Banner Behavioral Health Hospital

ALLIED HEALTH PROFESSIONALS RULES and REGULATIONS

PART ONE - DEFINITIONS AND CATEGORIES

1.1 **Definition**

Allied health professionals (AHPs) are individuals who:

(a) are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital;
(b) may write orders as allowed by their delineation of privileges;
(c) will perform Scope of Services under the supervision of the attending physician;
(d) will make regular progress notes in the patient record and document each visit; additional notes may be written depending on the clinical course of the patient and as indicated clinically;
(e) may not admit patients independently;
(f) may not perform clinical duties not described within their specific delineation of privileges; and
(g) are not members of the Medical Staff.

1.2 **Categories**

The following are the categories of AHPs currently authorized to provide services in the Hospital or Banner Psychiatric Center: Advanced practice nurses, physician assistants and crisis counselors. The Medical Executive Committee may recommend the addition or elimination of other categories of AHPs authorized to provide services at the Hospital. Any such recommended change in authorized categories of AHPs shall become effective upon Board approval and shall not require formal amendment of these Rules and Regulations.

PART TWO - QUALIFICATIONS

2.1 **Statement of Qualifications**

A statement of qualifications for each category of allied health professionals shall be developed by the Medical Executive Committee and the Board. Each statement must:

(a) Be developed with input, as applicable, from the physician director of the clinical unit or service involved, the physician supervisor of the AHP, and other representatives of the medical staff, Hospital management, and other professional staff;
(b) Require the individual AHP to hold a current license, Drug Enforcement Administration (DEA) registration (when applicable) or such other credential, if any, as may be required by state law; and
(c) Satisfy the qualifications as are set forth for allied health staff appointment, including appropriate professional liability insurance coverage, or for Medical Center employment, as applicable.

PART THREE - PREROGATIVES, OBLIGATIONS, TERMS AND CONDITIONS

3.1 **Prerogatives**

The prerogatives of an AHP are to:

(a) provide such specifically designated patient care services as are granted by the Board upon recommendation of the Medical Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the AHPs practice in the Hospital, and other applicable Medical Staff or Hospital policies;
(b) serve on committees when so appointed;
(c) attend open meetings of the staff or a committee; and
(d) exercise such other prerogatives as the Medical Executive Committee with the approval of the Board may accord AHPs in general or to a specific category of AHPs.

3.2 **Obligations**

Each AHP shall:

(a) meet the basic obligations required by Section 3.3 of the Medical Staff Bylaws for medical staff members;
(b) meet the general qualifications required by Section 3.1-5 Cooperativeness, Section 3.1-6 Teamwork and Section 3.1-8 Professional Ethics and Conduct of the Medical Staff Bylaws for medical staff members;
(c) exercise appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Hospital for whom services are provided;
(d) participate when requested in quality review program activities and in discharging such other functions as may be required from time to time;
(e) satisfy the special appearance requirements of the Bylaws;
(f) refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of practice authorized by the Board;
(g) pay all dues and assessments; and
(h) prior to practicing at Hospital, each AHP is required to obtain a Banner Health photo identification badge. The AHP is required to present legible Federal/State government issued photo identification (i.e. driver's license, passport, etc.) prior to receiving the identification badge.

3.3 **Terms and Conditions**

An AHP shall be individually assigned appointment as appropriate according to his or her professional training and is subject to formal periodic (biennial) review and disciplinary procedures as determined for the category. 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 as it applies to their scope of practice; and
- Banner's electronic New Provider Orientation.

Exceptions may be made for practitioners granted temporary or disaster privileges.

PART FOUR - ADVERSE ACTION REVIEW AND APPELLATE REVIEW, AUTOMATIC AND NONREVIEWABLE ACTIONS

4.1 **Adverse Action Review and Appellate Process**

4.1.1 **Initiation of Adverse Action Review and Appeal Process**

AHPs who are subject to Adverse Action (other than Nonreviewable or Automatic Actions defined in Sections 4.2 and 4.3) shall be afforded an Adverse Action Review and appeal process in accordance with these Rules & Regulations. Adverse Actions include: denial of a request to provide any patient care services within the applicable Scope of Practice or revocation, suspension, reduction, limitation or termination of privileges within the

applicable Scope of Practice. AHPs are not entitled to due process rights set forth in the Medical Staff Bylaws, and none of the procedural rules set forth therein shall apply.

