Banner Health

Banner Payson Medical Center

MEDICAL STAFF BYLAWS

Approved by the Banner Health Board of Directors: 06/10/2021
Revisions adopted: 09/09/2021, 10/14/2021

TABLE OF CONTENTS

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Payson 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 Banner Health Board of Directors ("Board").

These Bylaws shall include the integration and oversight by the Medical Center and Advanced Practice Providers practicing in a Provider Based Rural Health Clinic (PBRCH) as part of the Medical Center.

ARTICLE ONE: NAME

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

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 **PURPOSES**
The purposes of this Medical Staff are:

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

2.1-2 To continually provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Payson 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. This is 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 high 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 Chief Executive Officer on medico-administrative issues and on Medical Center policymaking 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 and taking action to decrease morbidity and mortality;
(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; and
(e) Complying with the Banner Care Management Initiatives.

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

2.2-5 To take action, as necessary, to enforce the Medical Staff Bylaws, Rules and Regulations and policies.

2.2-6 To participate in the Medical Center's long3 range planning activities.

2.2-7 To assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2-8 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 has Medical 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 license issued by the State of Arizona to practice medicine, dentistry, podiatry, or psychology.

3.1-2 DEA/CONTROLLED SUBSTANCE REGISTRATION

In order to prescribe controlled substances, the practitioner must possess a current Federal Drug Enforcement Administration (DEA) registration with the practitioner's in-state address in the State of the Medical Center; and a Controlled Substance License as required to meet state requirements (Wyoming and Nevada). Prescribing privileges shall be limited to the classes of drugs granted to the practitioner by the DEA/Controlled Substance and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant.

3.1-3 PROFESSIONAL EDUCATION AND TRAINING

(a) Graduation from an approved medical, osteopathic, dental, or podiatric school or attainment of a PhD. degree in a recognized scientific field from an accredited university; or certification by the Educational Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in the Medical Sciences.

For purposes of this section, an "approved" or "accredited" school or university is one fully accredited during the time of the practitioner's attendance by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing or by an accrediting agency on file with the U.S. Secretary of Education.

(b) Satisfactory completion of an approved postgraduate training program. An "approved" postgraduate training program is one fully accredited throughout the time of the practitioner's training by the Accreditation Council for Graduate Medical Education (ACGME), by the American Osteopathic Association, by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing, or a program equivalent to one accredited by the ACGME.

3.1-4 BOARD CERTIFICATION

(a) Board certified or qualified for Board certification. Where membership and privileges are granted on the basis of Board qualification, certification must be obtained within five years of completion of training or sooner as required by the department or within three years from the expiration of original Board certification or recertification. Failure to become certified within the time allowed under these Bylaws, as required by the appropriate Board, or Rules and Regulations of the applicant's department or section, shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges. Physicians granted membership on August 1, 2015,

the date these Bylaws were originally approved by the Banner Board, are exempt from the board certification requirement.

For purposes of this section, "Board certification" or "Board certified" means certified and/or shows active participation in the Maintenance of Certification (MOC) program, if applicable, 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 has completed the training necessary to be accepted to become/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 will be deemed qualified during this time period if the director of his/her training program certifies that he/she has met all training requirements for qualification by the appropriate board.

(b) Exceptions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:
a. where a particular field or specialty of the department does not have a Board certification;
b. where privileges are limited to surgical assisting or referring only; or
c. 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.

(c) Members are required to remain board certified. Recertification must be obtained within three (3) years from the expiration of board certification or recertification or within shorter time periods if required by the Department. Failure to become recertified within three years from the expiration of original Board certification or recertification shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

(d) The Medical Executive Committee may consider extending membership under the following circumstances for initial certification or maintenance of certification:
a. a practitioner has taken the exam, and is awaiting results or has exam scheduled and provides evidence of this; or
b. a practitioner has submitted evidence of a particular medical, physical, family, or financial hardship in which they were unable to become certified or recertified within the required time frame. In this instance, the practitioner must sit for the next available board exam to become certified or recertified.

In the event the practitioner fails to certify or does not take the exam, privileges will be immediately forfeited.

(e) The Medical Executive Committee may grant a waiver of recertification requirements with 75% Committee approval to practitioners:
a. With ten years of experience in their specialty; **AND**
b. Who provide evidence of completion of 30 hours of CME yearly.

3.1-5 **CLINICAL PERFORMANCE AND COMPETENCE**
Current competence, experience, clinical results, and utilization patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

3.1-6 **COOPERATIVENESS**
Demonstrated ability 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 and employee satisfaction. It is the policy of Banner Payson 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, hospital employee, patient or visitor) shall not be tolerated. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken.

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

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

3.1-9 **SATISFACTION OF CRITERIA FOR PRIVILEGES**
Evidence of satisfaction of the criteria for the granting of, and maintenance of, clinical privileges.

3.1-10 **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.

3.1-11 **PARTICIPATION IN GOVERNMENT PROGRAMS**
Ability to participate in Medicare/AHCCCS and other federally funded health programs.

3.1-12 **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.

3.1-13 **VERBAL AND WRITTEN COMMUNICATION SKILLS**
Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-14 **PROFESSIONAL LIABILITY INSURANCE**
Evidence of professional liability insurance with limits of at least $1 million for each claim and $3 million in aggregate. An applicant for Medical Staff membership only, with no clinical privileges, shall not be required to provide proof of professional liability insurance coverage (e.g., a member in the Community Based staff category).

