MEDICAL STAFF

Adopted: June 2014

BANNER BOSWELL MEDICAL CENTER
SUN CITY, ARIZONA

MEDICAL STAFF BYLAWS

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PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Boswell Medical Center (the "Medical Center") 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 relations between the organized Medical Staff and applicants to, and members of, the Medical Staff. 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 of Banner Health (the "Board").

INDEMNIFICATION

Indemnification for Medical Staff activities shall be provided by Banner Health pursuant to the policy adopted by the Board.

ARTICLE ONE: NAME

The organizational component of Banner Health to which these Bylaws are addressed is called "The Medical Staff of Banner Boswell Medical Center."

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 PURPOSES

The purposes of the Medical Staff are:

2.1-1 The primary function of the organized Medical Staff is to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges, and to approve and amend the Medical Staff bylaws.

2.1-2 To continually provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Boswell Medical Center.

2.1-3 To provide a mechanism for accountability to the Board 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 Medical Center 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 Medical Center 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 give input to the Board and CEO on medico-administrative issues and on Medical Center policy-making and planning processes.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff through its departments, 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 Medical Center, 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; and

(d) Promoting the appropriate use of Medical Center resources.

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

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 that are consistent with sound professional practices, and to enforce compliance with them.

2.2-5 To participate in the Medical Center'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 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 department rules and regulations:

3.1-1 LICENSURE

Evidence of a currently valid, unrestricted license, issued by the State of Arizona to practice medicine, dentistry, podiatry, psychology or audiology. Evidence of a currently valid, unrestricted license by another state will be accepted for federally employed military staff who treat only military patients and their families.

3.1-2 PROFESSIONAL EDUCATION AND TRAINING

(a) Applicants must have graduated from an approved medical, dental, podiatric school or school of osteopathy or attainment of a PhD, PsyD, or EdD degree in psychology. Foreign Medical Graduates must be certified by the Educational Council for Foreign Medical Graduates, or must have successfully completed the Foreign Medical Graduate Examination in the Medical Sciences. For purposes of this section, an "approved" or "accredited" school is one fully accredited for the entire time of the 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, by the Commission on Dental Accreditation, by the American Podiatric Medical Association, or by a successor agency to any of the foregoing; and

(b) Applicants (other than podiatrists, dentists, psychologists and audiologists) must demonstrate satisfactory completion of postgraduate training in an internship or residency accredited by the ACGME, the AOA, or the Royal College of Physicians and Surgeons of Canada, with such postgraduate training to be in a field or specialty appropriate and acceptable to the department to which the applicant would be assigned if appointed to the Staff. Applicants must provide evidence that he/she is within the board examination system or board certified in the specialty in which privileges have been requested; and

(c) Applicants for the Affiliate Staff who are podiatrists and dentists must demonstrate satisfactory completion of at least one year of postgraduate training accredited by the American Podiatric Association, the Council on Podiatric Medical Education (CMPE) or the National Commission on Accreditation of Dental Schools; and

(d) Applicants for the Affiliate Staff who are psychologists must possess a PhD, PsyD, or EdD degree in psychology from a program approved by the American Psychological Association, possess certification by the American Board of Professional Psychologists, be currently listed in the National Register of Health

Services Providers in Psychology, or meet the educational requirements for licensure in the State of Arizona. Applicants must also demonstrate at least one year of full-time experience or its equivalent in an inpatient setting (either pre- or post-doctoral) or in a mental health care setting.

(e) Hold a Master's or Doctoral degree in Audiology and hold a Certificate of Clinical Competency in Audiology from the American Speech-Language-Hearing Association.

(f) The right to request conflict resolution of any issue by presenting to the Medical Executive Committee a petition signed by at least one-third of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will schedule a meeting to discuss the issue.

3.1-3 **BOARD CERTIFICATION OR QUALIFICATION**

(a) Membership on the Medical Staff does not require board certification. However, except as specifically provided below, having Medical Staff privileges to practice at the Medical Center requires the applicant and Members to either be board certified or board qualified followed by board certification as provided in Section 3.1-3(c) by one of the following:

1. Physician: The American Board of Medical Specialties, the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada;

2. Podiatrist: The American Board of Podiatric Surgery; The American Board of Podiatric Orthopedics and Primary Podiatric Medicine; the American Podiatric Medical Association, or the Council on Podiatric Medical Education (CPME) or by a successor agency to any of the foregoing;

3. Dentist: The American Dental Association; or

4. Psychologist: The American Board of Professional Psychologists.

5. Audiology: No certification required.

(b) For purposes of this section, "Board certification" or "Board certified" means the applicant/member 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 department to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the applicant/member has completed the necessary training and has applied for and been accepted to become 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/member 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.

(c) Where Medical Staff privileges are granted on the basis of being Board certified or qualified for Board certification the applicant must be certified or qualified in the specialty to which privileges are granted or applied for. Where Medical Staff privileges are granted on the basis of being board qualified, board certification must be obtained within five years of completion of training, or sooner as required by the department. Failure to become board certified within the time allowed under these Bylaws or the Rules and Regulations of the Member's department or section shall result in the voluntary, automatic relinquishment of the Member's Medical Staff privileges.

(d) Physicians who were members of the Medical Staff prior to September 1, 2008 shall not be required to obtain or maintain board certification unless the Department to which such physician was assigned required such physicians to be board certified or board qualified. In addition, exceptions to the requirement to be board certified or board qualified may be granted in the following circumstances as determined by the Medical Executive Committee:

1. When the Board requires time to determine that a recently graduated physician who has submitted an application is board qualified, the physician will be deemed Board qualified for up to six months.

2. When a particular field or specialty of the department does not have a Board certification;

3. When the applicant's privileges are limited to surgical assisting only; or

4. To applicants/members where there is a shortage of qualified Medical Staff members in the practitioner's specialty necessary to meet the Medical Center'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.

(e) Subject to the waiver provisions set forth in paragraph (f) below, Members who are board certified are required to remain board certified. Recertification must be obtained within three years from the expiration of board certification or recertification or within such shorter time period if required by the Department. Subject to the waiver provisions set forth in paragraph (f) below. Failure to become recertified within the time allowed under these Bylaws shall result in the voluntary, automatic relinquishment of Medical Staff privileges. In addition to the provisions for granting a waiver of the board certification requirement, the Medical Executive Committee may consider extending membership in cases where:

1. a practitioner has been certified, has taken the exam and is awaiting results, or has the exam scheduled; or

2. a practitioner has submitted evidence of a particular medical, physical, family, or financial hardship that causes him/her unable to become recertified within the required time frame. In this instance, the practitioner must sit for the next available board exam to become certified or recertified. In the event the practitioner fails to become certified or recertified or does not take the exam, privileges will be immediately forfeited.

(f) A member of the Medical Staff who was, but is no longer board certified but does not qualify for any of the exceptions described above, but who has demonstrated his/her clinical competence through his or her activities at the Medical Center, may request a waiver of the requirement that such Member be board certified. Any such request must be made in writing and state the reasons why the Member is no longer board certified, what requirements such Member must meet to become board certified, or why such Member believes this requirement should be waived. Such request must also include information and documentation to establish that the physician is currently clinically competent based upon regular involvement in the care of patients at the Medical Center and in compliance with the Medical Center's quality metrics. The waiver may be granted only if approved by a vote of 75% of the members of the Medical Executive Committee in attendance at a duly called meeting and by the Board of Directors of the Medical Center. Any Member who is granted a waiver under this Paragraph must obtain a minimum of eighty (80) hours of continuing medical education in the Member's specialty every two (2) years in order to remain a member of the Medical Staff. Evidence of such continuing medical education shall be submitted to the Medical Staff Services Office of the Medical Center each year on or before the anniversary date of such Member's date of appointment to the Medical Staff. The failure by a Member who has been granted a waiver pursuant to this Paragraph to obtain required CME will result in the voluntary relinquishment of Medical Staff privileges.

(g) Members or prior Members of the Medical Staff who are not board certified and who are no longer board qualified may request to be granted a waiver in the manner specified in paragraph (f) above.

3.1-4 CLINICAL PERFORMANCE

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

3.1-5 PROFESSIONALISM

Demonstrated ability and willingness 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 as well as employee satisfaction. It is the policy of the Medical Center 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. Failure to do so may constitute disruptive behavior. Disruptive behavior by any practitioner against any individual (e.g., against another Medical Staff member, house staff, Medical Center employee, patient, or visitor) shall not be tolerated. Members/applicants who participate in activities constituting "disruptive

conduct" as described in the Professional Conduct Policy shall be considered to lack the qualifications required by this Section 3.1-5. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken.

3.1-6 **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.

3.1-7 **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.

3.1-8 **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.

3.1-9 **ABILITY TO PARTICIPATE IN FEDERAL PROGRAMS**

Practitioners seeking membership must demonstrate that they are not currently suspended, excluded, barred or sanctioned under the Medicare program, any Medicaid programs, including AHCCCS, or any other federal program for the payment or provision of medical services or any other government licensing agency, and are not listed by any federal agency as barred, excluded or otherwise ineligible for federal program participation.

3.1-10 **VERBAL AND WRITTEN COMMUNICATION SKILLS**
Ability 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.

3.1-11 **PROFESSIONAL LIABILITY INSURANCE**

Evidence of professional liability insurance, of a kind, and in an amount, satisfactory to the Board.

3.1-12 **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 specialty 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 Medical Center.

3.1-13 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 Medical Center, to professional qualifications, to the Medical Center's purposes, needs and capabilities, or to community need.

3.1-14 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, referring, federally employed military and community-based staff and as otherwise provided in these Bylaws. Members of the Medical Staff who were appointed or had applied prior to September 1, 2008 shall be grandfathered with respect to the requirements of Section 3.1-3.

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 working with his/her respective Department Chairman. 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 challenge any rule or policy established by the Medical Executive Committee by presentation to the Medical Executive Committee of a petition signed by at least 10% 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;

(c) The right to request a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;

(d) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken.

(e) The right to request a review by the Medical Executive Committee in the event that nonreviewable corrective action is taken.

(f) The right to request conflict resolution of any issue by presenting to the Medical Executive Committee a petition signed by at least one-third of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will schedule a meeting to discuss the issue.

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, department rules and regulations, and all other standards and policies of the Board, the Medical Staff and Medical Center;

(c) Discharge such staff, committee, department, and Medical Center functions for which he or she is responsible, including review and supervise the performance of other practitioners and serve on the on-call roster for charity, unassigned, and emergency patients;

(d) Prepare and complete in timely fashion, according to these Bylaws and to Medical Center policies, the medical and other required records for all patients to whom the practitioner provides care in the Medical Center, or within its facilities, services, or departments;

(e) Communicate with patients and make entries in Medical Center medical records solely in accordance with, and to the extent authorized by, Medical Staff Rules and Regulations;

(f) Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and to obtain consultation when necessary for the 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 any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or the Medical Center;

(l) Refrain from making treatment recommendations/decisions for economic benefit of the practitioner and unrelated to requirements of patients' insurance plans, including refraining from transferring patients to facilities where the practitioner, his/her group or his/her employer has an ownership interest when appropriate services are available on the Medical Center campus; and

(m) Disclose 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) Each member of the Medical Staff is expected to comply with all governmental laws and regulations relating to the provision of medical services, and to conduct his/her practice in the Medical Center at all times in a manner that will satisfy all standards, requirements and conditions necessary for the Medical Center to maintain licensure, accreditation and certification for participation in all applicable governmental and private payment programs to which it is a party.

(o) Each staff member shall serve on the on-call roster for charity, unassigned and emergency patients as determined by the applicable department, the Medical Executive Committee and the CEO.

3.4 TERM OF APPOINTMENT

Appointments to the Medical Staff and grants of clinical privileges are for a period not to exceed two years.

3.4-1 EXPIRATION

(a) 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 below.

(b) The Board, after considering the recommendations of the Medical Executive Committee, may set a more frequent reappraisal 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.

(c) An interim reappointment may be necessary to align the practitioner with the two-year 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 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 taken under these Bylaws and the Fair Hearing Plan shall be the right to seek injunctive relief pursuant to ARS 36-445 et. seq. No applicant to or member of the Medical Staff shall be entitled to monetary relief from the Medical Staff, the Medical Center or any third party, including any employee, agent or member of the Medical Staff or the Medical Center or any person engaged in peer review activities as a result of a breach or an alleged breach of any provision of these Bylaws and/or the Fair Hearing Plan.