4.1.2 **Notice of Adverse Recommendation or Action**
Within fifteen (15) calendar days after Adverse Action is taken against an AHP, the AHP and his/her supervising physician (if applicable) shall be notified in writing of the specific reasons for the Adverse Action and the AHPs rights per these Rules and Regulations**.**

4.1.3 **Request for Review of Adverse Recommendation or Action**
The AHP may request an Adverse Action Review following the procedure set forth in these Rules and Regulations. If the AHP does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) calendar days following the receipt of the notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

4.1.4 **Composition of the Review Committee**
The Chief of Staff shall appoint an ad hoc committee consisting of at least three members and a Nursing Administration representative to consider the request and serve as the Review Committee.

4.1.5 **Notice of Time and Place for Review**
The AHP shall be given ten (10) calendar days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, who will be called to support the Adverse Action.

4.1.6 **Statements in Support**
The Medical Staff Representative and the AHP 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 Medical Staff Office at least five (5) days prior to the review. The Medical Staff Office will provide copies to the other party and members of the Review Committee.

4.1.7 **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. The AHP, the Hospital and the Medical Staff Representative shall not be entitled to legal counsel at the Adverse Action Review or Appellate Review.

4.1.8 **Burden of Proof**
The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP 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.

4.1.9 **Action on Committee Review**
Upon completion of the review, the Review Committee shall consider the information and evidence presented, make a recommendation, which shall include the basis therefore, and forward it to the Chief of Staff. The AHP and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

4.1.10 **Duty to Notify of Noncompliance**
If the AHP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan/Allied Health Professionals Rules and Regulations 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. The AHP will be deemed to waive any procedural deviation that he/she has not raised promptly with the Chief of Staff pursuant to this section.

4.1.11 **Request for Appellate Review**
If the AHP is dissatisfied with the Committee's recommendation, he/she may submit a written request for an Appellate Review, provided that the Chief Executive Officer receives such request within ten (10) days following the AHP'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 these Rules and Regulations 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. For appeals based upon procedural errors, notice of noncompliance must have been properly given.

4.1.12 **Interview with Medical Executive Committee**

Upon a proper and timely request for an Appellate Review, the AHP shall be given an interview with the Medical Executive Committee or a subcommittee thereof consisting of at least three (3) members. The AHP 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.

4.1.13 **Final Determination by the Medical Executive Committee**

The Medical Executive Committee shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the Medical Executive Committee shall not be subject to further appeal. The final decision will be submitted to the Board.

4.2 **Automatic Suspension or Limitation**

Automatic suspension shall be immediately imposed under the conditions contained in this section. In addition, further corrective action may be recommended in accordance with the provisions contained within these Rules and Regulations whenever any of the following actions occur:

4.2.1 **License**

(a) Revocation: Whenever a practitioner's license to practice in this State is revoked, Allied Health 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, Allied Health 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.

4.2.2 **Controlled Substances Registration**

Whenever a practitioner's DEA or other controlled substances 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.

4.2.3 **Professional Liability Insurance**

A practitioner's appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Banner Board. 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 and must reapply for AHP membership and privileges.

4.2.4 **Exclusion from Medicare/State Programs**

The CEO, with notice to the Chief of Staff, will immediately and automatically suspend the Allied Health 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 will 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.

4.2.5 **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, shall automatically be suspended. Failure to appear within 90 calendar days of the request to appear shall result in revocation of staff membership and clinical privileges. Thereafter, the affected practitioner must reapply for AHP membership and privileges.

4.2.6 **Failure to Pay Staff Dues**

A practitioner who fails to pay staff dues shall automatically be suspended from the AHP 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 AHP membership and privileges.

4.2.7 **Failure to Execute Releases and/or Provide Documents**

A practitioner who fails to execute a general or specific release and/or provide documents during a term of appointment when requested by the Chief of Staff or designee 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.

4.2.8 **Freedom from Infectious TB**

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

4.2.9 **Failure to Participate in an Evaluation**

A practitioner who fails to participate in an evaluation of his/her qualifications for AHP 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.

4.2.10 **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.