3.1-15 **ABSENCE OF FELONY CHARGES**
Demonstrate that he/she has never been convicted of or entered a plea of guilty to or a plea of no contest to any felony related to the practice of medicine.

3.1-16 **EFFECTS OF OTHER AFFILIATIONS**
No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:
(a) Licensure to practice;
(b) Completion of a postgraduate training program at any Banner facility;
(c) Certification by any clinical board;
(d) Membership on a medical school faculty;
(e) Staff appointment or privileges at another health care facility or in another practice setting; or
(f) Prior staff appointment or any particular privileges at Medical Center.

3.1-17 **NONDISCRIMINATION**
No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the delivery of quality and efficient patient care in the Medical Center, to professional qualifications, to the Medical Center's purposes, needs and capabilities, or to community need.

3.1-18 **EXEMPTIONS FROM QUALIFICATIONS**
Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the honorary staff and as otherwise provided in these Bylaws.

3.2 **RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP**
Each staff member, regardless of assigned staff category, shall have the following rights:
(a) The right to meet with the Medical Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department chair. The member must submit written notice to the Chief of Staff at least two weeks in advance of the regular meeting;
(b) The right to initiate a recall election of a Medical Staff Officer and/or a department chair by following the procedures set forth in Section 7.5 and/or Section 8.4;
(c) The right to initiate the scheduling of a general staff meeting by following the procedures set forth in Section 10.1-2;
(d) The right to challenge any rule or policy established by the Medical Executive Committee by presentation to the Medical Executive Committee of a petition signed by a majority of the Active Staff, as herein defined. Upon receipt of such a petition, the Medical Executive Committee will provide information clarifying the intent of the rule or policy or schedule a meeting to discuss the issue;
(e) The right to request conflict resolution of any issue by presentation to the Medical Executive Committee

of a petition signed by a majority of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will schedule a meeting to discuss the issue.

(f) The right to request a meeting when a majority of members in a specialty believe that the department leadership has not acted appropriately.

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

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

(i) The right to request that the Medical Executive Committee request a Joint Conference Committee meeting with the Board to resolve concerns regarding medical staff bylaws, credentialing recommendations, policies or other issues which such medical staff has been unable to resolve through informal processes with the Chief Executive Officer, senior management, or the Board of Directors.

3.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

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

(a) Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate;

(b) Abide by the Banner Health Bylaws, these Bylaws, 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;

(d) Serve on the on-call roster for charity, unassigned, and emergency patients as determined by the applicable department, the Medical Executive Committee and the Chief Executive Officer;

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

(f) Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and obtain consultation when necessary for the health or safety of those patients;

(g) Participate in continuing education programs;

(h) Use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and Banner Health's business information designated as confidential by Banner Health or its representatives prior to disclosure;

(i) Refrain from disclosing confidential information to anyone unless authorized to do so;

(j) Protect access codes and computer passwords and to ensure confidential information is not disclosed;

(k) Disclose to the Medical Staff when requested any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or the Medical Center;

(l) Refrain from making treatment recommendations/decisions for economic benefit of the practitioner and unrelated to needs of the patient;

(m) Comply with all applicable state and federal law in disclosing to a patient any direct financial interest that the practitioner, his/her group or his/her employer has in a separate diagnostic or treatment facility prior to transferring the patient to such facility.

(n) Participate in Banner training program for the electronic medical record (EMR) prior to exercising clinical privileges and to remain current with regard to relevant changes, upgrades and enhancements to the EMR.

(o) Participate in Banner's Medical Staff New Provider Orientation Program as required by the Medical Executive Committee and Administration.

3.4 TERM OF APPOINTMENT

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

3.4-1 EXPIRATION

The appointment of each staff member shall expire every two years on the last day of the birth month of the practitioner, except as provided in this Section.

3.5 EXHAUSTION OF ADMINISTRATIVE REMEDIES

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

3.6 LIMITATION OF DAMAGES

Every applicant to and member of the Medical Staff agrees that his or her sole remedy for any adverse or

corrective action for failure to comply with these Bylaws shall be the right to seek injunctive relief pursuant to the Arizona Peer Review Statute, ARS 36-445 et. seq. An alleged breach of any provision of these Bylaws and/or Fair Hearing Plan shall provide no right to monetary relief from the Medical Staff, the Medical Center or any third party, including any employee, agent or member of the Medical Staff or the Medical Center and any person engaged in peer review activities.

3.7 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.7-1 QUALIFICATIONS

A practitioner who is or who will be providing professional direct patient care services pursuant to a contract or employment with the 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. For purposes of this section, practitioners providing specified professional services does not include outside practitioners assisting the Medical Staff with its peer review functions.

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

3.8 EXCLUSIVE CONTRACTS

The Medical Center may enter into an Exclusive Agreement with members of the Medical Staff which limit the rights of other practitioners to exercise clinical privileges and/or the rights and prerogatives of Medical Staff membership. Such Agreements may only be entered into after a determination that expected improvements to the quality of care, coverage, cost-efficiency and/or service excellence will outweigh the anticompetitive effect of the Agreement as required by the Board's Physician Exclusive Agreements policy. Applications will not be accepted or processed for applicants that are not a part of the Exclusive Agreement provider group. No reporting is required under federal or state law when privileges or membership is limited or terminated because an Exclusive Agreement is entered into, and no such reports shall be made.

Where a physician leaves a group with an Exclusive Agreement or where the Exclusive Agreement is cancelled, the physician's medical staff membership and privileges will automatically expire.