3.7 RESIGNATIONS

Resignations from the Medical Staff, including voluntary relinquishments of clinical privileges, require fifteen (15) days written notice. All bylaws, rules and regulations, policies and obligations, including Emergency Department on-call assignments, shall continue to apply in the interim period.

3.8 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.8-1 QUALIFICATIONS

A practitioner who is or who will be providing professional 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 any other staff member. This section shall not apply to outside practitioners assisting the Medical Staff with its peer review functions.

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

(b) Termination of such employment or contracts shall not result in automatic termination of Medical Staff membership and privileges unless the practitioner meets the qualifications for privileges under a non-employed/non-contracted specialty or if the applicable contract for services is not an exclusive contract otherwise provided in the applicable contract in the applicable contract for professional services.

(c) The CEO will inform the Medical Executive Committee upon establishment of a full-time or part-time contracted or employed group or physician position.

3.9 EXCLUSIVE AGREEMENTS

The Medical Center may enter into an Exclusive Agreement with members of the Medical Staff which limit the rights of other practitioners to exercise some or all of the clinical privileges and/or the rights and prerogatives of Medical Staff membership previously granted to them. Such Agreements may only be entered into after a determination that expected improvements to and/or continuation of the quality of care, coverage, cost-efficiency and 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 a practitioner's privileges or membership are limited because an Exclusive Agreement is entered into, and no such reports shall be made.

3.9-1 REVIEW OF POSITIONS

(a) Prior to entering into an Exclusive Agreement for a program or service not previously covered by an Exclusive Agreement, and prior to renewing or transferring 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 achieve 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, renewed or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care, including information relating to the

qualifications of the practitioners who would be providing services under the Agreement, and whether the Agreement is necessary to achieve the expected benefits. The report must be submitted, if at all, within 60 days of when the CEO provided the Medical Executive Committee with an explanation of the need for, and expected benefits of, the Agreement. The CEO is ultimately responsible for determining, at his/her discretion, whether to enter into, renew or transfer the Agreement.

(d) In the event the Medical Executive Committee disagrees with the decision of the CEO to enter into, renew or transfer an Exclusive Agreement, the Medical Executive Committee may request that the decision be reviewed by a Joint Conference Committee as set forth in Section 14.1. The request must be made, if at all, within 10 days of when the Medical Executive Committee's receives notification of the CEO's decision.

3.10 MEDICAL DIRECTORS

A medical director is a practitioner engaged by the hospital either full or part-time in an administrative capacity in accordance with Article Six of these Bylaws. Where provided for by contract, a medical director's responsibilities shall include assisting the Medical Staff to carry out its peer review and quality improvement activities. Medical Directors must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1.

3.10-1 MEDICAL DIRECTOR, CARE COORDINATION

The Medical Director of Care Coordination (MDCC) shall automatically be granted Active Staff membership and serve as an ex-officio member without vote on Medical Staff Committees consistent with the scope of his or her responsibilities as related to care coordination and/or utilization management. For the MDCC to exercise privileges at the facility he/she must apply for membership and privileges in the manner described in these Bylaws and must continuously satisfy the qualifications and complete the requirements set forth in Sections 3.1 and 5.2.

3.11 GRADUATE MEDICAL EDUCATION

Participants in approved training programs at the Medical Center, in the role of a medical student, intern, resident and/or fellow are not credentialed as members of the Medical Staff and provide patient care/services within the scope of individual competency and prescribed program structure. Each participant shall be supervised, as defined in Administrative Policies and Procedures and the Medical Staff Rules and Regulations.

3.12 CHIEF MEDICAL OFFICER

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.

3.13 CREDENTIALING PROCESS

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

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.0 CATEGORIES

There will be five categories of appointment to the staff; active, courtesy, affiliate, referring and honorary.

4.1 ACTIVE STAFF

4.1-1 QUALIFICATIONS FOR ACTIVE STAFF

The active staff shall consist of physicians who demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center or are regularly involved in the care of patients in the Medical Center facilities. Active staff must admit or otherwise be involved in a minimum of 50 patient admissions, consultations, inpatient/outpatient procedures at the

Medical Center and OR demonstrate substantial involvement in Medical Staff or hospital activities by attending at least one-third of his or her department and/or committee meetings and one General Staff meeting every two years. Active staff must document his/her efforts to support the Medical Center's patient care mission to the satisfaction of the Medical Executive Committee and Board. Active Staff status may be requested, when qualifications are met, any time after the first year.

Physicians in the Active Category with no clinical privileges will be categorized as Active Staff – No Clinical Privileges.

4.1-2 **PREROGATIVES OF ACTIVE STATUS**

An active staff member may:

(a) Exercise such clinical privileges as are granted by the Board.

(b) Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member; and

(c) 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.

4.1-3 **OBLIGATIONS OF ACTIVE STATUS**

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 organizational, administrative, quality and patient safety reviews, and utilization management activities of the Medical Staff, and faithfully perform the duties of any office or position to which elected or appointed; and

(b) Pay all staff dues and assessments as required.

4.1-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure of an active staff member to satisfy the qualifications or obligations of the active staff category for any reappointment period 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.

4.2 **COURTESY STAFF**

4.2-1 **QUALIFICATIONS**

The Courtesy Staff shall consist of physicians who admit patients to the Medical Center only on an occasional basis or are only occasionally involved in the affairs of the Medical Staff or Medical Center. Practitioners who practice remotely, in any fashion, will be appointed to the Courtesy category (i.e. telemedicine, teleradiology).

4.2-2 **PREROGATIVES**

A Courtesy Staff member may:

(a) Admit patients, except as set forth in department rules and regulations, privilege criteria and Medical Center admission policies;

(b) Exercise such clinical privileges as have been granted by the Board;

(c) Demonstrate his/her continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers.

(d) Be appointed to committees unless otherwise provided by these Bylaws; and

(e) Vote on matters presented at committees to which he or she has been appointed and at department meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.2-3 **OBLIGATIONS**

A Courtesy Staff member must meet the basic obligations set forth in these Bylaws, including the applicable provisions of Section 3.3, and pay all staff dues and assessments.

4.2-4 **CHANGE IN STAFF CATEGORY**

Upon request or at the time of reappointment, Courtesy Staff members may be advanced to the active staff category if the qualifications set forth in 4.2-1 are satisfied.

4.3 **AFFILIATE STAFF**

4.3-1 **QUALIFICATIONS**

The Affiliate Staff shall consist of dentists (not including oral surgeons), podiatrists, psychologists and audiologists who treat patients at the Medical Center or who are involved in the affairs of the Medical Staff or Medical Center.

4.3-2 **PREROGATIVES**

An Affiliate Staff member may:

(a) Exercise such clinical privileges as have been granted by the Board;

(b) Demonstrate his/her continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers;

(c) Be appointed to committees unless otherwise provided by these Bylaws; and

(d) Vote on matters presented at committees to which he or she has been appointed and at department meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.3-3 **OBLIGATIONS**

An Affiliate Staff member must meet the basic obligations set forth in these Bylaws, including the applicable provisions of Section 3.3, and pay all staff dues and assessments.

4.4 **REFERRING CATEGORY**

4.4-1 **QUALIFICATIONS**

The Referring Staff shall be composed of physicians who do not apply or are not eligible for clinical privileges. Members of the Referring Staff must meet all minimum eligibility requirements for Medical Staff membership with the exception of Board certification.

4.4-2 **RESPONSIBILITIES**

Each member of the Referring Staff must provide the name(s) of a physician(s) (who must be an appointee to the Medical Staff with clinical privileges) who agrees to accept those of the Referring Staff member's patients who present to the Emergency Department or require admission. The Referring Staff member must

update covering physician information with the hospital immediately if the agreement terminates or if the Referring Staff member changes covering physicians.

4.4-3 **PREROGATIVES**

Appointees to the Referring Staff may not admit patients, treat patients, or write orders for patient care. Appointees to the Referring Staff shall not be eligible to vote, hold office or hold committee chairmanships. If a Referring Staff member desires full staff status and clinical privileges, the practitioner must complete the full credentialing process and meet all eligibility requirements for clinical privileges as outlined in these bylaws.

4.5 **COMMUNITY-BASED PHYSICIANS**

Community-based physicians are physicians who request Medical Center services for their patients and wish to be affiliated with the Medical Center. Community-based physicians are not members of the Medical Staff and do not have clinical privileges at the Medical Center.

4.5-1 **QUALIFICATIONS**
Physicians seeking to affiliate with the Medical Center must apply for community-based status and provide evidence of the following qualifications:

(a) Arizona licensure in good standing;

(b) Ability to participate in Medicare/AHCCCS and other federally funded health programs;

4.5-2 **PREROGATIVES**

The prerogatives of community-based physicians are to:

(a) Order Medical Center outpatient diagnostic services for patients;

(b) Access Medical Center information, via Clinical Connectivity, for their own patients;

(c) Attend Continuing Medical Education programs at the Medical Center;

(d) Receive Medical Staff Newsletters and other Medical Center Publications;

(e) Attend department and general staff meetings.

4.5-3 **OBLIGATIONS**

Community-based physicians must agree to use Medical Center patient information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations.

Denial or termination of community-based status: Community-based physicians or physicians seeking community-based status are not entitled to due process rights under the Fair Hearing Plan. A physician who believes he or she was wrongly denied community-based status or whose status was terminated may submit information to the Medical Executive Committee, demonstrating why the denial 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 Medical Executive Committee's decision.

4.6 **HONORARY STAFF**

4.6-1 **QUALIFICATIONS**
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 long-standing service to the Medical Center or other noteworthy contributions to its activities.

4.6-2 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; are exempt from the reappointment process; and are not required to pay dues or assessments. Honorary staff members are not allowed to admit or treat patients or to consult.

4.7 FEDERALLY EMPLOYED MILITARY STAFF

4.7.1. QUALIFICATIONS

The Federally Employed Military Staff shall consist of physicians and dentists who desire to treat patients who are eligible for care at military health facilities and who continuously satisfy the qualifications set forth in Section 3.1, except that Federally Employed Military Staff need not hold an Arizona license, provided they hold a current license to practice in one of the 50 states.

A Federally Employed Military Staff member who desires to treat civilian patients, (i.e. emergency room call) must provide evidence that all general qualifications for staff membership and privileges are met. This includes holding an active, unrestricted Arizona license.

4.7.2 PREROGATIVES

The Federally Employed Military Staff member may:

(a) Admit patients who are eligible for care at military health facilities; or if covering emergency room call, may admit civilian patients provided adequate arrangements for follow-up care are in place.

(b) Exercise such clinical privileges as are granted by the Board;

(c) Be appointed to committees;

(d) Vote on matters presented at committees to which he or she has been appointed;

(e)Participate in education programs.

4.7.3 OBLIGATIONS

The Federally Employed Military Staff members must meet the basic obligations set forth in these Bylaws, including in Section 3.2, and pay all staff dues and assessments as required.

ARTICLE FIVE: APPLICATION PROCESS AND DELINEATION OF PRACTICE PRIVILEGES

5.1 APPLICATION PROCESS

5.1-1 PROCESS FOR PRACTITIONERS TO APPLY FOR MEMBERSHIP AND PRIVILEGES

Completed applications for membership and privileges must be submitted at the time of initial appointment to, or as otherwise directed by, the Medical Center's Medical Staff Office, who then will submit the application to the Chairman of the Department in which the applicant seeks privileges and to the Credentials Committee. Expedited applications for initial appointment and completed applications for reappointment must also be submitted to, or as otherwise directed by, the Medical Center's Medical Staff Office, who then will submit such applications for review and action in accordance with the processes set forth in the Credentialing Procedures Manual. The procedures for processing and acting on applications for appointment and reappointment to the Medical Staff are set forth in further detail in the Credentialing Procedures Manual. Expedited applications for initial appointment may be approved by a subcommittee of the Board that is delegated authority by the Board to act on its behalf in approving such applications.

5.1-2 **PROCESS FOR ALLIED HEALTH PROFESSIONALS TO APPLY FOR PRIVILEGES**

Completed applications by allied health professionals ("AHPs") applying for initial appointment and privileges (scope of practice) and completed applications by practitioners applying to be appointed to the ancillary staff ("Ancillary Staff") must be submitted to, or as otherwise directed by, the Medical Center's Medical Staff Office, who will then submit the application to the Chairman of the Department in which the applicant seeks privileges for review and action in accordance with the applicable Credentialing Policies and Procedures. Completed applications for reappointment must be submitted by AHPs and Ancillary Staff to, or as otherwise directed by, the Medical Center's Medical Staff Office who will process such applications in accordance with the applicable Credentialing Policies and Procedures.