4.2.11 **Failure to Maintain a Supervising Physician**

A practitioner who is required to maintain a supervising physician but fails to do so, shall automatically be suspended. If, within 30 calendar days of notification of suspension, another physician with appropriate privileges on the BBHH Medical Staff agrees to serve as the supervising physician and is approved by the appropriate licensing agency, if so required, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for AHP membership and privileges.

4.2.12 **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.

4.2.13 **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.

4.2.14 **Failure to Maintain Cardiopulmonary Resuscitation (CPR) Certification**
If a practitioner is required to maintain CPR certification and fails to maintain such certification, privileges, privileges shall automatically be suspended. If evidence of certification is provided within 60 calendar days of 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.

4.2.15 **Failure to Complete De-Escalation/Seclusion and Restraint Training**
If a practitioner is required to obtain de-escalation/seclusion and restraint training and fails to obtain such training, privileges shall automatically be suspended. If evidence of de-escalation/seclusion and restraint training is provided within 60 calendar days of 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.

4.3 **Nonreviewable Actions**

Not every action entitles the practitioner to rights pursuant to the Adverse Action Review and Appellate Review. Those types of corrective action giving rise to automatic suspension as set forth in Section 4.2 are not reviewable under the Adverse Action Review and Appellate Review. In addition, the following occurrences are also nonreviewable under the Adverse Action Review and Appellate Review:

4.3.1 Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
4.3.2 Issuance of a warning or a letter of admonition or reprimand.
4.3.3 Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
4.3.4 Termination or limitation of temporary privileges or disaster privileges.
4.3.5 Supervision and any other requirements imposed as a condition of granting privileges.
4.3.6 Termination of any contract with or employment by the Hospital.
4.3.7 Any recommendation voluntarily imposed or accepted by a practitioner.
4.3.8 Denial of membership for failure to complete an application for membership or privileges.
4.3.9 Removal of membership for failure to complete the minimum supervisory requirements.
4.3.10 Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
4.3.11 Refusal of the Medical Executive Committee to consider a request for appointment, reappointment, or privileges within one year of a final adverse decision regarding such request.
4.3.12 Any requirement to complete an educational assessment or training program.
4.3.13 Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
4.3.14 Retrospective chart review.
4.3.15 Denial, removal or limitation of AHP membership or permission to provide patient care services as a result of 1) the decision of the CEO to enter into, terminate or modify an exclusive contract for clinical services; or 2) the termination or modification of the

practitioner's relationship with the exclusive provider.

4.3.16 Grant of conditional appointment or appointment for a limited duration.

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

PART FIVE - SCOPE OF SERVICE

5.1 **Description**

The scope of service that may be provided by any group of AHPs shall be developed by the Medical Executive Committee and approved by the Board. For each group, guidelines must include at least:

5.1.1 specifications of categories of patients to whom services may be provided.

5.1.2 a description of the services to be provided and procedures to be performed, including any special equipment, procedures, or protocols that specific tasks may involve, and responsibility for documenting the services provided in the medical record.

5.1.3 a description of the scope of assistance that may be provided to a physician and any limitations thereon, including the degree of physician supervision required.

5.1.4 the services provided by AHPs who are not Banner employees must be commensurate with the qualifications and competencies required of medical center employees who perform the same or similar services.

PART SIX - APPOINTMENT PROCEDURES

6.1 **General**

The procedures for processing individual applications from AHPs, for reviewing ongoing performance, for periodic reappraisal, and for disciplinary action shall be established by the Medical Executive Committee and the Board.

A physician assistant, nurse practitioner or crisis counselor who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Medical Center, 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 a non contracted/employed AHP staff member.

6.2 **Application**

All applications for staff membership must be submitted by the applicant in writing and on the form designated by the Medical Executive Committee and approved by the Board. At the time an application is submitted, the applicant will be provided access to the Bylaws of the Medical Staff and Medical Staff Rules and Regulations.