3.8-1 REVIEW OF POSITIONS

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

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

(c) The Medical Executive Committee shall be given an opportunity to report its findings to the Chief Executive Officer before the Exclusive Agreement is entered into or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care and whether the Agreement is necessary to establish the expected benefits. The report must be submitted, if at all, within 60 days of the Chief Executive Officer's explanation of the need for, and expected benefits of, the Agreement to the Medical Executive Committee. The Chief Executive Officer is ultimately responsible for determining, in his/her discretion, whether to enter into the Agreement.

(d) In the event the Medical Executive Committee disagrees with the decision of the Chief Executive Officer to enter into an exclusive contract, the Medical Executive Committee may request a Joint Conference Committee as set forth in Section 13.5. The request must be made, if at all, within ten days of notification by the Chief Executive Officer's decision.

3.9 MEDICAL DIRECTORS of SERVICE LINE

3.9-1 ROLE

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

3.9-2 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall automatically be granted Active Staff membership without privileges if applicable. 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 including, but not limited to, responsibility for reviewing care, conducting investigations, identifying trends and resolving issues and such other duties as delegated by the Medical Executive Committee. For the Chief Medical Officer to exercise privileges at the Medical Center 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 Section 3.1.

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.1 CATEGORIES

The Medical Staff shall include the categories Active, Consulting, Clinic Based Physician (as applicable), Community Based, Telemedicine, and Advanced Practice Provider (as applicable). At the time of appointment and at the time of each reappointment, the Medical Staff Member's staff category shall be recommended by the Credentials Committee if applicable and Medical Executive Committee and approved by the Board

4.2 ACTIVE STAFF

4.2-1 REQUIREMENTS FOR ACTIVE STAFF

The Active Staff category shall consist of practitioners who actively support the Medical Staff and the Medical Center by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.

In the event that a member of the Active Staff does not meet the qualifications for reappointment to the Active Staff but is otherwise abiding by these Bylaws and the other Medical Staff Documents, the member may be appointed to the Consulting Staff, and such appointment shall not, in and of itself, entitle the Applicant to the procedural rights set forth in the Fair Hearing Plan.

4.2-2 PREROGATIVES OF ACTIVE STAFF

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization, unless otherwise specified elsewhere in these Bylaws. Any Active Staff Member may attend Medical Staff meetings and serve on committees of the Medical Staff or Medical Center.

4.2-3 OBLIGATIONS OF ACTIVE STAFF

Each Member of the Active Staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; participate in unassigned patient call coverage for emergency care services; provide continuous care and supervision of his/her patients in the Medical Center or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Medical Center; attend **50% of the General** Medical Staff meetings; and perform such further duties as may be required under these Bylaws or Rules and Regulations including any future changes to these Bylaws or Rules and Regulations, and comply with directives issued by the Medical Executive Committee.

4.3 CONSULTING STAFF

4.3-1 REQUIREMENTS FOR CONSULTING STAFF

The Consulting Staff category shall consist of practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Medical Center for consultation, call coverage, referral of patients, or other patient care purposes.

4.3-2 PREROGATIVES OF CONSULTING STAFF

Members of the Consulting Staff shall not be eligible to vote or hold office within the Medical Staff organization. A Consulting Staff Member may serve on committees of the Medical Staff or Medical Center and may attend Medical Staff meetings and educational programs unless otherwise specified elsewhere in these Bylaws. Consulting Staff members may serve as attending, admitting, or surgeons of record

4.3-3 OBLIGATIONS OF CONSULTING STAFF

Each member of the Consulting Staff shall discharge the basic obligations of staff members as required in these Bylaws; participate in unassigned patient call for emergency care services within his/her clinical specialty as may be specified; provide continuous care and supervision of his/her patients in the Medical Center or arrange a suitable alternative; actively participate in quality/performance improvement, risk management, and monitoring activities recognized by the Medical Center and Banner Health; participate in the training and subsequent use of the electronic medical record system,

including computerized physician order entry; and perform such further duties as may be required under these Bylaws or Rules and Regulations.

4.4 TELEMEDICINE STAFF

4.4-1 REQUIREMENTS FOR TELEMEDICINE STAFF

The Telemedicine Staff category shall consist of practitioners who remotely practice privileges granted and do not physically treat patients in the Medical Center. The Telemedicine Staff category is for members who provide diagnostic treatment delivered through a telemedicine medium. Members of the Telemedicine Staff shall not serve as the attending, admitting, or surgeon of record for any patient.

4.4-2 PREROGATIVES OF TELEMEDICINE STAFF

Members of the Telemedicine Staff may practice privileges granted from a remote location through electronic communication. Telemedicine Staff shall not be eligible to vote or hold office within the Medical Staff organization. Telemedicine Staff may attend educational events, and any meetings of the Medical Staff unless otherwise specified elsewhere.

4.4-3 OBLIGATIONS OF TELEMEDICINE STAFF

Each member of the Telemedicine Staff shall discharge the basic obligations of staff members as required in these Bylaws; participate in the training and subsequent use of the electronic medical record system, including computerized physician order entry; and perform such further duties as may be required under these Bylaws or Rules and Regulations.