5.2 **EXERCISE OF PRIVILEGES**

5.2-1 **IN GENERAL**

a) The following must be successfully completed, as applicable, prior to exercising privileges at the Medical Center:
   - Banner's electronic medical record/computerized physician order entry (CPOE) training; and
   - Banner's electronic New Provider orientation (NPO)

   Exceptions may be made for practitioners granted temporary disaster privileges.

b) Except in an emergency, a practitioner providing services at the Medical Center may exercise only those clinical privileges specifically granted.

5.2-2 **PRIVILEGES IN EMERGENCY SITUATIONS**

In 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, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of department affiliation, staff category, or 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.

5.2-3 **EXPERIMENTAL PROCEDURES**

Any drugs, procedures or other therapies or tests which are deemed to be experimental by the Banner Institutional Review Board ("Experimental Procedures") may be performed only after applicable protocols have been approved by the Banner Institutional Review Board and only after the regular credentialing process has been completed and privileges to perform and/or use such Experimental Procedures have been granted to the practitioner.

5.3 **PROCEDURE FOR DELINEATING PRIVILEGES**

5.3-1 **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 Manual. When requesting additional privileges, the practitioner shall submit the request in writing and submit documentation as required by privilege criteria. Medical Staff Services shall query the NPDB, applicable AZ licensing board and OIG and provide all documents to the Department Chairman for review. If the practitioner satisfies all requirements for the additional privilege(s), the Department Chairman will forward the file to the Credentials Committee, Medical Executive Committee and the Board.

5.3-2 **SUPERVISION**

Whenever a practitioner is required by the Medical Staff to be supervised, the practitioner is responsible for making these arrangements. After completion of such supervision requirements, the observation reports

and other required documentation will be submitted to the appropriate Department Chairman for review. Where the practitioner has successfully completed the requirements, the Department Chairman may grant unobserved privileges, subject to ratification by the Credentials Committee, Medical Executive Committee and the Board.

5.3.3 PROCEDURE FOR DELINEATING PRIVILEGES

Practitioners who have an "office based practice" will be sent a letter requesting the number and types of procedures performed during the previous two year period or provide copies of ten (10) history and physical exams. In additions, a competency reference will be forwarded to a peer who can attest to the practitioner's clinical competency within the last twelve (12) months.

5.4 BASIS FOR PRIVILEGES DETERMINATIONS

Clinical privileges shall be granted in accordance with education and training, experience, current licensure, utilization practice patterns, current health status, and demonstrated 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, supervised cases, 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.

5.5 PRIVILEGE DECISION NOTIFICATION

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

5.6 PRIVILEGES FOR NEW PROCEDURES

Departments will consider new technologies and procedures to determine whether the privilege to use such technologies or perform such procedures is subsumed under existing core or other privileges or requires additional education and training, experience and demonstrated competence and/or new staff competencies. Physicians desiring to utilize new technologies or perform new procedures may do so once the Medical Executive Committee has considered and approved the department's recommendation to create/not create new criteria and reappointment criteria for privileges and, where new and reappointment criteria are established, has determined that the physician has demonstrated that he/she has the necessary qualifications. The Medical Executive Committee's determination is subject to ratification by the Banner Board.

5.7 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES

5.7-1 REQUEST FOR PRIVILEGES

As a result of emerging technology, practitioners in different specialties may be qualified by training, demonstrated competence, and judgment to perform procedures traditionally under the jurisdiction of one department. In the event that a practitioner requests privileges to perform a procedure not currently within the jurisdiction of his or her department, the practitioner will notify the Chief of Staff in writing. The notice must contain basis for such practitioner's determination that he or she is qualified for the requested privileges, including proof of training and number of procedures performed.

5.7-2 DETERMINATION OF APPROPRIATENESS

The Chief of Staff, with the approval of the Medical Executive Committee, will establish an interdisciplinary Ad Hoc Committee or request the Credentials Committee and/or the applicable Department Chairman to evaluate the request. The Chairman of the Ad Hoc Committee shall be a disinterested person currently not performing these procedures. The Ad Hoc Committee shall give the affected practitioner and other interested persons an opportunity for an interview. After receipt of the Ad Hoc Committee's report, the

Medical Executive Committee will recommend to the Board whether inter-disciplinary privileges are appropriate and, if applicable, the criteria and process for granting such privileges.

5.8 SPECIAL CONDITIONS

5.8-1 ORAL SURGEONS AND DENTISTS

Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Chairman of the Department of Surgery. Dentists are responsible for that portion of their patients' history and physical examinations related to dentistry. An oral surgeon who meets the requisite qualifications may be granted the privilege of performing a history and physical examination and assessing the medical risks of the proposed procedure to the patient but only in those instances where the patient has no known current unrelated medical problems. Where any medical problems exist, a physician member of the Medical Staff must perform a basic medical appraisal on such patient, must determine the risk and effect of any proposed surgical or special procedure, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When significant medical abnormality is present, the final decision whether to proceed must be agreed upon by the oral surgeon or dentist and the physician consultant. The chairman of the Department of Surgery will decide the issue in case of dispute. Where the patient is an inpatient, the oral surgeon or dentist must arrange for a physician member of the Medical Staff to be an attending physician. (Per DHS reg R9-10-207)

5.8-2 PODIATRISTS

Surgical procedures performed by a podiatrist are under the overall supervision of the Chairman. Podiatric inpatients and outpatients must receive a complete medical history and physician examination by a practitioner who has been granted privileges to perform the examination.

Podiatrists are always responsible for the portion of their patient's history and physical examination that is applicable to the care to be provided to the podiatrist. A podiatrist who meets the requisite qualifications may be granted the privilege of performing a history and physical examination and assessing the medical risks of the proposed procedure to the patient but only in those instances where the patient has no known current unrelated medical problems. Where any medical problems exist, a physician member of the Medical Staff must perform a basic medical appraisal on such patient, must determine the risk and effect of any proposed surgical or special procedure, and must be responsible for the care of any medical problem When significant medical abnormality is present, the final decision whether to proceed will be agreed upon by the podiatrist and the physician consultant. The chairman of the Department of Surgery will decide the issue in case of dispute. A podiatrist may write orders. Appropriate consultation will be requested as required by patient's condition.

5.8-3 CLINICAL PSYCHOLOGY PRIVILEGES

The exercise of privileges in Psychology will be in conjunction with appropriate physician Staff members. Clinical psychologists shall not have privileges to admit patients to the Medical Center, but shall see patients upon the request and recommendation of physician members of the Medical Staff.

5.8-4 EMERGENCY PRIVILEGES

In the event of an emergency, which threatens life or permanent injury, a practitioner shall do everything possible as permitted by licensure to treat the patient, regardless of departmental affiliation, Staff category, or level of privileges. A practitioner exercising emergency privileges shall as expeditiously as possible obtain appropriate consultative assistance and arrange for appropriate follow-up care.

5.9 TEMPORARY PRIVILEGES

5.9-1 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 or Department Chairman. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws and the policies of the Medical Staff and Medical Center.

5.9-2 **CIRCUMSTANCES**

Upon the recommendation of the Chief of Staff or Department Chairman, or their respective designees, the CEO or designee may grant temporary privileges in the following circumstances:

(a) Application pending final action: Temporary privileges may be granted to an applicant who has submitted a complete application that has been verified and raises no concerns, including, but not limited to, the items listed below, and has been approved by the Credentials Committee and Department Chairman, has received a favorable recommendation and is awaiting review and approval of the Medical Executive Committee and the Board.

1. current licensure and DEA certification (if applicable) with no current or previously successful challenges or restrictions,
2. relevant training or experience,
3. current competence,
4. ability to perform privileges requested,
5. query and evaluation of NPDB,
6. not been subject to involuntary termination of Medical Staff membership at another organization, and
7. not been subject to involuntary limitation, reduction, denial or loss of clinical privileges at another organization.
8. not been limited in his/her ability to participate in Medicare/AHCCCS or other federally funded health programs.

Temporary privileges may be granted to an applicant for an initial period not to exceed 90 days. One extension may be granted for an additional period not to exceed 90 days. Any such renewal shall be made by the Department Chairman and CEO or their designee 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. <u>One Time Request</u>: Temporary privileges may be granted to a practitioner for the care of a specific patient when he or she has a required skill not provided by another credentialed practitioner. The request for specific privileges and the patient care need must be documented. Verification of appropriate licensure, adequate professional liability insurance, DEA Registration, if applicable, documentation to meet privilege criteria and board certification requirements and National Practitioner Data Bank (NPDB) report will be performed prior to the granting of temporary privileges except where patient need requires otherwise. Such temporary privileges may not be granted to a practitioner more than three (3) times in any 12 month period after which the practitioner must apply for staff appointment. Such privileges shall be in effect for a specific period of time, but in no case for a time to exceed ninety (90) days or at time of the patient's discharge, whichever comes first. One additional period of ninety (90) days, or at time of the patient's discharge, whichever comes first, for temporary privileges may be granted upon recommendation by the Chief of Staff or designee. The individual must agree to fully and completely abide by the provisions of the Bylaws, Rules and Regulations Policy Manual, as well as the appropriate Department Rules and Regulations.

2. Coverage of Service: In special circumstances where a service is not adequately covered to meet patient care needs, temporary privileges may be granted upon receipt of application and verification of the following information: verification of appropriate licensure, board certification requirements, adequate professional liability insurance, and DEA Registration if applicable, receipt of education and training certificates, National Practitioner Data Bank report, and documentation required to meet privilege criteria. 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 days and may not be granted to a practitioner more than two (2) times in any twelve (12) month period.

3. Additional Privileges: Temporary privileges to perform specific procedures which have been approved to be performed at the Medical Center but for which the member has not previously been granted privileges may be granted, but only after the member has applied for such privileges and provides documentation of appropriate training and current clinical competence. Temporary privileges for specific additional procedures may not be granted more than once and may not be granted for a period of more than 90 days.

4. Locum Tenens: To a practitioner who will be serving as a locum tenens for a staff member or to fulfill an important patient care need, but only after receipt of a complete application for appointment as a locum tenens, including a request for specific privileges; and primary source verification of education, highest level of training, licensure, DEA/controlled substances registration, confirmation of adequate professional liability insurance coverage; and current competency/recent experience verification for privileges requested. The locum tenens lasts for 90 days and may be renewed for one additional 90 day period upon approval of the department chairman. A locum tenens may not be granted more than once in any 12 month period.

5.9-3 **TERMINATION**

The CEO, Chief of Staff, Department Chairman or their designee, 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 Chief of Staff, the applicable Department Chairman or their respective designees shall have the authority to provide for alternative medical coverage for the patients of the terminated practitioner who remain in the Medical Center. The wishes of the patient will be considered, where feasible, in choosing an alternate practitioner.

5.9-4 **RIGHTS OF THE PRACTITIONER**

A practitioner is not entitled to the procedural rights afforded by these Bylaws or the Fair Hearing Plan 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.

5.10 **TEMPORARY DISASTER PRIVILEGES**

5.10-1 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. In order for volunteer practitioners to be considered eligible to be granted temporary disaster privileges, the following information will be obtained: a valid government-issued photo ID such as a driver's license or passport, and at least one of the following:

(a) Current picture Medical Center ID card with professional designation

(b) Current license to practice (primary source verified)

(c) Identification indicating the volunteer practitioner 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.

(d) Identification indicating that the volunteer practitioner has been granted authority by a government entity to provide patient care, treatment or services in disaster circumstances.

(e) Confirmation by a member of the medical staff with personal knowledge currently privileged by the Medical Center 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 or completion of inpatient care, whichever occurs first, and may be terminated in accordance with Section 5.10.3. A volunteer practitioner is not entitled to the procedural rights afforded by these Bylaws because a request for disaster privileges is refused or because such privileges are terminated or otherwise limited.

5.10-1 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 practitioner begins working at the Medical Center. If not verified within 72 hours, the reason must be documented.

5.10-2 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 appropriate Department Chairman, or other designee. Clinical privileges will be based upon the specialty and training of the volunteer practitioner.

5.10-3 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 practitioner.