6.3 **Application Content**

Every applicant must furnish complete information regarding:

a) School of advanced practice degree or specialty degree and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended, and for all postgraduate training, names of those responsible for monitoring the applicant's performance. Verification of education and training will be verified by the program.

b) Military Service (if applicable)

c) Verification of all nursing or other professional licensures or certifications to practice and sanctions against such license, termination or restriction of licensure and any previously successful or currently pending challenges to licensure (voluntary or involuntary).

d) Drug Enforcement Administration (DEA) registration if applicable.

e) Specialty certification, recertification, or eligibility status.

f) Health status and any health impairments (including alcohol and/or drug dependencies) which may affect the applicant's ability to perform professional and staff duties fully, including influenza vaccination by December 1 or each year and freedom from infectious tuberculosis.

g) Professional liability insurance coverage, in the amount acceptable to the Board including the names of present and past insurance carriers, and complete information on malpractice claims history and experience including claims, suits, and settlements made, concluded, and pending. Malpractice history will be reviewed as reported by the National Practitioner Data Bank. Verification from malpractice insurance carriers will be sought if concerns are identified which necessitate further investigation.

h) Any pending or completed action involving the withdrawal of an application for or the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary or involuntary relinquishment (by resignation or expiration) of: license or certificate to practice in any state or country; DEA or other controlled substances registration; specialty or sub-specialty board certification or eligibility; staff membership status, prerogatives, or clinical privileges at any hospital, clinic, or health care institution; professional liability insurance coverage.

i) Specific clinical privileges requested.

j) Supporting documentation as required by specific criteria for privileges requested.

k) Any sanctions or exclusions by the Office of the Inspector General of the Department of Health and Human Services, any exclusions from government contracts by the General Services Administration/any government entity, or any convictions of any crime relating to health care.

l) Any pending or past felony criminal charges or convictions involving alcohol, drugs, criminal damage, assault or moral turpitude against the applicant including their resolution.

m) Any pending or past misdemeanor charges or convictions involving alcohol, drugs, criminal damage, assault, or moral turpitude including their resolution.

n) Names and addresses of all hospitals or health care organizations where the applicant has or has had any association, employment, privileges or practice with the inclusive dates of each affiliation. All time intervals since graduation must be accounted for. Verification of practice history, employment, other staff memberships and time gaps will be verified for the previous 10 years unless concerns are identified, which necessitate further investigation.

o) Information from the National Practitioner Data Bank (NPDB), and other data banks as required by the Medical Executive Committee and/or regulatory bodies.

p) Evidence of the applicant's agreement to abide by the provisions of the Bylaws of the Medical Staff, Allied Health Staff Rules and Regulations, and Professional Conduct Policy.

q) Name and contact information for sponsoring physician(s) if required by specific privilege criteria.

r) Photocopy of the applicant’s driver’s license or other government issued photo ID (e.g. passport), or copy of a current picture hospital identification card.

s) Peer References (see Part 6.4 below)

t) Attestation statement by the applicant documenting completion of Continuing Education related to his/her area of practice during the past two years. Proof of attendance and program content will be submitted upon request of the review committee.

u) Signed disclosure and authorization to obtain investigative consumer report from Banner Health Secure Hire.

6.4 **Peer References**

The application must include the names of three (3) health care professionals, including Sponsoring Physician, not related to the applicant, who have personal knowledge of the applicant's qualifications and who will provide specific written comments on these matters. Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. At least one of the three references must be in the same specialty. The named individuals must have acquired the requisite knowledge through recent observation (within the past two years) of the applicant's professional performance and clinical competence over a reasonable period of time. References that are "fair" or "poor" shall be viewed as unfavorable in connection with the evaluation of an application. Further references may be required at the discretion of the Medical Staff.

6.5 **Effect of Application**

The applicant must sign the application and in so doing:

a) Attests to the correctness and completeness of all information furnished and in so doing acknowledge that any material misstatement in or omission from the application may constitute grounds for denial or revocation of appointment;

b) Signifies willingness to appear for interviews in connection with the application;

c) Signifies willingness to undergo a physical or mental health evaluation upon the request of the Professional Wellness Committee.

d) Agrees to abide by the terms of the Bylaws of the Medical Staff, Allied Health Staff Rules and Regulations, and the policies of the medical staff and the Hospital, regardless if membership and/or clinical privileges, are granted;

e) Agrees to exhibit professional conduct and refrain from disruptive conduct as defined in the hospital's Professional Conduct Policy;

f) Agrees to maintain an ethical practice and to provide continuous care to his or her patients;

g) Authorizes and consents to representatives of the medical staff and Hospital consulting with any individual who or entity which may have information bearing on the applicant's qualifications and consents to the inspection of all records and documents that may be material to evaluation of such qualifications;

h) Authorizes and consents to the sharing of information in accordance with the Board's Sharing of Information policy; and

i) Releases from any liability Banner Health, the Board, Hospital employees, medical staff members, and all others who review, act on, or provide information regarding the applicant's qualifications for staff appointment and clinical privileges.