4.5 COMMUNITY BASED STAFF (if applicable)

4.5-1 REQUIREMENTS FOR COMMUNITY BASED STAFF

The Community Based Staff category shall consist of practitioners who do not practice in the Medical Center but request services for their patients and desire to maintain Medical Staff membership. The Community Based Staff category is a membership-only category of the Medical Staff with no clinical privileges. As members of the Medical Staff, Community Based Staff shall be credentialed and shall be granted membership with approval by the Board. Since no clinical privileges are granted, Community Based Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

4.5-2 PREROGATIVES OF COMMUNITY BASED STAFF

Members of the Community Based Staff may visit their hospitalized patients and review their patients' medical records (if CPOE training has been completed); order outpatient diagnostic services and be appointed to Medical Staff committees and vote on matters presented at those Medical Staff committees unless otherwise provided by these Bylaws or another Medical Staff Document. Members of the Community Based Staff cannot exercise clinical privileges and may not write orders, progress notes, or any notations in the medical record. Members may attend continuing medical education programs or meetings of the Medical Staff without a vote. Community based members shall not be eligible to vote or serve as an officer of the medical staff.

4.5-3 OBLIGATIONS OF COMMUNITY BASED STAFF

Each member of the Community Based Staff shall discharge the basic obligations of staff members as required in these Bylaws including paying all Medical Staff dues and assessments if applicable. They shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each member of the Community Based Staff shall establish appropriate referral and coverage arrangements with an Active or Consulting Staff member for the medical care of his/her patients that require Hospital services.

4.5-4 CHANGE IN MEDICAL STAFF CATEGORY

A member of the Community Based Staff may request a change in category to the Active, Consulting, or Telemedicine Staff if such member of the Community Based Staff: meets the necessary qualifications; is able to provide evidence of current clinical competence; and meets all qualifications for the specific privileges they are applying for.

4.5-5 DENIAL OR TERMINATION OF COMMUNITY BASED STAFF MEMBERSHIP

Notwithstanding anything contained in any Medical Staff Document to the contrary, members of the Community Based Staff are not entitled to due process rights under these Bylaws or the Corrective Action/Fair Hearing Plan. An Applicant who believes he/she was wrongly denied membership on the Community Based Staff or a member of the Community Based Staff who believes his/her membership was wrongly terminated may submit information to the Medical Executive Committee demonstrating why such denial or termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission. The Applicant or member shall have no appeal or other rights in connection with the Medical Executive Committee's decision.

4.6 EMERITUS/HONORARY STAFF RECOGNITION

4.6-1 **REQUIREMENTS FOR EMERITUS/HONORARY STAFF**

Emeritus/Honorary status shall be granted to practitioners retired from professional practice who are recognized for their noteworthy contributions and outstanding service to the Medical Center and/or long-standing service of at least 15 years to the Medical Center. The recommendation for Emeritus Staff will be recommended by the Medical Executive Committee. Emeritus Staff practitioners are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any other credentialing processes.

4.6-2 **PREROGATIVES OF EMERITUS/HONORARY RECOGNITION**

Emeritus Staff shall be invited and welcome to attend educational and social functions of the Medical Center and Medical Staff.

4.7 CLINIC BASED PHYSICIAN STAFF (IF APPLICABLE)

4.7-1 **REQUIREMENTS FOR CLINIC BASED STAFF**

The Clinic Based Staff category shall consist of practitioners who practice solely in a Provider Based Rural Health Clinic as part of the Medical Center and who actively support the Medical Staff and the Medical Center by contributing to efforts to fulfill Medical Staff functions.

4.7-2 **PREROGATIVES OF CLINIC BASED STAFF**

Members of the Clinic Based Staff shall be eligible to vote and hold office within the Medical Staff organization. A Clinic Based Staff Member may serve on committees of the Medical Staff or Medical Center and may attend Medical Staff meetings and educational programs.

4.7-3 **OBLIGATIONS OF CLINIC BASED STAFF**

Each member of the Clinic Based Staff shall discharge the basic obligations of staff members as required in these Bylaws and Rules and Regulations; provide continuous care of his/her patients in the Rural Health Clinic; actively participate in quality/performance improvement, risk management, and monitoring activities recognized by the Medical Center and Banner Health; participate in the training and subsequent use of the electronic medical record system, including computerized physician order entry; and perform such further duties as may be required under these Bylaws or Rules and Regulations.

Clinic Based Staff will not be required to participate in the Medical Center unassigned patient call for emergency care services.

4.8 CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff Member, the Medical Executive Committee may recommend a change in medical staff category of a Member consistent with the requirements of the Bylaws. The Board shall approve any change in category.

4.9 ADVANCED PRACTICE PROVIDER

The term, Advanced Practice Provider (APP) refers to individuals who provide direct patient care services in the Medical Center. An additional category of Clinic Based Advanced Practice Provider will be used to define those APP's whose practice is limited to direct patient care services in the Provider Based Rural Health Clinic and further defined by their scope of privileges.

Advanced Practice Providers (APPs) are licensed healthcare professionals, who are Board Certified and have at least a master's degree. APPs are highly trained to practice medicine and prescribe within the scope of their training as outlined by their specific scopes of practice. The providers in the category include:

- Physician Assistants (a minimum of a master's degree is required if trained after 2020)
- Advanced Practice Nurses (i.e. nurse practitioners)
- Nurse Anesthetist (a minimum of a master's degree is required if trained after 1998)
- Certified Nurse Midwives

APPs will be privileged and credentialed via the organized medical staff's privileging process and approved by the Banner Health Board of Directors (Board). Individuals applying for clinical privileges to practice as an APP are eligible for membership to the Medical Staff as applicable by facility. Additional roles and responsibilities are defined in the Advanced Practice Provider Policy

4.10 ALLIED HEALTH PROFESSIONAL

Allied Health Professionals are not eligible for membership to the Medical Staff and roles and responsibilities are defined in the Allied Health Professional Policy.