5.10-4 Volunteer practitioners functioning under disaster privileges will be identified as such by wearing an identification badge provided upon the granting of privileges.

5.10-5 Such privileges may be terminated in accordance with Section 5.8-3. A practitioner is not entitled to the procedural rights afforded by these Bylaws or the Fair Hearing Plan because a request for temporary disaster privileges is refused or because such privileges are terminated or otherwise limited.

5.11 TELEMEDICINE AND TELERADIOLOGY PRIVILEGES

5.11-1 The Medical Executive Committee shall determine which patient care, treatment, and services may be provided by practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine and Teleradiology 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. Under such circumstances, the requirements in 5. above shall apply.

5.11-2 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of the Medical Center. The practitioner may be privileged at the Medical Center using credentialing information from the distant site if the distant site is a Joint Commission accredited organization and if the application from the distant site meets quality standards as determined by the Medical Staff. Under this option, the Medical Center would obtain and utilize the other distant site's primary source verified information including, but not limited to, licensure, education, training, the ability to perform privileges requested, and health status. The Medical Center will re-verify licensure and perform a query of the National Practitioner Data Bank and Criminal Background Screening. The information will be used for decision making in regard to granting of telemedicine privileges. The application approval process outlined in the Credentialing Procedures Manual will apply.

5.11-3 The Medical Executive Committee shall continually evaluate the Medical Center's ability to provide these services safely, and must evaluate the performance of the services by practitioners at reappointment, renewal, or revision of clinical privileges.

5.11-4 The provider at the distant site hay have total or shared responsibility for patient care, treatment, and services as determined by the patient's attending physician.

ARTICLE 6: CORRECTIVE ACTION

6.1 CRITERIA FOR INITIATING CORRECTIVE ACTION

An investigation or a 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 Rules, Regulations or policies, or if the practitioner is or may be engaged in a course of conduct, either within or outside the Medical Center, 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 designee, 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. The Chief of Staff shall notify the practitioner of the general nature of the request orally or in writing and may communicate additional information regarding the request. The Chief of Staff may notify the Medical Executive Committee if the matter is, in his or her opinion, plainly without merit. The Medical Executive Committee may dismiss such matter with a notation on its record to that effect. If the matter may have merit, the Chief of Staff shall refer the matter to an ad hoc committee for investigation.

An ad hoc committee to investigate the matter shall be formed by the Medical Executive Committee (or the Chief of Staff acting on behalf of the Medical Executive Committee), by the Department Chairman or at the request of the Chief Executive Officer or the Board. The ad hoc committee shall report directly to the Medical Executive Committee.

The Medical Executive Committee and the Chief of Staff shall approve the appointment of the members to the ad hoc committee. Alternatively, with authorization by the Chief of Staff, the Credentials Committee may act as the investigation ad hoc committee.

(b) PROCEDURE FOR PROFESSIONAL REVIEW
Within sixty (60) days, the ad hoc investigating committee shall conclude an investigation, document its findings and make a recommendation to the Medical Executive Committee. If the ad hoc investigating committee deems it necessary and appropriate, with the approval of the Chief of Staff, the ad hoc Investigating committee may use a person not on the Medical Staff to assist in evaluating matters that it is investigating. Prior to making any adverse recommendation to the Medical Executive Committee, the affected practitioner shall have an opportunity for an interview with the ad hoc investigating committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws or the Fair Hearing Plan shall apply thereto. A record of such interview shall be made by the ad hoc investigating committee and included with its report and recommendation which shall be forwarded to the Medical Executive Committee by the ad hoc investigating committee chairman.

In certain instances, an investigation may not be concluded within sixty (60) days. In such instances, the investigation shall be concluded as soon as reasonably practicable. A sixty (60) day interim report from the ad hoc investigating committee Chairman must be made to the Department Chairman and the Medical Executive Committee stating the estimated completion date. The affected practitioner shall have no procedural rights arising out of such delay. At its next scheduled meeting, the Medical Executive Committee shall consider the recommendation of the ad hoc investigating committee. After its deliberations, the Medical Executive Committee may uphold, modify or reject the recommendation. If the recommendation includes reviewable corrective action, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws and the Fair Hearing Plan.

(c) Certain matters that may lead to corrective action are routinely considered by each Medical Staff department and/or the Peer Review Committee as a part of their 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 department or the Peer Review Committee, the Peer Review Committee shall refer the matter to the Medical Executive Committee for review and/or action.

6.3 SUMMARY SUSPENSION

A member who has been summarily suspended shall be entitled to the procedural rights set out in the Fair Hearing Plan. A suspended member's patients then in the Hospital shall be assigned to another member by the appropriate Department Chairman. Whenever possible, the wishes of the patient will be considered in choosing a substitute member.

6.3-1 INITIATION

Whenever a member's conduct indicates that immediate action should be taken to prevent injury or damage to the health or safety of any patient, employee or other person present in the Hospital, the CEO upon recommendation of the Chief of Staff and/or Department Chairman may summarily suspend appropriate privileges of the member.

A summary suspension is effective immediately upon imposition and shall continue in effect until such time as a final decision is made regarding the practitioner's privileges

6.3-2 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. The review must be requested within fifteen (15) business days of the practitioner's receipt of notice of suspension. Such review shall take place within fifteen (15) 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.

6.3-3 EXPEDITED HEARING RIGHTS

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

6.3-4 ALTERNATIVE COVERAGE

Immediately upon imposition of summary suspension, the Chief of Staff, Chairman of the Professional Review Committee, the applicable Department Chairman 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 Medical Center. Patients' wishes shall be considered in the selection of an alternative practitioner.

6.3-5 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 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 of License: Whenever a practitioner's license to practice in this state expires, the practitioner's Medical Staff appointment and clinical privileges shall immediately and automatically expire, unless the practitioner is moved to the honorary staff category

6.3-6 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.

6.3-7 MEDICAL RECORDS

A temporary suspension of privileges shall be imposed for failure to complete medical records in accordance with the Medical Staff Medical Records Policy.

6.3-8 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 3.1-12 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.

6.3-9 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 as required by law and Medical Center policy. 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.

Below will not be effective until the 2014 Flu season.

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.

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, including freedom from infectious tuberculosis and freedom from influenza.

6.3-10 ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

A practitioner who fails to provide documentation of continuous ACLS certification shall automatically have his/her privileges for moderate sedation suspended. Affected practitioners may request reinstatement of moderate sedation privileges during a period of ninety (90) days following suspension by submitting a current, valid ACLS certificate. Failure to submit ACLS certification within ninety (90) days will be processed as a voluntary relinquishment of moderate sedation privileges and the practitioner will have to reapply and meet all eligibility criteria. On-line ACLS training courses will be accepted (must be AHI or ASHI accredited).

6.3-11 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. 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 Medical Center and the Medical Staff for any

liability they might have solely as a result of a breach of this agreement. 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).

6.3-12 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, may automatically be suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Failure to appear without good cause may result in automatic suspension and/or initiation of corrective action proceedings. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.3-13 FAILURE TO PAY STAFF DUES

A practitioner who fails to pay staff dues as set forth in Section 12.3 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.

6.3-14 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, Department Chairman 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.

6.3-15 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 as required by Section 11.1 shall automatically be suspended. If, within 30 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.

6.3-16 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 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.

6.3-17 REMOVAL FROM CALL FOR FINANCIAL CONFLICTS

A practitioner who transfers patients for medical care to any diagnostic or treatment facility in which the practitioner, his/her group, or his/her employer has a direct financial interest despite available services located on the Medical Center's campus may be removed from Emergency Room call by the CEO, the Chief Medical Officer or the Board absent evidence that the transfer request was initiated by the patient or by the patient's insurance carrier. Removal from call under this Section does not preclude the imposition of other corrective action as a result of inappropriate transfers.

6.3-18 FAILURE TO BECOME BOARD CERTIFIED

Except as provided in Section 3.1-3, whenever a practitioner's time period in which to become board certified expires, the practitioner is deemed to have immediately and voluntarily relinquished his/her Medical Staff clinical privileges.

6.3-19 FAILURE TO COMPLETE CPOE TRAINING

A practitioner who fails to complete CPOE training in accordance with the timelines established by the Medical Center shall automatically be suspended. Any such practitioner who fails to complete such training within six (6) months of appointment to the Medical Staff shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges. Exceptions will be made on a case by case basis to be determined by the facility CEO.

6.3-20 FAILURE TO OBTAIN NPI AND ENROLL IN PECOS/OPT OUT OF MEDICARE (EFFECTIVE WHEN CMS IMPLEMENTS)

A practitioner who has not obtained a National Provider Identification Number (NPI) shall be automatically suspended. A practitioner who is not enrolled in the Provider Enrollment Chain, and Ownership System; (PECOS) or who has not submitted the required affidavit to the Medicare Carrier to opt out of the Medicare Program and who fails to enroll or opt out within 10 business days of being requested by Banner to enroll or opt out shall automatically be suspended. If evidence that the practitioner has obtained an NPI and/or has enrolled in PECOS or has opted out of Medicare 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.

6.4 REVIEWABLE ACTIONS

The following actions are considered reviewable under the Fair Hearing Plan except when a version of the action is considered "non-reviewable" under the subsequent definition.

(a) Denial of initial Staff appointment.

(b) Denial of reappointment.

(c) Revocation of Staff appointment.

(d) Denial or restriction of requested clinical privileges.

(e) Reduction in clinical privileges.

(f) Revocation of clinical privileges.

(g) Individual application of, or individual changes in, mandatory concurring consultation requirement.

(h) Suspension of staff appointment or clinical privileges.

(i) Removal from Staff for refusing to provide information to a Medical Staff Committee and/or Department concerning quality review or care issues.

6.5 NONREVIEWABLE ACTIONS

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 6.3 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) Termination of any contract with or employment by the Medical Center.
(f) Any recommendation voluntarily accepted by a practitioner.

(g) Denial of membership and privileges for failure to complete an application for membership or privileges.

(h) Removal of membership and privileges for failure to complete supervision within the time period specified in these Bylaws.
(i) Removal of membership and privileges for failure to complete supervision as may be required by the Medical Executive Committee or the Medical Staff department in which privileges are granted.

(j) Reduction or change in staff category.

(k) Refusal of credentials committee, department, or Medical Executive Committee to consider a request for appointment, reappointment, staff category, department assignment, or privileges within one year of a final adverse decision regarding such request.

(l) Removal or limitation of Emergency Department call obligations.

(m) Any requirement to complete an educational assessment or training program.

(n) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.

(o) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.

(p) Retrospective chart review.

(q) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the Medical Center 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.

(r) Grant of conditional appointment/reappointment **or** appointment/reappointment for a limited duration.

(s) Automatic suspension of Allied Health/Ancillary Staff membership and privileges due to loss of sponsoring physician.

Where an action that is not reviewable under these Bylaws or the Fair Hearing Plan has been taken against a practitioner, the affected practitioner may request review of the action and may submit information demonstrating why the action is unwarranted. Depending upon the nature of the action and the Committee or individual who took the action, the Medical Executive Committee or the CEO shall consider the request and decide, in its/his/her sole discretion, 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 or CEO's decision.

6.6 HEARING AND APPEAL RIGHTS

6.6-1 HEARINGS AND APPELLATE REVIEW

When a reviewable action has been taken against an applicant or member of the Medical Staff, such practitioner shall be afforded the rights set forth in the Fair Hearing Plan, including a right to a hearing and appellate review in accordance with the terms of the Fair Hearing Plan and Banner Health's Appellate Review Policy (as such Policy is included in the Fair Hearing Plan).

6.6-2 REQUEST FOR HEARING

When a practitioner's hearing rights are triggered, the practitioner shall be 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 30 days, all as is further set forth in the Fair Hearing Plan.

6.6-3 **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.

6.6-4 **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 special 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 hearing 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.

6.6-5 **HEARING PROCESS**
The 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.

6.6-6 **SCHEDULING THE APPELLATE REVIEW**
Upon receipt of a timely and proper request for appellate review, the General Counsel of Banner Health 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 Executive Committee and members of the Appeals Subcommittee.

6.6-7 **APPELLATE REVIEW PROCESS**
The practitioner and the Medical Executive Committee may submit written and oral statements in support of their respective positions in accordance with the terms of the Fair Hearing Plan. The practitioner has the burden of demonstrating, by a preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, the Fair Hearing Plan or applicable law, and created demonstrable prejudice; or that the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 GENERAL OFFICERS OF THE 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 **MEMBER AT LARGE**

There will be one member at large elected in the same manner and process as the general officers.