6.6 **Application Fee**

A non-refundable application fee in the amount established by the Medical Executive Committee must be submitted by the applicant prior to the processing of the application. The application fee will also apply in the event of reapplication.

6.7 **Processing the Application**

6.7.1 **Applicant's Burden**

The applicant has the burden of producing adequate information for a proper evaluation of his or her qualifications and of resolving any doubts about any of the qualifications required for AHP membership or clinical privileges, and of satisfying any requests for information or clarification (including health examinations). The applicant has the burden of demonstrating his or her qualifications to the satisfaction of the Hospital. Applications not demonstrating compliance with the requirements for allied health staff membership and privileges will be deemed to be incomplete. Incomplete applications will not be processed. If information is not obtained from the applicant within sixty (60) days after a written request has been made, the application will be deemed withdrawn. After this time, if the applicant wishes to pursue application, he/she will be required to reapply through the Banner Health CVO in accordance with their policies and procedures.

6.7.2 **Verification of Information**

An Application Request Form shall be submitted to the Banner Health Credentials Verification Office which shall forward a copy to the Hospital's Medical Staff Office to determine eligibility. If the applicant meets minimum established eligibility criteria, the CVO office will be notified and the applicant will be mailed a more detailed application for completion. Representatives of the Banner Health CVO shall obtain primary source verification of application contents, and notify the applicant of any problems in obtaining the required information. Upon such notification, it is the applicant's obligation to provide the required information. When collection and verification is accomplished, the application shall be deemed to be conditionally complete and shall be transmitted with all supporting materials to the Medical Staff Office which will obtain the National Practitioner Data Bank Query and will submit the application to the Medical Executive Committee. Should the application subsequently be determined to be incomplete, processing will stop.

6.7.3 **Credentials Review**

6.7.3.1 Nurse Practitioners – Nursing Administration in cooperation with the Senior Administrator shall review the completed application, the supporting documentation, and any other relevant information and determine if the applicant meets all of the necessary qualifications for staff membership as requested. Nursing Administration shall transmit its recommendation(s) regarding staff appointment and prerogatives to Medical Staff Services for credentials review by the Vice Chief of Staff and MEC review.

6.7.3.2 Physician Assistants and Crisis Counselors – The application will be reviewed by the Vice Chief of Staff who shall present the application to the MEC as in Section 6.7.3.

6.7.3 **Medical Executive Committee Action**

The application will be reviewed by the Vice Chief of Staff and at the next regular meeting of the MEC, shall present the application, the supporting documentation, and any other relevant information available.

The MEC may conduct an interview with the applicant. Where the applicant maintains that his/her post graduate training and/or certification are equivalent to that required for membership, the Committee will assess the supporting documentation to determine equivalency. The Medical Executive Committee shall prepare a written report with recommendations as to approval or denial of, or any special limitations on, staff appointment, category of staff membership, and prerogatives, and scope of clinical privileges, or defer action for further consideration. The Medical Executive Committee will make recommendations to the Board of Directors as provided in the Bylaws of the

Medical Staff.

6.7.4 **Effect Of Medical Executive Committee Action**

a) Favorable Recommendation: Medical Executive Committee recommendation that is favorable to the applicant in all respects shall be promptly forwarded to the Board.

b) Conditional Appointment/Reappointment: The Medical Executive Committee may recommend that the applicant or member be granted conditional appointment for the term of appointment or reappointment. Conditional appointment/reappointment is not a reduction or limitation of membership or privileges, and does not constitute corrective action. Where the Medical Executive Committee recommends conditional appointment/reappointment, the CEO will advise the applicant of the Medical Executive Committee's expectations for conduct and/or performance and the possible consequences if those expectations are not met, which shall be defined in a stipulation agreement.