ARTICLE FIVE: CLINICAL PRIVILEGES

5.1 PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES

Completed applications for membership and privileges (including applications for Advanced Practice Providers and Allied Health Professionals) are submitted at the time of initial appointment to the Department Chair if applicable, Credentials Committee if applicable, and Medical Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Medical Staff is set forth in further detail in the Credentials Manual.

5.2 PROCESS FOR "DISTANT SITE" CREDENTIALING OF TELEMEDICINE PROVIDERS

For purposes of this section, Distant Site defined as the site where the practitioner providing the telemedicine service is located.

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

5.3 PROCESS FOR CREDENTIALING AND PRIVILEGING ADVANCED PRACTICE PROVIDERS AND ALLIED HEALTH PROFESSIONALS

Completed applications for Advanced Practice Providers and Allied Health Professionals for membership and privileges are submitted prior to the time of initial appointment and reappointment to the, Department Chair if applicable, Credentials Committee, if applicable and Medical Executive Committee subject to final approval by the Board. The process for appointment and reappointment to the Advanced Practice Providers and Allied Health Staff is set forth in further detail in the Credentials Manual.

5.4 EXERCISE OF PRIVILEGES

5.4.1 IN GENERAL

Privileges may not be exercised at the Medical Center until the practitioner has successfully completed Banner's CPOE/EMR (Computer Physician Order Entry/Electronic Medical Record) training and orientation.

5.4.2 PRIVILEGES IN EMERGENCY SITUATIONS

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to the degree permitted by the practitioner's license, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of 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.

5.4.3 EXPERIMENTAL PROCEDURES

Experimental drugs, procedures, or other therapies or tests (Experimental Procedures) may be performed only after approval of the involved protocols by the Banner Institutional Review Board. Any Experimental Procedure may be performed only after the regular credentialing process has been completed and the privilege to perform or use such procedure has been granted to the practitioner.

5.5 TELEMEDICINE PRIVILEGES

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 services may also be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand.

5.6 PROCEDURE FOR DELINEATING PRIVILEGES

5.6-1 REQUESTS

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. Specific requests must also be submitted for modifications of privileges in the interim between reappointment periods. All requests for clinical privileges will be processed in accordance with the procedures set forth in the Credentials Manual. In some instances,

staff membership may be granted to a practitioner who desires not to request clinical privileges.

5.7 BASIS FOR PRIVILEGES DETERMINATIONS

Clinical privileges shall be granted in accordance with education and training, experience, 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, peer review, supervised cases (if applicable), and where appropriate, practice at other hospitals will also be considered. In review of requests for changes in privileges, evidence of appropriate training and experience and current clinical competence must be documented.

5.8 PRIVILEGE DECISION NOTIFICATION

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

5.9 PRIVILEGES FOR NEW PROCEDURES

The Medical Executive Committee 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 Credentials Committee if applicable and the Medical Executive Committee have considered and approved the recommendation to create new criteria for privileges and, where new criteria are established, has determined that the practitioner has demonstrated the necessary qualifications. The Medical Executive Committee's determination is subject to ratification by the Banner Board.

5.10 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES

5.10-1 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 specialty. In the event that a practitioner requests privileges to perform a procedure not currently within the jurisdiction of his or her specialty, the practitioner will notify the Credentials Committee (if applicable) and the Medical Executive Committee 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.

5.10-2 DETERMINATION OF APPROPRIATENESS

The Credentials Committee (if applicable) will evaluate the request and shall give the affected practitioner and other interested persons an opportunity for an interview as applicable. The Credentials Committee will forward the recommendation to the Medical Executive Committee and they will recommend to the Board whether interdisciplinary privileges are appropriate and, if applicable, the criteria and process for granting such privileges.

5.11 TEMPORARY PRIVILEGES

5.11-1 CONDITIONS

Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately licensed practitioner, who is appropriately Board certified or qualified for Board certification, when the information substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has satisfied the requirement of these Bylaws. Special requirements of supervision and reporting may be imposed by the Chief of Staff. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws, Rules and Regulations and the policies of the Medical Staff and Medical Center. Temporary privileges shall be time-limited as specified for the type of temporary privileges listed below.

5.11.1.1 **Review:** Any prerequisite approval for the granting of temporary privileges is entirely discretionary, and neither denial nor termination of temporary privilege triggers any right to a hearing or other review.

5.11.1.2 **Grant, Denial:** The process for granting each kind of temporary privilege is upon recommendation by the Credentials Committee Chair (if applicable) Chief of Staff, or their respective designees and the Chief Executive Officer or designee.

5.11-2 **CIRCUMSTANCES**

(a) Applicant awaiting review and approval of the Medical Executive Committee and Board/Pendency of Application: Temporary privileges may be granted to an applicant who has submitted a complete and clean application, as defined within the Credentials Manual and is awaiting review and approval of the Credentials Committee (as applicable), Medical Executive Committee and the Board. Temporary privileges may be granted for up to one hundred twenty (120) days.

i. Additional privileges: Temporary privileges may be granted to a Provider requesting one or more additional privileges is awaiting review and approval of the Credentials Committee, as applicable, Medical Executive Committee and the Board.

(b) Applicant with a routine application as defined in the Credentials Manual:
Temporary privileges may be granted to an applicant with a routine application for appointment after a recommendation for approval by the Banner Medical Staff Subcommittee. Temporary privileges shall last until action is taken by the Banner Governing Board and shall not exceed 120 days.