7.1-3 **QUALIFICATIONS**

Each general officer and member at large 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 Medical Center.

(d) Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general and department officers of the Medical Staff, the CEO, and the Board.

(e) Not have a disabling conflict of interest with the Medical Staff or Medical Center as determined by the Medical Executive Committee.

(f) File a Statement of Disclosure with the Medical Executive Committee upon being nominated and annually while in office.

(g) Not serve simultaneously as an officer and a Department Chairman or Section Chief.

7.1-4 TERM OF OFFICE

The term of office of general staff officers and the member at large is two years. Officers and the member at large 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. No officer shall serve in multiple officer or Department Chairman/Section Chief positions simultaneously.

7.2 ELIGIBILITY FOR RE-ELECTION

A general staff officer or member at large is eligible for nomination and re-election in succeeding terms.

7.3 NOMINATIONS

7.3-1 NOMINATING COMMITTEE

(a) A nominating committee shall consist of the Chief of Staff and four Active members of the Medical Staff appointed by the Medical Executive Committee. The Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each office and the member at large. Nominees must disclose interests that potentially compete with the interests of the Medical Staff and/or the Medical Center, including ownership and financial interests in competing facilities or employment or contractual relationships with the Medical Center. At the August 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 by mail or e-mail within 21 days following presentation to the Medical Executive Committee and the CEO.

(b) Nominations may also be made by petition signed by at least 10% of the Active category. Such petition must be submitted 21 days following distribution of the original of nominations

7.4 ELECTIONS, VACANCIES, AND REMOVALS

7.4-1 ELECTION PROCESS

The Medical Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.

MAIL BALLOT PROCESS

(a) The Secretary shall mail one official ballot and two official envelopes, with instructions, to each active staff member of the Medical Staff within 14 days after nominations are completed. Potential conflicts of interest shall be noted on the ballot or in a notice enclosed with the ballot. The name of the voting member shall appear on the official outer envelope. The sealed ballot must be returned on or before the date specified in the instructions, which shall be no more than 14 days after the mailing of the ballots.

Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

(b) The Secretary, or his/her designee, shall identify the outer envelope as containing the vote of a qualified voter and shall deposit the sealed inner envelope into the ballot box. On the date designated in the ballot instructions, the inner envelopes shall be opened and the ballots counted by the Medical Executive Committee or its designee.

(c) A majority of the votes cast for any office shall be necessary to elect any officer. If more than two nominees appear on the ballot and no nominee receives a majority of the votes cast, a second vote shall be conducted in the manner stated above between the two candidates receiving the highest number of votes.

ELECTRONIC BALLOT PROCESS

(a) At the request of the Medical Executive Committee, the Secretary shall conduct an election using an electronic ballot process following procedures as adopted from time to time by the Medical Executive Committee, which procedures shall provide that all active staff members receive the same type of information and have the same time periods within which to exercise their voting rights as they would have under the mail ballot process described above.

In the case of a tie, when only two nominees appear on the ballot, a majority vote of the Medical Executive Committee shall decide the election.

7.4-2 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 or member at large position shall be filled by appointment by the Chief of Staff with the approval of the Medical Executive Committee.

7.4-3 TERMS OF OFFICE

With the exception of ex officio members, all members of the Medical Executive Committee shall serve a two year term. General staff officers shall serve terms that terminate December 31 in even-numbered years. Department chairmen and section chiefs all serve terms that terminate December 31 in odd-numbered years. Members serving on the Medical Executive Committee by virtue of appointment by the Chief of Staff shall serve two year terms that terminate on December 31 of odd-numbered years. (Department chairmen elected for a term that commenced in January 1, 2009 shall serve a three year term to expire on December 31, 2011.) The Chief of Staff may appoint these members to subsequent two-year terms with approval of the Medical Executive Committee, or appoint new members with approval of the Medical Executive Committee.

7.4-4 RESIGNATIONS AND REMOVAL FROM OFFICE

(a) Resignations: any officer or the member at large 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 or membership on the Medical Executive Committee may be initiated by the Medical Executive Committee or by petition signed by at least 25% of the active staff members, for failure to maintain qualifications of the office as outlined in Section 7.1-3 and/or uphold the duties of the office as outlined in 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 Chief of Staff or his designee.

7.5 DUTIES OF OFFICERS

7.5-1 CHIEF OF STAFF

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 and 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 multi-disciplinary 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 Medical Center;

(f) represent the views and policies of the Medical Staff to the CEOs;

(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 Medical Staff from the Board;

(j) at the Board's request, report on the performance and maintenance of quality and patient safety as delegated by the Board to the Medical Staff; and

(k) meet and discuss with the Board Subcommittee any matters of concern to the Medical Staff.

7.5-2 **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. The vice chief of staff shall be a member of the Medical Executive Committee, Co-chair of the Professional Review Committee, 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.

7.5-3 **IMMEDIATE PAST CHIEF OF STAFF**

The immediate past chief of staff shall be a 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.

7.5-4 **SECRETARY-TREASURER**

The secretary-treasurer shall be a member of the Medical Executive Committee and shall be the Co-chairman of the Quality Council in collaboration with the Chief Medical Officer. As secretary, he/she shall determine 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.

7.6 **DUTIES OF MEMBERS AT LARGE**

The member at large shall attend meetings of the Medical Executive Committee and represent the interests of the general staff. The Member at Large shall serve as the Chairman of the Credentials Committee.(To be effective in 01/14.)

ARTICLE EIGHT: CLINICAL DEPARTMENTS

8.1 **CLINICAL DEPARTMENTS**

The Medical Staff shall be divided into two clinical departments; Department of Medicine and Department of Surgery. Each department shall be organized as a separate component of the Medical Staff and shall have a chairman selected and entrusted with the authority, duties, and responsibilities as specified in this Article. When appropriate, the Medical Executive Committee may recommend the creation, elimination, modification, or combination of departments or sections. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws.

8.2 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one department. A physician may be appointed to more than one department if that physician meets eligibility criteria for both departments, as recommended by the Department Chairmen. A practitioner may be granted clinical privileges in more than one department; the exercise of clinical privileges within the jurisdiction of any department is always subject to the rules and regulations of that department.

The following additional specialties will be assigned to the Department of Medicine:

Allergy/Immunology
Audiology
Cardiology
Clinical Psychology
Critical Care
Dermatology
eICU
Emergency Medicine
Endocrinology
Family Practice
Gastroenterology
Hematology/Oncology
Hospitalist
Internal Medicine
Medical Imaging
Nephrology
Neonatology
Neurology
Pediatrics
Physical Med/Rehabilitation
Psychiatry
Psychology
Pulmonary Medicine
Radiation Oncology
Rheumatology

The following specialties will be assigned to the Department of Surgery:

Anesthesiology
Colon/Rectal Surgery
Dentistry
General Surgery
Gynecology
Neurological Surgery
Obstetrics
Ophthalmology
Oral and Maxillofacial Surgery
Orthopedic Surgery
Otorhinolaryngology
Pathology
Plastic Surgery
Podiatry
Thoracic Surgery
Urology
Vascular Surgery

8.3 FUNCTIONS OF DEPARTMENTS

Departments shall continually seek to improve quality of care for all patients through an effective peer review process as defined by Medical Staff policy. Each department shall:

(a) develop and approve clinically relevant quality indicators that identify variances which trigger evaluation of the care by a physician reviewer; review and approve criteria/indicators annually which include but are not limited to:

1. medication use
2. blood use
3. operative/invasive review
4. unexpected deaths
5. identification of known or potential problems that have an adverse effect on patient care.

(b) develop recommendations for the qualifications and credentialing criteria appropriate to obtain and maintain clinical privileges in the department and its sections.

(c) establish and implement clinical policies and procedures, and monitor its members' adherence to them.

(d) identify and engage in opportunities for education and process improvement.

(e) establish quality parameters and indicators and recommend appropriate action to the Medical Executive Committee.

(f) participate in Banner clinical initiatives and assist with the adoption of appropriate clinical standards to facilitate improved aggregated clinical outcomes and patient safety as determined by the Medical Staff and Banner;

(g) adopt its own rules and regulations to clarify or expand these Bylaws to meet the needs of its particular area of practice. Department rules and regulations shall not conflict with these Bylaws and shall be subject to approval by the Medical Executive Committee and the Board. Any rule, regulation or policy that may be temporarily adopted on an emergency basis shall be approved by the Chief of Staff prior to communication or enforcement.

(h) consider the aggregated results of the review for quality and appropriateness of patient care and make recommendations relating thereto to the Medical Executive Committee.

(i) provide a forum for discussion of Medical Staff matters of concern to its members.

(j) assure adequate on-call coverage for emergency patients consistent with the physician resources available within the department. The Department will have the responsibility to determine whether a mandatory or voluntary Emergency Department (E.D.) On Call is adequate to serve the needs of the community. Members serving on the On Call Schedule shall treat all patients regardless of the ability of patients to pay for those services. If the Department recommends a mandatory E.D. call, they must forward their recommendation to the Medical Executive Committee for approval.

(k) be responsible for the conducting of continuing education within the department.

(l) coordinate the professional services of its members with those of other departments and with Medical Center nursing and support services.

(m) participate in budgetary planning pertaining to department activities with Medical Center administration, including the review of new technologies.

(n) establish a department committee and any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the department committee and subcommittee members shall be defined within the department rules and regulations.

(o) support utilization management review in regard to appropriateness of admissions and consultations, level of care, continued stays, diagnostic testing, transfers, and discharges.

(p) evaluate the professional practice of all individuals with privileges granted by the department by defining the process for making decisions to maintain or modify existing privileges prior to or at the time of renewal, determining the type of data to be collected, using the collected information to evaluate individuals' professional practice, and uniformly investigating and addressing clinical practice concerns (consistent with these bylaws) collected through the Medical Staff's internal reporting structure.

8.4 **SECTIONS**

Sections representing particular specialties may be established by the Departments. Such sections shall be directly responsible to a Department. The Section Chair shall be a member of the Active Staff, will serve a two-year term and shall be entitled to serve as a voting member of the Medical Executive Committee. The section chairperson will assist the Department chairperson for any quality management activities related to the specialists of that section. Sections shall be responsible for the selection of their respective chairman.

If a section is formed representing any of the following specialties, the elected chairperson shall be entitled to serve as a voting member of the Medical Executive Committee after it has been demonstrated that the section has been functioning as a section for a minimum of two (2) years:

Anesthesia - Section of the Department of Surgery

Emergency Medicine - Section of the Department of Medicine

Medical Imaging - Section of the Department of Medicine

Pathology - Section of the Department of Surgery

The Departments of Medicine and Surgery, with the approval of the Medical Executive Committee, may authorize the creation of sections for other specialties or subspecialty groups; however, the chairpersons of other sections other than those listed above will not be entitled to serve as a member of the Medical Executive Committee.

Sections are optional, collegial and professional and will have no work other than that assigned by a Department Chairman. Sections may be organized to perform any of the functions assigned to the Department. Minutes reflecting the activities of sections of the individual departments are required in conjunction with the following activities:

1. peer review;
2. continuing education;
3. grand rounds;
4. discussion of policy;
5. discussion of equipment needs;
6. development of recommendation for Department chairperson or Medical Executive Committee;
7. participation in the development of criteria for clinical privileges (when requested by the Department chair);
8. at the special request of a Department chairperson or the Medical Executive Committee to discuss a specific issue.

8.5 DEPARTMENT OFFICERS

8.5-1 QUALIFICATIONS

Each department shall have a chairman who shall be and remain, during his or her term, a member in good standing of the active Medical Staff; shall be a board certified (or considered equivalently qualified by the Medical Executive Committee); shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department; and shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center. Departments will also have a vice-chairman and may have other officers as defined in the department's rules and regulations.

8.5-2 SELECTION

A Department Chairman shall be elected every two years by the active staff members of the department. For this election, a request for nominations will be sent to department members prior to October of odd-numbered years for terms starting in January of even-numbered years. Members of the Department may nominate any Active member by submitting the nominee's name and Officer Position in writing (in person or by email) to the Medical Staff Services Department anytime between the date of the request for nomination and the Department meeting date. A list of nominees will be presented at the Department meeting. Nominations may also be made at the department meeting, so long as the nominee is qualified and has consented to the nomination. Following the department meeting, the slate will be deemed finalized and ballots mailed or sent out electronically. Vacancies in elected department offices due to any reason shall be filled for the unexpired term through a special election held for that purpose at a meeting of the department.