c) Limited Period of Appointment: From time to time, the Medical Executive Committee may recommend a period of appointment of less than two (2) years. A limited appointment may be extended without completion of a new application and review required by these Bylaws provided that a reappointment application is completed and processed within two years. The practitioner will submit a supplemental application and any other requested information, which will be reviewed, along with any additional information deemed appropriate, by the Medical Executive Committee. An appointment may be granted for less than two (2) years to align the practitioner with the two-year birth month reappointment cycle. Such appointment is not a limited appointment.

d) Adverse Recommendation: An adverse Medical Executive Committee recommendation shall entitle the applicant to the rights provided by the Adverse Action Review and Appellate Review except where the recommendation is nonreviewable.

e) Deferral: Action by the Medical Executive Committee to defer the application for further consideration shall be followed up at its next regular meeting or upon receipt of adequate information with its recommendations as to approval or denial of, or any special limitations on staff appointment, prerogatives, and scope of clinical privileges.

6.7.5 **Board**

At its next regularly scheduled meeting and in accordance with the Banner Expedited Review Policy, the Board Medical Staff Committee may adopt or reject, in whole or in part, a recommendation of the Medical Executive Committee, make a recommendation to the Banner Board, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral. Favorable action by the Board is effective as its final decision. If the Board's action is adverse to the applicant in any respect, the CEO shall, by special notice, promptly so inform the applicant who is then entitled to the procedural rights provided in the Fair Hearing Plan. Board action after completion of the procedural rights provided in the Fair Hearing Plan or after waiver of these rights is effective as its final decision.

6.7.6 **Verification of Identification**

Prior to practicing at Hospital, each practitioner is required to obtain a Banner Health photo identification badge. Prior to being issued a badge, the practitioner is required to present (in person) a legible valid Federal/State government issued photo identification (i.e. driver's license, passport, etc.) to Medical Staff Office personnel. The Medical Staff Office will then review and verify the practitioner's identity.

6.8 Temporary Privileges

6.8.1 Conditions

Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately certified/licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has provided evidence of satisfactory professional liability insurance. 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 Rules and Regulations and the policies of the Hospital.

6.8.2 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.

6.8.3 **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.

6.8.4 **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.

6.8.5 **Rights of the Practitioner**
A practitioner is not entitled to the procedural rights afforded by these AHP Rules and Regulations 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.

6.9 **Disaster Privileges**

6.9.1 Temporary disaster privileges may be granted by the CEO or designee only when the following two conditions are present: the Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs.

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.

Such privileges expire within thirty (30) calendar days or upon the termination of the disaster, 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.

6.9.2 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.

6.9.3 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.

6.9.4 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.

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

PART SEVEN - REAPPOINTMENT

7.1 **Information Collection and Verification**

7.1.1 **From AHP**

The Medical Staff Office or its agent, as approved by the Medical Executive Committee and Board, shall send each AHP an application for reappointment and notice of the date on which membership and privileges will expire. The application for reappointment must be submitted on the form designated by the medical Executive Committee and approved by the Board. The application shall include information to demonstrate the AHP's continued compliance with the qualifications for allied health membership and to update the member's credentials file.

The Medical Staff Office or its agent shall verify the information provided on the reappointment form and notify the AHP of any specific information inadequacies or verification problems. The AHP has the burden of producing adequate information and resolving any doubts about it.

Failure to return the satisfactorily completed forms shall be deemed a voluntary resignation from the AHP staff and shall result in automatic termination of membership at the expiration of the current term. Reinstatement may be requested if the reappointment application is complete, verified and submitted for approval within 90 calendar days of expiration of membership, and the applicant has provided a summary of relevant activities from the time of expiration, which will be verified. Otherwise, the initial application process and fees will apply.

7.1.2 **From Internal Sources**

The Medical Staff Office, or its agent, shall collect all relevant information since the time of the member's last appointment regarding the individual's professional and collegial activities, performance, technical skills and conduct in the Hospital. Such information may include:

7.1.2.1 Findings from the performance review and utilization management activities;
7.1.2.2 Participation in relevant continuing education activities or other training or research programs at the Hospital;
7.1.2.3 Level of clinical activity at the Hospital;
7.1.2.4 Information from Risk Management;
7.1.2.5 Health status;
7.1.2.6 Timely and accurate completion of medical records;
7.1.2.7 Cooperativeness in working with other practitioners and hospital personnel;