(c) To Fulfill an Important Patient Care, Treatment and Service Need (Locum Tenens):
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:

- appropriate licensure;
- adequate professional liability insurance;
- DEA registration and controlled substance (if applicable);
- current clinical competency, including one peer reference;
- education and training;
- board certification (if applicable)
- evidence of freedom from infectious tuberculosis and recent flu vaccination (when applicable);
- no involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial or loss of privileges at the practitioner's primary facility;
- freedom from government sanctions; and NPDB query responses as required to meet privilege criteria.

Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 120 consecutive days upon completion of CPOE training. One extension may be granted for an additional period not to exceed 120 days after which the practitioner must apply for membership and privileges before providing additional patient care, treatment or services. Any such extension shall be made by the Chief of Staff when the information available continues to support a favorable determination regarding the practitioner's application for temporary (locums) privileges.

(d) Temporary privileges for the care of a specific patient, and/or proctoring may be granted only after the Medical Staff Office has received a request for the specific privileges desired; confirmed appropriate licensure and professional liability insurance coverage and favorable results of the National Practitioner Data Bank Query.

5.11-3 **TERMINATION**

The Chief Executive Officer, Chief of Staff, department chair or credentials chair (if applicable) may terminate any or all of a practitioner's temporary privileges effective immediately on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the

Medical Center will be assigned to another practitioner. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

5.11-4 **RIGHTS OF THE PRACTITIONER**

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

5.12 DISASTER PRIVILEGES

5.12-1 Disaster privileges may be granted to volunteer licensed independent practitioners when the Emergency Operations Plan has been activated in response to a disaster and the Medical Center is unable to meet immediate patient care needs. Disaster privileges may be granted by the Chief Executive Officer, Chief of Staff or their designees. Disaster privileges will be granted on a case-by-case basis at the discretion of the Chief Executive Officer or Chief of Staff (or their designee) but they are not required to grant privileges to any individual.

5.12-2 Before a practitioner is considered eligible to function as a volunteer licensed independent practitioner, the Medical Center obtains his or her valid government-issued photo identification issued by a state or federal agency (for example, a driver's license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation;
- A current license to practice in the United States;
- Primary source verification of licensure;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group;
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
- Confirmation by a licensed independent practitioner currently privileged by the Medical Center or a staff member with personal knowledge of the volunteer practitioner's identity and ability to act as a licensed independent practitioner during a disaster.

5.12-3 The volunteer practitioner must complete and sign the "Disaster Verification and Approval Form" and the "Emergency Licensure and Certification Procedure" form. A Banner Identification badge and/or ESAR-VHR badge must be worn when entering the facility for assigned duties.

5.12-4 Primary source verification of licensure will begin within 72 hours of the practitioner presenting to the Medical Center or as soon as the immediate situation is under control (whichever comes first). If not verified within 72 hours, the reason must be documented and evidence of the volunteer practitioner's ability to continue to provide adequate care, treatment and services.

5.12-5 The practitioner will be assigned to a currently credentialed Medical Staff member and practice only within his/her scope of practice. Oversight of the professional performance of practitioner who receives disaster privileges (e.g. direct observation, mentoring, clinical record review) will be the responsibility of the Chief of Staff or Chief Medical Officer or their respective designee.

5.12-6 The Chief Executive Officer, Chief of Staff or their designee may terminate any or all of a practitioner's disaster privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Medical Center will be assigned to another practitioner. A practitioner is not entitled to the procedural rights afforded by these Bylaws because a request for temporary privileges is refused in whole or in part or because all or any portion of the temporary privileges are terminated, not renewed, restricted, suspended, or limited in any way.

ARTICLE 6: CORRECTIVE ACTION

6.1 CRITERIA FOR INITIATING CORRECTIVE ACTION

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

6.2 COLLEGIAL INTERVENTION

6.2-1 These bylaws encourage the use of progressive steps by Medical Staff leaders and Medical Center management, as appropriate, beginning with collegial and educational efforts to address issues pertaining to clinical competence and/or professional conduct. Initial collegial efforts may be made prior to resorting to corrective action when appropriate. Such collegial interventions shall not constitute corrective action and shall not afford the right to a fair hearing and appeal as set forth in the Fair Hearing Plan and shall not require reporting to the state licensure Board or the NPDB except as otherwise provided in these Bylaws.

6.2-2 Collegial intervention is part of the Medical Center's professional review activities and may include, but not limited to:

(a) Advising providers of applicable polices such as policies regarding appropriate behavior; unassigned call obligations, and timely and appropriate medical records documentation;
(b) Informal discussion or formal meetings regarding concerns raised about conduct or performance;
(c) Consultation with providers;
(d) Sharing of data to assist individuals to conform practices to appropriate guidelines and norms;
(e) Written letters of guidance, reprimand or warning regarding concerns about conduct or performance; or
(f) Warnings regarding potential consequences of failure to improve conduct or performance.

6.2-3 The Chief of Staff in conjunction with the Chief Medical Officer may determine whether a matter should be handled in accordance with another policy or should be referred to Medical Executive Committee for further action.

6.2-4 The relevant medical staff leader will document all collegial intervention efforts and will place such documentation in the individual's confidential file.

6.3 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 Chief Executive Officer, or the Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request.

(b) The Medical Executive Committee (MEC) or Peer Review Committee at the facility, or subcommittee thereof ("Committee") shall consider the request and determine if an investigation is warranted. The Committee shall conduct an investigation whenever significant concerns are identified regarding a practitioner's competence or conduct. The Committee may use one or more "evaluation tools" described below to determine whether corrective action is necessary. Evaluation tools include but are not limited to an interview with the practitioner, concurrent or retrospective chart review, concurrent observation and/or consultation requirements and interviews with other medical staff members and/or Medical Center employees. The involved practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension pursuant to Section 6.6-10 of these Bylaws. The involved practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such tools. The Medical Executive Committee will be kept informed of the status of such investigations, if the PRC is conducting investigation.

