termination of Medical Staff membership and/or privileges.
(dd) Conduct a review of the Bylaws at least every two (2) years or more frequently when deemed necessary.

8.3-4 **MEETINGS**

The Medical Executive Committee shall meet as often as necessary, but at least six times a year and shall maintain a record of its proceedings and actions.

8.3-5 **ATTENDANCE REQUIREMENTS**

All members of the Medical Executive Committee are required to attend a minimum of 50% of the committee meetings. Attendance requirement may be applied on a semi-annual basis. If attendance does not meet the minimum requirement, the Chief of Staff may appoint a representative for the Medical Executive Committee to replace that member.

8.4 PROFESSIONAL WELLNESS COMMITTEE

8.4-1 **COMPOSITION**

The Professional Wellness Committee shall be created when necessary and shall

consist of a chairman and at least two members appointed by the Chief of Staff. When possible the committee shall include at least one member in recovery and one behavioral health professional. The committee shall meet as necessary.

8.4-2 **DUTIES**

The duties of the Professional Wellness Committee are to:

(a) provide education to the Medical Staff, Hospital Staff and Administrative leaders if requested or when system issues are identified regarding physician and AHP health, impairment recognition issues, types and levels of impairment, problems associated with impairment, resources available for the diagnosis, prevention, treatment and rehabilitation of impairment, and the process for referral to the committee, while maintaining informant confidentiality; if requested and whenever possible;
(b) evaluate the credibility of a complaint, allegation, or concern relating to substance abuse or health status;
(c) maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened;
(d) recommend available resources for diagnosis and/or treatment of physicians and AHP experiencing possible illness and impairment issues;
(e) serve as a resource for physicians and AHPs experiencing illness and impairment issues;
(f) assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
(g) assist Medical Staff leadership with an intervention, when so requested by Chief of Staff or designee;
(h) recommend to the affected practitioner that either a psychological, psychiatric and/or physical examination is obtained;
(i) ensure the recommendations of the committee/subcommittee are followed;
(j) monitor the practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required;
(k) require the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the Professional Wellness Committee; and
(l) advise the Medical Executive Committee of instances in which a practitioner is providing unsafe treatment or if an affected practitioner fails to adhere with the committee's recommendations so appropriate actions can be initiated.

8.5 PHARMACY AND THERAPEUTICS COMMITTEE

8.5-1 **COMPOSITION**

The Pharmacy and Therapeutics Committee shall be a multidisciplinary committee reporting to the Medical Executive Committee. It shall consist of a Chairman appointed by the Chief of Staff, with MEC approval, and at least one other member of the Medical Staff, and hospital representatives from Pharmacy, Nursing, Quality Management and Administration and ad hoc members as necessary.

8.5-2 **DUTIES**

Pharmacy and Therapeutics committee recommends the adoption or assists in the formulation of policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to medications in both the hospital and any associated ambulatory department.

The committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (physicians, licensed independent practitioners, nurses, pharmacists) for complete current information on matters related to medications and pharmaceutical care (i.e. Medication Use Evaluation and Improving Organizational Performance).

The following are activities of the Pharmacy & Therapeutics Committee:

(a) serve in an advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the safe use of medications;
(b) serve in an advisory capacity to the Medical Staff and Pharmacy Department in the selection or choice of medications which meet the most effective therapeutic quality standards;
(c) evaluate objectively the clinical data regarding new medications or agents proposed for use in the hospital;
(d) develop a formulary of accepted medications for use in the hospital and provide for continued review;
(e) participate in the formulation and analysis of Medication Use Evaluations;
(f) review and approving pharmacy policies and procedures;
(g) review incident reports involving medications and medication errors, adverse drug reactions, pharmacy interventions, and pharmacy incidents and make appropriate recommendations.
(h) Meetings: At least once per year to review the facility formulary and to review pharmacy policy and procedures and when requested to meet by the MEC.

8.6 PROFESSIONAL REVIEW COMMITTEE

8.6-1 COMPOSITION

The multi facility Professional Review Committee (PRC) shall consist of the following members:

1. CMO BBHH
2. Chief of Staff BBHH
3. Psychiatrist member from BBHH
4. Psychiatrist member from BTMC
5. Psychiatrist member from BDWMC
6. Ad Hoc member for external review such as from BUMC-P/BUMC-S
7. Ad Hoc member for non-psychiatric medical care as needed at BBHH
8. Non-voting member: CEO of Banner Behavioral Service Line
9. Non-voting member: CNO of Banner Behavioral Health Hospital

Members shall be appointed for terms of three years and may be appointed for successive terms.