8.5-3 TERM OF OFFICE

Elected department chairmen and other department officers, if any, shall serve a two-year term terminating on December 31 of even-numbered years or until their successors are chosen, unless a vacancy occurs for any reason. Department officers shall be eligible to succeed themselves.

8.5-4 RESIGNATION

A Chairman may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on receipt or at any later time agreed to by the Chairman and the Medical Executive Committee.

8.5-5 **VACANCIES**

If the department has a Vice Chairman, that person will automatically assume the Chairmanship. If the department does not have a Vice Chairman, the Medical Executive Committee will temporarily appoint an acting Chairman to serve until the department can conduct a departmental election.

8.5-6 **REMOVAL**

An elected department officer may be removed for failure to maintain the qualifications of the office as required by these Bylaws. Removal must be initiated by petition signed by at least one-third of the active staff members of the department. Such vote shall occur by written ballot conducted in the same manner as that used in the election of department officers. Removal shall require a two-thirds vote of the active staff members of the department. Removal of a contract department officer is governed by the terms of the contract or employment arrangement with the Medical Center.

8.5-7 **DUTIES**

Each chairman shall have the authority, duties, and responsibilities listed below.

(a) Act as presiding officer at department meetings;

(b) Be a member of the Medical Executive Committee, account to the Medical Executive Committee for all administrative and clinically related activities within the department and must attend a minimum of 50% of the Medical Executive Committee meetings;

(c) Maintain quality control programs, as appropriate, and provide continuous assessment and improvement of the quality of care, treatment, and services;

(d) Recommend to the Medical Executive Committee and implement department rules and regulations, criteria for clinical privileges that are relevant to the care provided in the department, programs for orientation and continuing medical education of members of the department, and policies and procedures that guide and support the provision of care, treatment and services within the department;

(e) Provide guidance on overall medical policies of the Medical Center, and recommend strategies for integrating department services into the primary functions of the medical center, and coordinating interdepartmental and intradepartmental services;

(f) Recommend the clinical privileges and staff category of practitioners who are members of or applying to the department;

(g) Provide continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, and refer to the Professional Review Committee issues relating to professional conduct and the quality and appropriateness of patient care and professional performance;

(h) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;

(i) Implement, within the department, actions directed by the Medical Executive Committee or the Board;

(j) Participate in every phase of administration of the department, including cooperation with the nursing service and Medical Center administration;

(k) Appoint such sections and committees as are necessary to conduct the functions of the department;

(l) Appoint such committee chairmen or members as required by these Bylaws and department rules and regulations;

(m) Perform such other duties as may, from time to time, be reasonably requested by the Chief of Staff or the Medical Executive Committee;

(n) Assess and recommend to the Medical Executive Committee and the CEO off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center;

(o) Assess and recommend to the Medical Executive Committee and the CEO a sufficient number of qualified and competent persons to provide care, treatment, and services;

(p) Assess the qualifications and competence of department or section personnel who are not licensed independent practitioners and who provide patient care, treatment, and services; and

(q) Recommend space and other resources needed by the department/section.

ARTICLE NINE: COMMITTEES

9.1 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, and 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.

9.2 GENERAL PROVISIONS

9.2-1 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.

9.2-2 SUBCOMMITTEES

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

9.2-3 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. The chairman of all standing committees shall be members of the active staff. Chairmen of special or ad hoc committees may be appointed from the Courtesy or honorary staff.

9.2-4 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 two years which shall coincide with the term of the Chief of Staff or until the member's successor is appointed, unless such member or chairman sooner resigns or is removed from the committee.

(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, or by action of the Medical Executive Committee. A committee member removed by 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 following appointment by the Chief of Staff in consultation with the Medical Executive Committee.

9.2-5 VOTING RIGHTS

Each Medical Staff committee member shall be entitled to one vote on committee matters. Medical Center personnel assisting the Medical Staff in performance of the functions of the committee shall have no voting rights (excluding elections an Department Rules and Regulations which require Active staff status to participate.

9.2-6 **DEPARTMENT/SECTIONS**

All members present at a Department or Section meeting are eligible to vote in Department and Section matters (excluding election and Department Rules and Regulations).

9.3 MEDICAL EXECUTIVE COMMITTEE

The organized Medical Staff authorizes the Medical Executive Committee to carry out Medical Staff responsibilities in accordance with law and regulation.

9.3-1 COMPOSITION

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

(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) Chairmen of the Departments of Medicine and Surgery

(f) Credentials Committee chairman

(g) One (1) Member at Large

(h) Section Chief of Anesthesia, Emergency Department, Medical Imaging, Pathology

(i) Chief Medical Officer (attendee, without vote)

(j) Chief Executive Officer (ex officio, without vote)

(k) Other representation as necessary (ex-officio, without vote)*

(l) Medical Director of Care Coordination (ex-officio, without vote)

*Appointed by the Chief of Staff and approved by a majority vote of the Medical Executive Committee.

Service Line Directors for:
Acute Care
SNF
Ambulatory Care
Cardiovascular (select one)
Neurology
Oncology
Orthopedics
Other representation as necessary

9.3-2 DUTIES

Duties of the Executive Committee. The authority of the Executive Committee is delegated by the Medical Staff and may be limited by amending these Bylaws or removing any or all members of the Executive Committee pursuant to the removal provision set forth in Section (12.10-1-2-1). The duties of the Executive Committee shall include, without limitation, the following:

(a) Act on all matters of Medical Staff business, except for the election or removal of general staff officers and except for granting final approval of the Medical Staff Bylaws or amendments to the Medical Staff Bylaws.

(b) Receive and act upon reports and recommendations from Medical Staff departments, 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;

(e) Review aggregate quality performance data and make recommendations for quality improvement;

(f) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;

(g) Make recommendation to the CEO and to the Board of Medical Center medico-administrative matters;

(h) Review the qualifications, credentials, performance, and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding such matters;

(i) Account to the Board for the quality and efficiency of medical care provided to patients in the Medical Center, including a summary of specific findings, actions, and results and including an assessment of the quality of services rendered pursuant to contract;

(j) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;

(k) 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;

(l) Assist in obtaining and maintaining accreditation of the Medical Center; and

(m) Act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its authority as set forth herein.

9.3-3 **MEETINGS**

The Medical Executive Committee shall meet as often as necessary, but at least six times per year and shall maintain a record of its proceedings and actions. Special meetings of the Medical Executive Committee may be called at any time by the Chief of Staff and the CEO. The Medical Executive Committee, in its discretion, may appoint a subcommittee to fulfill the Medical Executive Committee's obligations with respect to the appointment/reappointment process during periods when the Medical Executive Committee does not regularly meet. A summary of the actions taken by such subcommittee will be submitted to the Medical Executive Committee for ratification or other action at the Medical Executive Committee's next regularly scheduled meeting.

9.3-4 **ATTENDANCE REQUIREMENTS**

All members of the Medical Executive Committee are required to attend a minimum of 75% of the Medical Executive Committee meetings per calendar year. Telephonic attendance is acceptable for 25% of meetings. Members must attend 50% of the meetings in person. If a member's attendance does not meet the minimum, the member shall be deemed to have voluntarily resigned from the Medical Executive Committee. The Chief of Staff may appoint a representative for the Medical Executive Committee to replace that member.

9.4 BIOETHICS COMMITTEE

9.4-1 COMPOSITION

The Bioethics Committee shall consist of physicians and such other staff as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and board members. The Chair of the Committee shall be a member of the Active Staff, appointed by the Chief of Staff for a two year term.

9.4-2 DUTIES

The Bioethics Committee at the Medical Center provides recommendations relating to ethical dilemmas that may arise during the provision of care. The Bioethics Committee is an interdisciplinary group that offers consultative services for ethical issues, questions, or dilemmas related to patient care, and is available to consult with families, patients, health care professionals, and Medical Center employees desiring assistance with ethical decision making. Additional duties of this Committee may include:

(a) participating in development of guidelines for consideration of cases having bioethical implications;

(b) developing and implementing procedures for the review of such cases;

(c) developing and/or reviewing institutional policies regarding care and treatment of such cases;

(d) retrospectively reviewing cases for the evaluation of bioethical policies;

(e) consulting with concerned parties to facilitate communication and aid conflict resolution; and

(f) educating the Medical Center staff and Medical Staff on bioethical matters.

9.4-3 CONSULTATION

A physician is encouraged to consult with the Bioethics Committee whenever he/she:

(a) believes that the refusal of medical care by a patient's legally authorized representative is not in the patient's best interest;

(b) believes that the refusal by a pregnant woman threatens the life or safety of a viable fetus;

(c) believes that the refusal by the sole parent of a minor child risks abandoning the minor child; or

(d) is uncertain of his or her obligations.

9.5 BYLAWS COMMITTEE

9.5-1 COMPOSITION

The Bylaws Committee shall consist of at least five members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as Chairman.

9.5-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a review of the Bylaws annually or more frequently when deemed necessary;

(b) submitting to the Medical Executive Committee recommendations for changes in the Bylaws; and

(c) receiving and evaluating, for recommendation to the Medical Executive Committee, suggestions for modifying the Bylaws.

9.6 **CANCER COMMITTEE**

9.6-1 **COMPOSITION**
The Chairman shall be a practitioner especially qualified in the treatment of malignancies with representatives from the areas of Surgery, Internal Medicine, Hematology/Oncology, Radiation Oncology, Medical Imaging, Family Practice, and Pathology. Additional representatives from Nursing, Social Services, Rehabilitation, Tumor Registry and Administration will also be appointed. The Tumor Registrar is responsible for the abstraction of data documentation at the meeting.

9.6-2 **DUTIES** The duties of the Cancer Committee will be:

(a) Formulate policies for the cancer care management activities of the Hospital;

(b) Maintain liaison with the American Cancer Society, County and State Departments of Health, the American College of Surgeons, and other pertinent organizations;

(c) Support and provide oversight for a Tumor Board (Peer Review Protected under ARS 36-445.01), clinical cancer conference, patient care audits, prevention programs and screening programs with the goal of improved diagnosis, treatment, follow-up rehabilitation and continuing care; and

(d) Actively review and supervise the Tumor Registry cancer database for quality control of abstracting, staging and reporting.

9.6-3 **MEETINGS**

The Cancer Committee shall meet at least quarterly.

9.7 **CREDENTIALS COMMITTEE**

9.7-1 **COMPOSITION**

The Credentials Committee shall consist of at least five active staff members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chairman, and a representative of Medical Center administration. The Chairman of the Credentials Committee shall serve as a voting member of the Medical Executive Committee.

9.7-2 **DUTIES**

The duties of the Credentials Committee shall be to examine the qualifications of each applicant to determine whether the qualifications for staff membership have been met. It shall forward applications recommended for privileges to the Medical Executive Committee.

9.7-3 **ALLIED HEALTH SUB COMMITTEE**

COMPOSITION

The Allied Health Sub-committee shall consist of at least one allied health professional who has been granted privileges at the Medical Center, at least one member of the Medical Staff who is also a member of the Credentials Committee, the Chief Medical Officer and the Chief Nursing Officer. The Committee may be chaired by any appointed member as determined by the Chief of Staff.

DUTIES
The duties of the Allied Health Sub-committee include:

(a) Examine the qualifications of allied health applicants to determine whether the qualifications for staff membership have been met. Recommend scope of practice for Allied Health Professionals to the Medical Staff Departments and Credentials Committee.

(b) Recommend Allied Health privilege eligibility criteria to the Medical Staff Departments and Credentials Committee.

MEETINGS
The Sub-committee will meet on an as needed basis.

9.8 CRITICAL CARE COMMITTEE

9.8-1 COMPOSITION

The Critical Care Committee shall consist of at least three active staff members appointed by the Chief of Staff in consultation with the Chairman of Medicine and Surgery. The committee is multi-disciplinary.

9.8-2 DUTIES

The duties of the Critical Care Committee shall be to:

(a) Oversee the functioning of the critical care areas considering staffing, policies and equipment matters, as well as interpersonal problems between physicians and staff;

(b) Establish written policies for operation of the unit to meet requirements of accrediting bodies and the Department of Surgery and Medicine; and

(c) Evaluate the quality of care and make recommendations to the Medical and Surgical Committee in cases where the standard of care is thought by the Critical Care Committee to be questionable.