(c) Certain matters that may lead to corrective action are routinely considered by the PRC and/or MEC 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 PRC/MEC, the PRC/MEC shall conduct a review as set forth herein, and no request for an investigation and/or corrective action is required.

6.4 PROCEDURE FOR PEER REVIEW

(a) Within 60 days of being advised of significant behavioral concerns or concerns regarding competence, the PRC/MEC shall conclude an investigation and document its findings. If the findings warrant that corrective action be taken, the affected practitioner shall have an opportunity for an interview with the PRC/MEC. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. A record of such interview shall be made and included with its report. In certain instances, the PRC/MEC investigation may not be concluded within 60 days. In such instances, the investigation shall be concluded

as soon as reasonably practical. The affected practitioner shall have no procedural rights arising out of such delay. After its deliberations, the PRC will make its recommendation, and if adverse, shall forward it to the Medical Executive Committee.

(b) If the PRC recommends that corrective action be taken, the Medical Executive Committee shall review the recommendation to determine whether it is supported by substantial evidence and whether the Bylaws were followed. Prior to recommending reviewable corrective action, the Medical Executive Committee shall give the affected practitioner an opportunity for an interview. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. If the Medical Executive Committee recommends corrective action that is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws.

6.5 PRECAUTIONARY SUSPENSION

6.5-1 INITIATION

Whenever a practitioner willfully disregards these Bylaws or the Rules and Regulations or Medical Center policies, or whenever a practitioner's conduct may require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health and/or safety of any patient, employee or other person present in the hospital or to prevent interference with the orderly operation of the Medical Center; any of the following individuals shall have the right to summarily suspend membership and all or any portion of the clinical privileges of a practitioner:

(a) Chief of Staff or designee, acting as a member of and on behalf of the Medical Executive Committee;
(b) Chief Medical Officer;
(c) Member of the Peer Review Committee, acting on behalf of the Peer Review Committee;
(d) Applicable department chair or designee, acting as a member of and on behalf of the applicable department committee;
(e) Chief Executive Officer or designee;
(f) Medical Executive Committee member, acting as a member of and on behalf of the Medical Executive Committee;
(g) The Peer Review Committee;
(h) Chair of the Banner Board of Directors;
(i) Removal of membership and privileges or limitation of privileges where privileges have been terminated or limited at a Distant Site.

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

6.5-2 REVIEW BY THE PEER REVIEW COMMITTEE AND MEDICAL EXECUTIVE COMMITTEE

1) Process for review for facilities with a Peer Review Committee
A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Peer Review Committee or a subcommittee thereof having no less than three (3) members. The review must be requested within 10 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 10 business days of the request for review, unless the PRC/MEC has already met with the practitioner. Upon deliberation, the PRC or subcommittee thereof may recommend to the MEC that summary suspension be terminated or continued.
Where the suspension is continued, the affected practitioner 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 10 business days of the practitioner's receipt of notice of the PRC's decision. Such review shall take place by the MEC within 10 business days of the request for review.

2) Process for review for facilities with only MEC that functions as the PRC
A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the MEC or a subcommittee thereof having no less than three (3) members. The review must be requested within 10 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 10 business days of the request for review, unless the MEC has already met with the practitioner. Upon deliberation, the MEC or subcommittee thereof may direct that summary suspension be terminated or continued.

6.5-3 EXPEDITED HEARING RIGHTS

In the event summary suspension is continued, special notice of the decision shall be sent to the

affected practitioner who may request a hearing or an expedited hearing pursuant to the Fair Hearing Plan.

6.5-4 **ALTERNATIVE COVERAGE**
Immediately upon imposition of summary suspension, the Chief of Staff, Chief Medical Officer, Chief Executive Officer, department chair 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.

6.6 **AUTOMATIC SUSPENSION OR LIMITATION**
When grounds exist for automatic suspension, the privileges of the practitioner will be automatically suspended without prior action by the Medical Executive Committee or the Board. Alternative medical coverage will be provided for patients as set forth in Section 6.5-4. The Chief of Staff will notify the practitioner of the suspension.

The following circumstances shall constitute conditions for automatic suspension, and further corrective action may be recommended in accordance with the provisions contained within these Bylaws:

6.6-1 **LICENSE**

(a) Revocation: Whenever a practitioner's license to practice in this State is revoked, Medical Staff appointment and clinical privileges are immediately and automatically revoked.
(b) Restriction: Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that are within the scope of the limitation or restriction are similarly immediately and automatically restricted.
(c) Suspension: Whenever a practitioner's license is suspended, Medical Staff appointment and clinical privileges are automatically suspended for the term of the licensure suspension.
(d) Probation: Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.
(e) Expiration: Whenever a practitioner's license expires, Medical Staff appointment and clinical privileges are immediately and automatically revoked, and practitioners must reapply.

6.6-2 **PROFESSIONAL LIABILITY INSURANCE**
A practitioner's appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under Section 3.1-14 of these Bylaws. Privileges will be reinstated upon primary source verification of the provided information during a 90-day period following the suspension. Failure to provide updated information within the 90-day period shall be deemed a voluntary resignation of membership and privileges and practitioners must reapply.