8.6-2 QUALIFICATIONS

PRC members (except the Chief Medical Officer) must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1. Such members must demonstrate leadership skills and may not have disabling conflicting interests.

8.6-3 DUTIES

The duties of the Professional Review Committee shall include to:

a) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members utilizing Just Culture methodology;

b) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
c) Review sentinel events, near misses, and complex clinical issues;
d) Review potential conflicts of interest and recommend actions to address actual conflicts;
e) Investigate, review and resolve complaints of disruptive conduct by any member of the Medical and AHP Staff;
f) Serve as a resource for moral and ethical issues;
g) Monitor and evaluate the quality and appropriateness of patient care and professional performance;
h) Seek peer review assistance from external sources if and when the PRC determines that such assistance is appropriate and/or necessary.
i) Review aggregate quality performance data of individual physicians and make recommendations for quality improvement in the context of peer review;
j) Share information with the Departments and Committees to provide opportunities for learning and process improvement;
k) Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative and educational functions as well as issues referred from a department chair, Medical Director or Chief Medical Officer;
l) Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, consultation and suspension as warranted
m) Recommend to the Medical Executive Committee as required the limitation, revocation or termination of Medical Staff membership and/or privileges;
n) Establish a subcommittee or subcommittees as are necessary to perform its duties. Members of subcommittees may include practitioners who are not members of the PRC and/or who are not members of the Medical Staff.
o) Serve as ex officio appointee(s) with vote on committees of the Medical Staff if and as requested by the Chief of Staff or CEO.

8.7 UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee shall meet on a date and time agreed upon by its members on at least a quarterly basis.

8.7-1 COMPOSITION

The committee will be co-chaired by an appointed member of the medical staff and the Medical Director, Care Coordination and be multi-disciplinary in nature consisting of the director of case management, physicians, clinical, administrative and ancillary staff. At least two (2) members of the committee must be physicians.

8.7-2 DUTIES

The committee shall perform the following functions:

i. Support and direct the Utilization Management program
ii. Reviews the appropriateness of:
    a) Admissions
    b) Level of Care
    c) Continued Stays
    d) Professional Services – procedures, testing and treatment
    e) Length of Stay
    f) Status Determination
    g) Discharges
    h) Transfers

iii. Suggests and coordinates education to address specific processes with regard to medical and utilization management.
iv. Recommending changes to workflows as necessary to best meet the needs of the facility and organization.
v. Ensuring adherence to established policies, procedures, regulatory and accreditation requirements, as well as applicable professional standards.

8.7-3 **REPORT**
The Utilization Management Committee will report directly to the Medical Executive Committee.

ARTICLE NINE: MEETINGS

9.1 **MEDICAL STAFF MEETINGS**

9.1-1 **REGULAR MEETINGS**
General staff meetings will be held at least annually.

9.1-2 **SPECIAL MEETINGS**
A special meeting of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, or the Board. The Chief of Staff will call for such a meeting upon petition signed by 10% of the members of the active staff.

9.2 **COMMITTEE MEETINGS**

9.2-1 **REGULAR MEETINGS**
Committees shall meet at a frequency as determined by these bylaws. The chairman shall set the time and agenda for the meeting.

9.2-2 **SPECIAL MEETINGS**
A special meeting of any committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Chief of Staff, or the Medical Executive Committee. A notice of such special meeting will be provided to all members of the committee.

9.2-3 **EXECUTIVE SESSION**
Any committee may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group and other individuals who have a legitimate reason to be present may remain during such session. Separate minutes must be kept of any executive session.

9.3 **ATTENDANCE REQUIREMENTS**

9.3-1 **CHART REVIEW**
A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the committee to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to appear may result in automatic suspension under Section 6.6-7.

9.3-2 **CLINICAL CONFERENCE**
Whenever the Medical Executive Committee perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified by the Chief of Staff of the time, date, place of the program, the subject matter to be covered, and its special applicability

to their practice. Attendance is mandatory. Failure to attend may result in initiation of corrective action proceedings.

9.3-3 **SPECIAL APPEARANCE**

Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the Chief of Staff may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefor. Failure of a practitioner to appear at any such meeting may result in initiation of corrective action proceedings.

9.4 **QUORUM**

9.4-1 **GENERAL STAFF MEETINGS**

The presence of 50% of the voting members of the staff at any regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws.