9.8-3 MEETINGS

The Critical Care Committee will meet at least quarterly.

9.9 ENDOVASCULAR COMMITTEE

9.9-1 COMPOSITION

The Endovascular Committee shall be a multidisciplinary committee. It shall consist of at least two members from the specialties of Interventional Cardiology, Interventional Radiology and Endovascular Surgery appointed by the Chief of Medicine and Chief of Surgery in conjunction with the Chief of Staff.

9.9-2 DUTIES

The duties of the Endovascular Committee will be:

(a) Develop and monitor quality outcome measures;

(b) Conduct reviews to analyze and evaluate the quality and appropriateness of endovascular care and treatment and make recommendations based on the results of these reviews;

(c) Conduct peer reviews of endovascular cases and report findings and recommendations to the Peer Review Committee;

(d) Develop a multidisciplinary approach for the provision of endovascular services;

(e) Develop appropriate policies and procedures; and

(f) Report and make recommendations regarding clinical, quality review and administrative activities to the Medical Executive Committee.

9.9-3 MEETINGS

The Endovascular Committee will meet as necessary upon notice to all members and shall report to the Medical Executive Committee.

9.10 PROFESSIONAL HEALTH (WELLNESS) COMMITTEE

9.10-1 COMPOSITION

The Professional Health Committee shall consist of a chairman and four other members. When possible the Committee shall include at least one member in recovery and one behavioral health professional.

9.10-2 DUTIES

The Professional Health Committee will:

(a) Provide ongoing education to the Medical Staff and Administrative leadership on practitioner impairment recognition issues, on the different kinds and levels of impairment and the problems of impairment, and on resources available for the diagnosis, prevention, treatment and rehabilitation of impairment;

(b) Recommend or require available resources for diagnosis and/or treatment of practitioner experiencing possible illness and impairment issues;

(c) Serve as resource for practitioners experiencing illness and impairment issues;

(d) Evaluate potential illness and impairment and monitor ongoing compliance with treatment recommendations and requirements. Assist Medical Staff leadership with an intervention, when so requested by a Department Chairman, Chief of Staff, Peer Review Committee, Chief Medical Officer, CEO or respective designee;

(e) Require the affected practitioner to obtain a psychological, psychiatric and/or physical examination;

(f) Ensure the recommendations and/or requirements of the committee/subcommittee are being followed;

(g) Require the affected practitioner to obtain a report form his or her treatment 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 PHC or appropriate Department Chairman; and

(h) Advise the appropriate Department Chairman/Medical Executive Committee/Medical Staff Leader of the affected practitioner's failure to adhere to the recommendations and/or requirements.

1. **<u>Medical Staff</u>** – If the Committee does not feel that its recommendations and/or requirements are being followed, the Committee Chairman will notify the Medical Executive Committee and the practitioner's Department Chairman for consideration of appropriate corrective action in accordance with the Medical Staff Bylaws.

2. **<u>Allied Health/Ancillary Staff</u>** – If the Committee does not feel that its recommendations and/or requirements are being followed, the Committee Chairman will notify the practitioner's Department Chairman for consideration of appropriate corrective action in accordance with AHP/Ancillary policies. The Committee will also notify the practitioner's supervising physician of circumstances warranting notification to the Department Chairman.

9.11 PROFESSIONAL REVIEW COMMITTEE

9.11-1 **COMPOSITION:** The Professional Review Committee shall consist of at least five members, including the Chief Medical Officer who shall serve as Co-chairman in collaboration with a physician member of the PRC. Members shall be physicians engaged to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities. The Chief of Staff and a representative of Medical Center administration in addition to the Chief Nursing Officer shall serve as ex-officio members of the PRC (without vote). Members shall be appointed for staggered terms of three years and may be appointed for successive terms.

9.11-2 **QUALIFICATIONS:** PRC members must continuously satisfy the qualifications and complete the requirements set forth in Article I, Section 3. Such members must demonstrate leadership skills and may not have disabling conflicting interests.

9.11-3 **SELECTION AND REVIEW PROCESS:** The Chief of Staff in consultation with the CMO and the CEO shall appoint the members of the committee.

9.11-4 **DUTIES:** The duties of the Professional Review Committee include:

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

(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 Staff or Allied Health 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 of Medical Staff and Allied Health Staff members;

(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 or medical director;

(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) Designate one or more of its members to 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.

9.12 PHARMACY & THERAPEUTICS COMMITTEE

Propose moving the P&T Committee under the auspice of the Medical Staff.

9.12-1 **COMPOSITION**: The Pharmacy and Therapeutics Committee should consist of a chairperson, at least four members of the Medical Staff, the director of pharmacy, the clinical pharmacy coordinator or designee, and a representative from administration, nursing and quality management.

9.12-2 **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 Medical Center 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 Medical Center 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 Medical Center.

(d) Develop a formulary of accepted medications for use in the Medical Center and provide for continued review.

(e) Participate in the formulation and analysis of Medication Use Evaluations.

(f) Review and approve pharmacy policies and procedures.

(g) Review adverse drug reactions reports and make appropriate recommendations.

(h) Review medication occurrence reports and make appropriate recommendations.

(i) Review pharmacy intervention activities and make appropriate recommendations

(j) Present recommendations from the Pharmacy and Therapeutics Committee to the appropriate Medical Staff committee and/or the Medical Executive Committee.

9.12-3 **MEETINGS:** The Pharmacy & Therapeutics Committee will meet at least quarterly.

9.13 MEDICAL DIRECTOR QUALITY, OPERATIONS, SAFETY (MDQOS) COMMITTEE

9.13-1 COMPOSITION

The MDQOS Committee is a professional review council which shall consist of medical director representatives from the Medical Staff and the Hospital including the Chief Executive Officer, Chief Medical Officer who shall serve as Co-chairman in collaboration with the Secretary-Treasurer, Chief Nursing Officer, and the Director of Pharmacy.

9.13-2 DUTIES

To maintain, coordinate and integrate quality, safety and operational improvement efforts of the medical staff in conjunction with hospital and system efforts. This committee will replace the existing Quality Committee at BBWMC and will report its efforts to the Medical Executive Committee. The duties of the MDQOS Committee:

(a) Communicate performance improvement activities and findings to all pertinent hospital staff, medical staff and the Board of Directors.

(b) Identify continuing education needs of clinical, administrative and support personnel relative to the performance improvement process.

(c) Coordinate performance improvement activities and findings with the facility's utilization management, risk management, infection control, safety management, medical staff credentialing and medical records functions.

(d) Address management and quality of service issues which arise as a direct or indirect result of performance improvement activities.

(e) Ensure maintenance of a just culture environment in which healthcare errors are reduced and the importance of patient safety is a priority.

(f) Review strategic initiatives and management objectives on an annual basis and provide continuity between system initiatives and facility management and performance improvement objectives.

(g) Review performance of various interdisciplinary process improvement teams within the facility and offer feedback on the structure, focus, actions, measurement format and results.

(h) Annually select a high risk patient safety issue to be addressed by an interdisciplinary team through an HFMEA process.

(i) Review data related to patient safety and quality from Patient Satisfaction Surveys, Risk Management, Safety, Infection Control and other sources.

(j) Review lessons learned and action plans resulting from root cause analyses performed at the hospital and oversee the monitors resulting from those actions plans.

(k) Communicate quality and patient safety outcomes summary data to the MEC on a periodic basis and more frequently as issues are identified.

(l) Facilitate communication to hospital employees and the Medical Staff members related to Quality Committee's purpose and about key quality/safety improvement efforts within the facility.

9.13-3 **MEETINGS**

The MDQOS Committee will meet at least quarterly and report to the Medical Executive Committee.

9.14 **UTILIZATION MANAGEMENT**

9.14-1 **COMPOSITION**

The UMC shall consist of at least three active staff members appointed by the Chief of Staff. Required ex-officio participation shall include the Chief Nursing Officer (or designee), the Director of Case Management, the Director of HIMS, the Director of Quality Management, the Chief Medical Officer who shall serve as co-chair of the UMC and representatives of Finance.

9.14-2 **DUTIES**

The Utilization Management Committee (UMC) reviews and evaluated the use of hospital resources. The UMC reviews data pertaining to:

(a) Hospital admissions;
(b) Level of care;
(c) Continued stays;
(d) Procedures;
(e) Testing and treatment;
(f) Discharges and transfers;
(g) Avoidable days;
(h) Readmissions;
(i) Reimbursement;
(j) Denials.

9.14-3 **<u>MEETINGS</u>**

The UMC will meet as necessary upon notice to all members and shall report to the Departments of Medicine and Surgery for information but is accountable to the Medical Executive Committee.

9.15 **LASER SAFETY COMMITTEE**

9.15-1 **COMPOSITION**

The Laser Safety Committee will be comprised of at least three members of the Medical Staff including at least one representative from each medical discipline using laser appointed by the Chief of Staff, the Laser Safety Officer and at least one administrative and one nursing representative appointed by the Chief Executive Officer.

9.15-2 **DUTIES**

The Laser Safety Committee is responsible for:

(a) Establishing hospital policy for the oversight of use of lasers

(b) Reviewing and making recommendations to the Medical Executive Committee for approval of medical staff requests for laser privileges to assure practitioners are adequately trained. (NOTE: Medical staff may continue to perform the credentialing of doctors who are new to our facility, but the Laser Safety Committee ultimately must review the findings and make the final decision as whether or not the doctor(s) are allowed to perform procedures in our facility with the use of lasers.)

(c) Governing laser activity, establishing use criteria, and approving operating procedures, including approving requests by potential operators and ancillary personnel to operate or assist in the operation of a laser under the director of a licensed practitioner.

ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 REGULAR MEETINGS

General staff meetings will be held at least annually.

10.1-2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Chief of Staff, the CEO, 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.

10.2 CLINICAL DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

10.2-1 REGULAR MEETINGS

Clinical departments, sections and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. A department must meet at least 4 times per year.

10.2-2 SPECIAL MEETINGS

A special meeting of any department, section or 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 sent to all members of the department or committee.

10.2-3 EXECUTIVE SESSION

Any department or 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, including the CEO, the CMO, the Medial Staff Services Director and the Quality Management Director or their respective designees may remain during executive session. Separate minutes must be kept of any executive session.

10.3 ATTENDANCE REQUIREMENTS

10.3-1 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 department, section or 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. Failure to attend without good cause may result in automatic suspension and/or initiation of corrective action proceedings.

10.3-2 CLINICAL CONFERENCE

Whenever a department or section 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 chairman of the time, date, place of the program, the subject matter to be covered, and its special applicability to their practice. Attendance may be mandatory. Failure to attend without good cause may result in automatic suspension and/or initiation of corrective action proceedings.

10.3-3 SPECIAL APPEARANCE

Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the Chief of Staff, the chairman of the Professional Review Committee or the applicable department or section chairman 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 therefore. Failure of a practitioner to appear at any such meeting without good cause may result in automatic suspension and/or initiation of corrective action proceedings.

10.4 QUORUM

10.4-1 GENERAL STAFF MEETINGS

Those present and voting.

10.4-2 COMMITTEE MEETINGS

The presence of 50% of the members of the Medical Executive Committee shall constitute a quorum. The presence of 2 voting members shall constitute a quorum at any other committee meeting.

10.4-3 DEPARTMENT MEETINGS/SECTION MEETINGS

Three (3) members of the Department or Section will serve as a quorum.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 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 Medical Center, a practitioner:

(a) authorizes Medical Center 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 Medical Center;

(d) agrees to release from legal liability and hold harmless the Medical Center, Medical Staff, Medical Staff committees and all persons engaged in peer review activities which include, but are not limited to, those activities identified in Section 11.3 of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws, the Fair Hearing Plan, 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 and/or the Board, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review and/or corrective 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 Medical Center or its representatives; and

(f) authorizes the release of information, including peer review information, about the practitioner to other Banner facilities where the practitioner has or requests membership or privileges.

11.2 CONFIDENTIALITY OF INFORMATION

Information obtained or prepared by any representative of the Medical Staff or the Medical Center 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.

11.3 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 appointment, 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 Medical Center, committee, department, section, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.4 RELEASES AND DOCUMENTS

Each practitioner shall, upon request of the Medical Center, execute general and specific releases and provide documents when requested by the Chief of Staff or Chairmen of Departments 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.

11.5 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.