7.1.2.8 General attitude toward and interaction with peers, patients and Hospital personnel and will include results from patient satisfaction and employee surveys as available; and

7.1.2.9 Compliance with all applicable Bylaws of the Medical Staff, AHP rules and regulations, and policies and procedures of the medical staff and Hospital;

7.1.3 **From External Sources**

The Medical Staff Office shall collect relevant information since the time of the AHP's last appointment regarding the individual's professional and collegial activities, performance, clinical or technical skills and conduct. Such information may include:

7.1.3.1 Peer references including verification of clinical competency.

7.1.3.2 National Practitioner Data Bank.

7.1.3.3 Professional Liability Insurance – current coverage and any malpractice claims history resulting in settlement or judgments as reported by the National Practitioner Data Bank. Verification from prior malpractice insurance carriers will be sought if concerns are identified which necessitate further investigation.

7.1.3.4 Verification of all professional licensures or certifications to practice and sanctions against such license, termination or restriction of licensure and any previously successful or currently pending challenges to licensure, voluntary or involuntary.

7.1.3.5 Certification Status.

7.1.3.6 Attestation statement by the applicant documenting completion of Continuing Education during the time since last appointment. Documentation of Continuing Education may be requested at the discretion of the Medical Executive Committee.

7.1.3.7 AHP Staff memberships and privileges at other hospitals - for relevant professional experience and termination or restriction of membership or clinical privileges, voluntary or involuntary.

7.1.3.8 Medicare/Medicaid Sanctions.

7.1.3.9 DEA Registration.

7.1.3.10 Additional information from other databanks, including the NPDB, may be gathered by the Medical Staff Office or its agent, as required by the Medical Executive Committee and/or regulatory agencies.

7.1.3.11 Additional information from any Banner hospital where the practitioner has or has had privileges in accordance with the Banner Sharing of Information Policy.

7.2 **Medical Executive Committee Action**

The application will be reviewed by the Vice Chief of Staff and at the next regular meeting of the MEC, shall present the application, the supporting documentation, and any other relevant information available to it.

The MEC shall make a recommendation to the Board for reappointment or non-reappointment, special limitations, clinical privileges or defer action for further consideration.

7.3 **Final Processing and Board Action**

Final processing of reappointments follows the procedure set forth in Part 6.2.6. For purposes of reappointment, the terms "applicant" and "appointment" as used in that Part shall be read respectively, as "staff member" and "reappointment".

7.4 **Time Periods for Processing**

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 7.5. An interim reappointment may be necessary to align the practitioner with the two-year birth month reappointment cycle. All recommendations for reappointment shall be presented to the Board prior to the expiration of the appointment period.

7.5 **Reappointment of Limited Duration**

From time to time, the Medical Executive Committee may recommend a period of reappointment of less than two (2) years. These limited reappointments may be extended without completion of a new application and review required by these Rules and Regulations provided that a reappointment application is completed and processed at least once every two years. The practitioner will submit a supplemental application and any other requested information, which will be reviewed, along with any additional information deemed appropriate, by the Medical Executive Committee. An appointment may be granted for less than two (2) years in order to place the practitioner in the appropriate reappointment cycle. Such appointment is not a limited appointment.

PART EIGHT - PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES

8.1 **Procedure for Delineating Privileges**

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. When requesting additional privileges, the practitioner shall submit request in writing and submit documentation as required by privilege criteria. Medical Staff Office shall query the NPDB, AZ licensure, verify current competency, and provide documents to the Medical Executive Committee for review. If the practitioner satisfies all requirements for additional privilege(s), the Medical Executive Committee will forward favorable recommendation to the Board.

8.2 **Processing Requests**

All requests for clinical privileges shall be processed according to the procedures outlined in Parts 6 and 7 of this Credentialing Procedures Manual, as applicable.

8.3 **Consultation or Supervision**

Special requirements for consultation or supervision may be attached to any grant of privileges as a condition to the exercise of such privileges. In such cases, 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 MEC and must include reason for request.