9.4-2 **COMMITTEE MEETINGS**

The presence of 50% of the members of the Medical Executive Committee shall constitute a quorum. The presence of the chairman, or designee, and one voting member shall constitute a quorum at any other committee meeting.

ARTICLE TEN: CONFIDENTIALITY, IMMUNITY, RELEASES, AND INDEMNIFICATION

10.1 **AUTHORIZATIONS AND RELEASES**

By submitting an application for staff appointment or reappointment or by applying for or exercising clinical privileges or providing specified patient care services at the Hospital, a practitioner:

(a) authorizes Hospital representatives to solicit, provide, and act upon information bearing on or reasonably believed to bear upon the practitioner's professional ability, utilization practices, and qualifications;

(b) agrees to be bound by these Bylaws regardless of whether membership or clinical privileges are granted or are subsequently limited;

(c) acknowledges that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and the exercise of clinical privileges or provision of specified patient care services at the Hospital;

(d) agrees to release from legal liability and hold harmless the Hospital, Medical Staff, members of the Medical Staff, Medical Staff committees and all persons engaged in peer review activities, which include but are not limited to those activities identified in Article 11.3 (8.3)of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws or any applicable federal or state statute or regulation; agrees that his/her sole remedy for any corrective action taken or recommended by the Medical Staff, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review action shall be the right to seek injunctive relief pursuant to ARS 36-445 et seq.

(e) agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to the Hospital or its representatives; and

(f) authorizes the release of information about the practitioner in accordance with the Banner Sharing of Information Policy.

10.2 **CONFIDENTIALITY OF INFORMATION**

Information obtained or prepared by any representative for the purpose of evaluating or improving the quality and efficiency of patient care, reducing morbidity and mortality, or contributing to teaching or clinical research, shall, to the fullest extent permitted by law, be confidential. Such information shall only be disseminated to the extent necessary for the purposes identified above or except as otherwise specifically authorized by law. Such confidentiality shall also extend to information provided by third parties.

10.3 **ACTIVITIES COVERED**

The confidentiality and immunity provided by this Article applies to all information obtained or disclosures made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) applications for appointments, clinical privileges, or specified services;
(b) periodic reappraisals for reappointment, clinical privileges, or specified services;
(c) corrective or disciplinary actions;
(d) hearings and appellate reviews;
(e) quality review program activities;
(f) utilization review and management activities;
(g) claims reviews;
(h) profiles and profile analysis;
(i) significant clinical event review;
(j) risk management activities; and
(k) other hospital, committee, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4 **RELEASES AND DOCUMENTS**

Each practitioner shall, upon request of the Hospital, execute general and specific releases and provide documents when requested by the Chief of Staff or Committees or their respective designees. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases or provide documents upon request during a term of appointment to the staff shall result in automatic suspension as provided in Section 6.6-9.

10.5 **CUMULATIVE EFFECT**

Provisions in these Bylaws and in application and reapplication forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protection provided by relevant Arizona and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

10.6 **INDEMNIFICATION**

Banner Health shall provide indemnification for Medical Staff activities pursuant to the policy adopted by the Board.

ARTICLE ELEVEN: GENERAL PROVISIONS

11.1 STAFF DUES

The Medical Executive Committee shall establish the amount of annual Medical Staff and Allied Health Professional dues. Notice of dues shall be given to the staff by written notice in January. Dues are payable on or before March 31 of each year. If dues are not paid by April 1, a special notice of delinquency shall be sent to the practitioner and an additional 30 calendar days given in which to make payment. All new staff members shall be given 30 calendar days in which to make payment for the current year upon their appointment to the staff. Failure to render payment shall result in automatic suspension as provided in Section 6.6-8. Special assessments may be levied by a majority vote of the active staff, and rules of payment similar to those described above in terms of time frame shall apply. The honorary staff shall be exempt from payment of dues and assessments. All new staff members who have completed training with 12 months prior to applying for staff membership may submit a written request for a waiver of dues for the first year of staff membership.

11.2 SPECIAL NOTICE

When special notice is required, the Medical Staff Office shall send such notice by registered mail, return receipt requested to the address provided by the practitioner; email with confirmation of receipt, hand delivery with confirmation of receipt, or facsimile with confirmation of receipt. If the post office indicates that the letter has been refused, such notice shall be deemed to be delivered on the date delivery was first attempted. If the post office indicates the letter is undeliverable, the Medical Staff Office shall attempt to contact the practitioner at the location last identified by him or her. If such attempt is unsuccessful, notice shall be deemed to be delivered on the date delivery was first attempted.