ARTICLE TWELVE: GENERAL PROVISIONS

12.1 MEDICAL STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Executive Committee shall adopt such Medical Staff Rules and Regulations as may be necessary to implement the general principles found in these Bylaws; such rules and regulations shall be consistent with these Bylaws and Medical Center policies. The Medical Executive Committee may act for the staff in adopting or amending them. The Medical Staff Rules and Regulations may not conflict with the Banner Health Bylaws.

12.2 DEPARTMENT RULES AND REGULATIONS

Each department and section will formulate written rules and regulations for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with the Bylaws and Medical Center policies. These department rules and regulations must be reviewed and approved by the Medical Executive Committee and the Board as needed, but must be reviewed at least every two (2) years; any changes affecting qualifications, privileges, supervision, and call coverage must be approved by the Medical Executive Committee and the Board. The Rules shall also describe the department's process for collecting professional practice information, data and concerns as well as the department's responsibility to establish performance indicators.

12.3 CLINICAL PRIVILEGE ELIGIBILTY CRITERIA

Clinical Privilege Eligibility Criteria and Clinical Privilege Delineation Forms: Specific, detailed privilege eligibility criteria are outlined in the Clinical Privilege Manual that is an appendage to these bylaws. The eligibility criteria include any and all requirements the applicant must meet in order to be eligible to apply for the specific privilege. The clinical privilege delineation forms include the scope of privileges for each specialty and category of practitioner. Meeting privilege eligibility criteria alone does not guarantee that a practitioner will be granted the privilege. Clinical Privilege Delineation Forms are maintained in the Clinical Privilege Manual and include a list of specific privileges or limitations for each category of practitioner. The Clinical Privilege Manual is reviewed at least bi-annually. Proposed revisions to the Clinical Privilege Manual do not require approval by the Active Medical Staff. The applicable Medical Staff Department or the Credentials Committee can recommend revisions to the Medical Executive Committee, which will forward its recommendation to the Board for review and approval. Clinical privileges must be in accordance with the medical center's scope of service and may only be performed in an area that has the necessary staff, equipment and resources to safely support the procedure/care being performed.

12.4 STAFF DUES/FEES

The Medical Executive Committee shall establish the amount of annual Medical Staff, Allied Health Professional, and Ancillary Staff dues/fees. Notice of dues shall be given to the staff by written notice in the first quarter. Dues are payable within 60 days of written notice. If dues are not paid timely, a special notice of delinquency shall be sent to the practitioner and an additional 30 days given in which to make payment. All new staff members shall be billed on a pro rated basis and shall include dues with the application. Failure to render payment shall result in automatic suspension as provided in Section or nonprocessing of a new application. 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 and referring staff shall be exempt from payment of dues and assessments.
Staff dues may be utilized to pay stipends for Officers of the Medical Staff and other expenses approved by the Medical Executive Committee.

12.5 COMMUNICATION

Electronic communication is the Medical Center's designated method of communication with the Medical Staff. All applicants and members of the Medical Staff must provide a current email address for communication of regular Medical Center business. All applicants and members are responsible for reading email notifications and responding timely to Medical Center business.

12.6 SPECIAL NOTICE

When special notice is required, the Medical Staff Office shall send such notice by certified mail, email 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.

12.7 SUPPORT STAFF

The Medical Staff recognizes that the organizational structure required to carry out the credentialing, peer review and corrective action processes of the Medical Staff require the support of certain members of the administrative staff of the Medical Center who may or may not be members of the Medical Staff including, but not necessarily limited to, the Medical Center's CEO, Chief Medical Officer, Chief Nursing Officer and/or designees, and Quality Management, and members of the Medical Staff Services Department (collectively "Support Staff"). All activities of such Support Staff provided in support of the Medical Staff's credentialing, peer review and corrective action activities shall be conducted in a confidential manner and shall be afforded all of the privileges available to members of the Medical Staff performing such activities under these Bylaws and under applicable state and federal law. The activities of the Support Staff covered by this provision include, but not limited to, activities involved in reviewing practitioner applications, reviewing practitioners' care in and outside of the Medical Center, participating in the conduct of investigations, identifying trends, participating in the resolution of issues involving Medical Staff members and other practitioners working in the Medical Center, and any other activities as may be delegated from time to time by the officers or committees of the Medical Staff.

12.8 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.

12.9 PARLIAMENTARY PROCEDURE

The rules contained in the current edition of Roberts Rules of Order shall govern the Medical Staff in all cases to which they are applicable, in all cases which they are not inconsistent with these Bylaws, and any special rules of order the Medical Staff may adopt.

12.10 CONFLICT RESOLUTION

12.10.1 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. Any such challenge must be supported by a petition signed by at least one-third of the Active Staff and must set forth the basis for the challenge and a recommendation for changes to the rule or policy.

12.10.2 MEDICAL EXECUTIVE COMMITTEE REVIEW

The Medical Executive Committee will consider the challenge at its next meeting and will determine whether and to what extent to change the rule or policy or, in its discretion, to appoint a subcommittee to review the challenge and recommend potential changes to address the challenge. The Medical Executive Committee may use internal or external resources to assist in determining how best to address the challenge. If applicable, the Medical Executive Committee will review the subcommittee's recommendations and take final action on whether and to what extent to change the challenged rule or policy, subject to Board approval if required. The Medical Executive Committee will communicate all changes to its rules and/or policies made pursuant to this Section 12.10-2 to the Medical Staff.

12.10-3 CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY

A recommendation to use either internal or external resources to resolve a conflict between the Medical Staff and the Medical Executive Committee may be made by the Board, the CEO, the Medical 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 any conflicts between the Medical Staff and the Medical Executive Committee that cannot be resolved by such bodies.

12.11 HISTORIES AND PHYSICALS

A history and physical examination ("H&P") in all cases shall be completed by a physician, oral surgeon, or Allied Health Professional who is approved by the medical staff to perform admission H&Ps within 24 hours after registration or admission. The completed H&P must be on the medical record prior to surgery or invasive procedure or any

procedure in which 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. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services._The content of complete H&P is delineated in the General Rules and Regulations of the Medical Staff.

ARTICLE THIRTEEN: ADOPTION AND AMENDMENT

13.1 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 Medical Center 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.

13.2 PERIODOC BYLAWS REVIEW

The Bylaws shall be reviewed and revised as needed, but must be reviewed at least once each calendar year by the Bylaws Committee. When necessary, the Bylaws will be revised to reflect current practices with respect to Medical Staff organization and functions. Reviews shall also be conducted upon request of the Board.

13.3 ADOPTION AND AMENDMENT

The Bylaws 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 of the Active Staff who vote in a mail or electronic ballot vote. Ballots shall be sent to each Active Staff member, by mail or email. A copy of the proposed amendments and a summary thereof will accompany the ballot or be posted online. The ballots must be returned within **14** 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 vote.

Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws, except the Board may take action if the Medical Staff fails to act within sixty (60) days following receipt of notice from the Board to assure compliance with state and federal laws; in the event of substantial circumstances affecting the operation of the Medical Center, welfare of its employees and staff, or provision of optimal care to patients; or in the event the Medical Staff fails to perform its functions delegated hereunder. The action described in the preceding sentence shall be taken only after consideration of the proposed amendment by an ad hoc committee with equal representation from both the Medical Staff and the Board. Representatives from administration shall be ex-officio members without vote. Such committee shall meet, if at all, within sixty days of the date that notice of the Board's request for amendment is sent to the Medical Executive Committee.

13.4 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. However, prior to submitting a proposed Bylaw or Bylaw amendment to the Board, any such proposed Bylaw or Bylaw amendment must be supported by a petition signed by at least one-third of the Active Staff members and shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendment at its next meeting. The Medical Executive Committee may refer the proposed amendment to the Bylaws Committee or to an ad hoc committee for its consideration and recommendations, which shall be made to the Medical Executive Committee. If the Medical Executive Committee does not accept the Medical Staff's proposed amendment, and if the representatives of the Medical Staff who submitted the proposed amendment and the Medical Executive Committee do not agree on alternative language for the proposed amendment, the members of the Medical Staff who proposed the amendment may submit the proposed amendment for approval by the Board. If the members of the Medical Staff who proposed the amendment wish it to be considered by the Board, the proposed amendment shall first be submitted to the Active Staff for approval in accordance with the ballot process described in Section 13.3. Any ballot shall be accompanied by a copy of the proposed amendment, a summary thereof and comments of the Medical Executive Committee. If a proposed

amendment is approved by the Active Staff in accordance with Section 13.3, it shall be submitted to the Board for final approval.

13.5 BOARD OF DIRECTORS ACTION

13.5-1 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.

13.5-2 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 Executive Committee of its concerns. The Medical Executive Committee may request, and if so requested, the Board will establish, a joint conference committee comprised of three representatives of each body to resolve such concerns.

13.6 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.

13.7 CREDENTIALS PROCEDURE MANUAL, FAIR HEARING PLAN AND MEDICAL STAFF RULES AND REGULATIONS

13.7-1 PERIODIC REVIEW

The Credentials Procedure Manual, Fair Hearing Plan and Medical Staff Rules and Regulations shall be reviewed and revised at least every two years or as needed or when requested by the Board of Directors. The Credentials Procedure Manual, Fair Hearing Plan and Medical Staff Rules and Regulations must be adopted by the Medical Executive Committee. Amendments to the Credentials Procedure Manual, Fair Hearing Plan and/or Medical Staff Rules and Regulations may be adopted upon approval of the Medical Executive Committee and the Board.

13.7-2 COMMUNICATION TO THE MEDICAL STAFF

(a) Routine matters. Absent a documented need for urgent action, before amending any of the documents listed in Section 13.7-1, the Medical Executive Committee will communicate to the Medical Staff by email all proposed changes to the documents listed in Section 13.7-1 before approving such changes. Members of the Medical Staff may submit comments to the Chief of Staff c/o the Medical Staff Office within 10 days. If no comments are received within 10 days, the Medical Executive Committee's recommendation relating to the proposed amendment(s) will be submitted to the Board for approval. If any comments are received by the Chief of Staff, the Medical Executive Committee will determine whether to approve, modify or reject such proposed amendment(s).

(b) Urgent matters. In cases of a documented need for urgent action, the Medical Executive Committee and Board may provisionally adopt an amendment to one or more of the documents listed in Section 13.7-1 without prior notification to the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment in the manner described in Section 13.7-2(a). If comments are not received within 10 days, the amendment stands. If comments are received indicating that at least one-third of the Active Staff oppose the amendment, the Executive Committee will address such comments by utilizing the conflict resolution process set forth in Section 12.10. If necessary, a revised amendment will be submitted to the Medical Staff and, if approved, to the Board for action.

13.7 -3 MEDICAL STAFF AMENDMENTS

The Medical Staff may propose amendments to the Credentialing Procedures Manual, Fair Hearing Plan, Medical Staff Rules and Regulations or Allied Health Rules and Regulations to the Medical Executive Committee or directly to the Board. However, prior to submitting a proposed amendment to any of the documents listed in the preceding sentence to the Board, any such proposed amendment must be supported by a petition signed by at least one-third of the Active Staff members and shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendment at its next meeting. The Medical Executive Committee may refer the proposed amendment to the Bylaws Committee or to an ad hoc committee for its consideration and recommendations, which shall be made to the Medical Executive Committee. If the Medical Executive Committee does not accept the Medical Staff's proposed amendment, and if the representatives of the Medical Staff who submitted the proposed amendment and the Medical Executive Committee do not agree on alternative language for the proposed amendment, the members of the Medical Staff who proposed the amendment may submit the proposed amendment for approval by the Board.

ARTICLE FOURTEEN: JOINT CONFERENCE COMMITTEE

14.1 In the event the Medical Executive Committee or the Board have concerns or disagreements regarding credentialing recommendations, Exclusive Agreements with members of the Medical Staff, policies or other issues that have not been able to be resolved through informal processes between the Medical Executive Committee and the Medical Center or Banner Health administration, management or Board, the Board and the Medical Executive Committee shall establish a Joint Conference Committee consisting or three representatives appointed by the Board and three representatives who are members of the Medical Staff appointed by the Chief of Staff to resolve such concerns. The Joint Conference Committee shall conduct its proceedings in the manner specified in the Banner Health Bylaws.

ADOPTION AND APPROVAL

October 2010
March 2011
April 2011
October 2011
January 2012
May 2012
June 2012
January 2013
July 2013
January 2014
June 2014