8.4 **Advancement From Supervision**

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

PART NINE - LOA, REINSTATEMENT, RESIGNATION

9.1 **Leave of Absence**

A staff member may request a voluntary leave of absence by giving written notice to the Chief of Staff. The notice must state the reason for the leave and the approximate period of time of the leave which may not extend beyond the current term of appointment. During the period of the leave, the staff member's clinical privileges, prerogatives, and responsibilities, including payment of staff dues, are suspended. The request for such leave shall be considered by the Medical Executive Committee which shall forward its recommendation on the request to the Board for final action. A member must cover or arrange for coverage for scheduled call responsibilities and must complete all medical records prior to being granted a leave.

9.2 **Reinstatement Following Leave of Absence**

The staff member may request reinstatement of membership and privileges by sending a written notice to the Medical Staff Office. The staff member must either complete an application for reappointment, if the term of appointment has expired, or submit a written summary of relevant activities during the leave. The staff member must also provide evidence of current licensure, DEA registration, liability insurance coverage, and evidence of freedom from tuberculosis. The procedures in Part 6.2 of these Rules and regulations shall be followed in evaluating and acting on the request for reinstatement.

9.3 **Resignation**

Practitioners on the Allied Health Staff who wish to resign their membership may do so by sending or delivering a written notice to the Medical Staff Office. Such notice should include the date the practitioner wishes to have his or her resignation become effective. A voluntary resignation from the staff shall be effective after the practitioner has completed and signed all medical records for which he or she is responsible and acceptance of resignation by the Board.

9.4 **Reinstatement Following Resignation**

Practitioners may request reinstatement of membership and privileges within six (6) months of resignation date by sending written notice to the Medical Staff Office, completing an application for reappointment and providing a summary of relevant activities from the time of resignation, which will be verified. If the practitioner requests reinstatement within 30 days of the Board's acceptance of the resignation, a reappointment application will not be required as long as the practitioner's term has not expired, licensure, DEA and liability insurance coverage are current, as well as evidence of freedom from tuberculosis. Practitioners requesting reinstatement of membership and privileges more than six (6) months from resignation date must complete a new application for staff membership and privileges as described in Part 6. Appointment Procedures of these Rules and Regulations and must submit an initial application fee.

9.5 **Process for Reinstatement**

Requests for reinstatement of membership and privileges must be approved by the Medical Executive Committee and the Board before privileges may be reactivated.

PART TEN - DELAYS, REAPPLICATIONS, AND REPORTING

10.1 **Delays**

All applications will be processed within a reasonable period of time. However, any practitioner who believes that his or her request for membership and or privileges has been improperly delayed may request the Chief of Staff to investigate the reason for such delay. The Chief of Staff shall inform the practitioner of the reasons for the delay, if a delay has occurred, and shall notify the practitioner of the additional time expected to be necessary to act upon the practitioner's request.

10.2 **Reapplication after Adverse Committee Decision**

Except as otherwise provided in the Bylaws of the Medical Staff or as determined by the Medical Executive Committee in light of exceptional circumstances, an applicant or staff member who has received a final adverse decision regarding appointment or reappointment or clinical privileges is not eligible to reapply to the Allied Health Staff or for the denied privileges for a period of one (1) year from the date of the notice of the final adverse decision. Any such reapplication will be processed in accordance with the procedures set forth in Part 6 of these Rules and Regulations. The applicant or staff member must submit such additional information, as the medical staff and the Board may require, to demonstrate that the basis of the earlier adverse action no longer exists. If such information is not provided, the request will be considered incomplete and voluntarily withdrawn.

10.3 **Requests While Adverse Recommendation is Pending**
No applicant or staff member may submit a new application for appointment, reappointment, or clinical privileges while an adverse recommendation is pending. The Medical Executive Committee shall not submit to the Board any additional recommendations regarding a practitioner while an adverse recommendation is pending.

10.4 **Reporting Requirements**
The Hospital shall comply with any reporting requirements applicable under the Health Care Quality Improvement Act of 1986, including required reporting to the NPDB, and under the Arizona Revised Statutes. The Hospital shall also comply with the Banner Sharing of Information Policy.

PART ELEVEN - AMENDMENT AND ADOPTION

11.1 **Amendment**
These Allied Health Professional Rules and Regulations may be amended in accordance with the Bylaws of the Medical Staff.

11.2 **Adoption**
Approved and adopted by resolution of the Banner Health Board of Directors on March 14, 2013, upon the recommendation of the Medical Executive Committee.