11.3 CONSTRUCTION OF TERMS AND HEADINGS

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

11.4 PARLIAMENTARY PROCEDURE

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

11.5 CONFLICT RESOLUTION

11.5-1 STAFF MEMBER CHALLENGE

Any member of the Medical Staff may challenge any rule or policy established by the Medical Executive Committee by submitting to the Chief of Staff written notification of the challenge, with a petition signed by one third of the members of the Active Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

11.5-2 MEDICAL EXECUTIVE COMMITTEE REVIEW

The Medical Executive Committee will consider the challenge at its next meeting and will determine what changes will be made to the rule or policy or may, at its discretion, appoint a subcommittee to review the challenge and recommend potential changes to address the concerns. The Medical Executive Committee may use internal or external resources to assist in resolving the conflict. The Medical Executive Committee will review subcommittee recommendations and take final action on the rule or policy, subject to

Board approval as required. The Medical Executive Committee will communicate all changes to the Medical Staff.

11.5-3 **CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY**

A recommendation to use either internal or external resources to resolve the conflict may be made by the Board, the CEO, the Executive Committee, or members of the Medical Staff. Any conflict regarding the use of such resources or the process to be followed will be decided by the Board through the Medical Staff Subcommittee. The Board has final authority to resolve differences between the Medical Staff and the Executive Committee.

ARTICLE TWELVE: ADOPTION AND AMENDMENT

12.1 **MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

The Medical Staff shall be responsible for the development, adoption, and periodic review of these Bylaws which must be consistent with Hospital policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community. These Bylaws may not conflict with the Banner Health Bylaws.

12.2 **PERIODIC REVIEW**

The Medical Staff has responsibility to formulate, review, and recommend to the Banner Board Medical Staff Bylaws and amendments as needed. Reviews shall also be conducted upon request of the Banner Board.

URGENT AMENDMENT PROCESS.

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Executive Committee may provisionally adopt, and the Board may provisionally approve the urgent amendment without the prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Executive Committee of the urgent amendment within ten (10) days after the Board has approved the amendment. The voting members of the Medical Staff shall have ten (10) days in which to retrospectively review the amendment and provide written comment to the Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict resolution as referenced in Section 12.8-2 shall be implemented, and a revised amendment shall be submitted to the Board.

12.3 **MEDICAL EXECUTIVE COMMITTEE PROCESS**

The Bylaws of the Medical Staff are adopted by the Medical Staff and approved by the Board prior to becoming effective. Amendments to these Bylaws may be adopted upon approval of the Medical Executive Committee and approval by a majority electronic and/or ballot vote of members of the Active Staff voting. Ballots shall be sent to each Active Staff member by mail or email. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 calendar days after their mailing/emailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

Neither body may unilaterally amend the Medical Staff Bylaws, except the Board may take action if the Medical Staff fails to act within sixty (60) days notice from the Board to affecting the operation of the hospital, welfare of its employees and staff, or provision of hereunder. The

action described in the preceding sentence shall be taken only after from of the Board's request for amendment is sent to the Medical Executive Committee.

12.4 **MEDICAL STAFF PROCESS**

The Medical Staff may propose Bylaws or amendments thereto directly to the Board, including amendments to remove authority given to the Medical Executive Committee. A petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Medical Executive Committee.

The Medical Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Medical Executive Committee.

The Medical Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Medical Executive Committee.

When the Medical Executive Committee proposes language different from the original Medical Staff proposed language, the Medical Executive Committee shall put the matter to a vote of the Active Medical Staff. Ballots shall be sent to each Active Staff member by mail or email, along with the comments of the Medical Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 calendar days after their mailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the ballot. If the proposed amendment is accepted by the Medical Staff by a two-thirds majority of those voting, the amendment, along with the Medical Executive Committee comments, will be forwarded to the Board for consideration.

12.5 **BOARD OF DIRECTORS ACTION**

12.5-1 **WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION**

Medical Staff recommendations regarding proposed Bylaws or amendments thereto shall be effective upon the affirmative vote of the Board.

12.5-2 **BOARD CONCERNS**

In the event the Board has concerns regarding any provision or provisions of the proposed Bylaws or amendments thereto, the Board shall advise the Medical Staff of its concerns.

12.6 **JOINT CONFERENCE COMMITTEE**

The Medical Executive Committee may request a Joint Conference Committee to resolve concerns regarding Medical Staff Bylaws, credentialing recommendations, policies or other issues that the Medical Executive Committee has been unable to resolve through informal processes with Hospital or Banner Health administration, management or Board of Directors. This committee shall consist of three representatives appointed by Banner and three members of the Medical Staff appointed by the Chief of Staff as specified in the Banner Health Bylaws.

12.7 **TECHNICAL AND EDITORIAL AMENDMENTS**

Upon recommendation of the Bylaws Committee, the Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are technical or legal modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately upon Board approval.

12.8 CREDENTIALS PROCEDURE MANUAL, FAIR HEARING PLAN, MEDICAL STAFF RULES AND REGULATIONS, AND ALLIED HEALTH RULES AND REGULATIONS

12.8-1 PERIODIC REVIEW

The Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, and Allied Health Staff Rules and Regulations shall be reviewed as needed. Reviews shall also be conducted upon request of the Board.

12.8-2 COMMUNICATION OF AMENDMENT OF DOCUMENTS TO THE MEDICAL STAFF

(a) Routine matters. Absent a documented need for urgent action, before acting, the Medical Executive Committee will communicate to the Staff by email proposed changes to the Credentials Procedure Manual, Fair Hearing Plan, and Medical Staff Rules and Regulations before approving such changes. Members may submit comments and concerns to the Chief of Staff c/o Medical Staff Services within 10 calendar days. If concerns are not received within 10 calendar days, the Medical Executive Committee's recommendation relating to the proposed changes will be submitted to the Board for approval. If concerns are received, the Medical Executive Committee will determine whether to approve, modify or reject such proposed changes.

(b) Urgent matters. In cases of a documented need for urgent amendment, the Medical Executive Committee and Board may provisionally adopt an urgent amendment without prior notification of the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If concerns are not received within 10 calendar days, the amendment stands. If there is a conflict and 30% of the Active Staff oppose the amendment, the Medical Executive Committee will utilize the conflict resolution process set forth in Section 12.6. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

12.8-3 MEDICAL STAFF AMENDMENTS OF THE CREDENTIALS PROCEDURE MANUAL, FAIR HEARING PLAN AND MEDICAL STAFF RULES AND REGULATIONS AND ALLIED HEALTH STAFF RULES AND REGULATIONS

The Medical Staff may propose amendments to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations and Allied Health Staff Rules and Regulations to the MEC or directly to the Board. To submit the amendments directly to the Board, a petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Medical Executive Committee.

The Medical Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Medical Executive Committee.

The Medical Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Medical Executive Committee.

When the Medical Executive Committee proposes language different from the original Medical Staff proposed language, the Medical Executive Committee shall put the matter to a vote of the Active Medical Staff. Ballots shall be sent to each Active Staff member by mail or email, along with the comments of the Medical Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 calendar days after their mailing at which time they will be tallied. Any ballots received after the designated date shall not be

opened and shall not affect the outcome of the ballot. If the proposed amendment is accepted by the Medical Staff by a majority of those voting, the amendment, along with the Medical Executive Committee comments, will be forwarded to the Board for consideration.

ADOPTION

These Bylaws are adopted and made effective superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each and every member of the Medical Staff shall occur under and pursuant to the requirements of these Bylaws. The present Rules and Regulations of the Medical Staff are hereby adopted and placed into effect pursuant to these Bylaws.

DATES OF ADOPTION AND AMENDMENT

Adopted by the Board of Directors: 10/75

Amended by the Board of Directors

04/20/77	03/24/87	07/92	08/16/05
06/20/79	12/15/87	03/09/93	10/20/05
05/20/81	06/21/88	10/12/93	05/18/06
12/16/81	12/20/88	10/11/94	05/17/07
10/27/82	12/19/89	11/10/94	12/20/07
03/16/83	04/17/90	09/12/95	12/09/10
10/19/83	05/08/90	06/15/99	05/12/11
03/21/84	06/14/90	09/16/99	10/11/12
12/18/84	09/20/90	09/20/02	03/14/13
06/18/85	10/18/90	04/17/03	12/12/13
10/15/85	03/21/91	10/16/03	01/14/16
03/18/86	06/20/91	12/18/03	09/13/17
06/17/86	02/18/92	06/17/04	12/14/17
12/16/86	04/21/92	04/21/05	02/11/21