6.6-3 **DEA/CONTROLLED SUBSTANCE** (CSR-Required for Nevada and Wyoming facilities)
Whenever a practitioner's DEA/CSR or other controlled substance registration is revoked, restricted, suspended, or has expired, the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

6.6-4 **MEDICAL RECORDS**
A temporary suspension of privileges to admit patients or to schedule new procedures shall be imposed for failure to complete medical records within the time periods established by the Medical Executive Committee and designated in medical staff documents. Temporary suspension shall be lifted upon completion of the delinquent records. If a medical staff member remains on suspension for 30 calendar days and all delinquent records have not been completed, the practitioner shall be deemed to have voluntarily resigned from the medical staff.

6.6-5 **FAILURE TO BE VACCINATED OR TO OBTAIN EXEMPTION**
A practitioner's Medical Staff clinical privileges shall be immediately suspended for failure to provide evidence of flu vaccination or an approved exemption granted by Banner or, where granted an exemption, for failure to wear a mask as required by Banner policy. Privileges will be reinstated at the end of flu season.

As required by Banner policy, a practitioner's Medical Staff clinical privileges and membership will be automatically suspended for failure to provide evidence of Covid-19 vaccination or an approved exemption granted by Banner Health. After 30 days, privileges will be deemed voluntarily resigned if documentation of Covid-19 vaccination or an approved exemption is not received.

6.6-6 **EXCLUSION FROM MEDICARE/STATE PROGRAMS**
The Chief Executive Officer with notice to the Chief of Staff will immediately and automatically

suspend the Medical Staff privileges of an Excluded Practitioner. The Chief Executive Officer will restore limited privileges to an Excluded Practitioner upon his/her signing an agreement whereby he/she agrees (a) not to provide items or services to patients enrolled in Medicare/State Programs and (b) to indemnify the 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) program. If the practitioner fails to sign the agreement within a 90-day period, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

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

A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, shall automatically be suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. If the practitioner fails to appear within 3 months of the request to appear such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-8 **FAILURE TO EXECUTE RELEASES AND/OR PROVIDE DOCUMENTS**

A practitioner who fails to execute a general or specific release and/or provide documents, as set forth in Section 11.4, during a term of appointment when requested by the Chief of Staff, department chair or designee shall automatically besuspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-9 **FAILURE TO PARTICIPATE IN AN EVALUATION**

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges

6.6-10 **FAILURE TO COMPLETE ASSESSMENTS AND PROVIDE RESULTS**

A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings 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.

6.7 REPORTING REQUIREMENT

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

6.8 NONREVIEWABLE ACTION

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

(a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(b) Issuance of a warning or a letter of admonition or reprimand.
(c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
(d) Termination or limitation of temporary privileges or disaster privileges.

(e) Supervision and other requirements imposed as a condition of granting privileges.
(f) Termination of any contract with or employment by the Medical Center(s) or Banner Medical Group.
(g) Any recommendation voluntarily imposed or accepted by a practitioner.
(h) Denial of membership and privileges for failure to complete an application for membership or privileges.
(i) Denial or termination of community-based affiliation.
(j) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
(k) Reduction or change in staff category.
(l) Refusal of the credentials committee, if applicable or Medical Executive Committee to consider a request for appointment, reappointment, staff category or privileges within two years of a final adverse decision regarding such request.
(m) Removal or limitation of Emergency Department call obligations.
(n) Any requirement to complete an educational assessment or training program.
(o) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(p) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
(q) Retrospective chart review.
(r) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the Chief Executive Officer to enter into, terminate or modify an exclusive contract for certain clinical services; or (2) the termination or modification of the practitioner's relationship with the exclusive provider.
(s) Grant of conditional appointment/reappointment or appointment/reappointment for a limited duration less than two year.
(t) Termination or limitation of membership or privileges based upon a limitation in the type or extent of clinical services which may be provided to Medical Center inpatients from a remote location.
(u) Denial, termination or limitation of telemedicine privileges following denial, termination or limitation of telemedicine privileges at the Distant Site

Where an action that is not reviewable under 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, the Peer Review Committee or the Chief Executive Officer 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, Peer Review Committee or Chief Executive Officer's decision.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1-1 IDENTIFICATION

The officers of the medical staff shall include:
(a) Chief of Staff
(b) Vice Chief of Staff
(c) Secretary/Treasurer
(d) Immediate Past Chief of Staff (ex officio)

7.1-2 QUALIFICATIONS

(a) Each medical staff officer must:
   a. Be a member of the active staff at the time of nomination and election and remain a member in good standing during his or her term of office.
   b. Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
   c. Have demonstrated a high degree of interest in and support of the Medical Staff and the 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 officers of the Medical Staff, the Chief Executive Officer, 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.

(b) Candidates for the Chief of Staff, Vice Chief of Staff and Secretary/Treasurer must meet the qualifications for medical staff officers.

(c) A practitioner may not simultaneously hold multiple medical staff positions.

7.2 TERM OF OFFICE

The term of office of medical staff officers shall be two years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office. At the end of the Chief of Staff's term, the Vice Chief of Staff shall automatically succeed to the office of Chief of Staff provided that qualifications are still met as set forth in 7.1-2 and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.

7.3 ELIGIBILITY FOR REELECTION

A medical staff officer is eligible for nomination and reelection in succeeding terms, not to exceed a total of two successive two-year terms.

7.4 NOMINATIONS

7.4-1 In July of the year in which the Vice Chief of Staff's term of office shall expire, nominations will be sought for the office of Vice Chief of Staff or for the Secretary/Treasurer if applicable.

7.4-2 All 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 or with competing facilities.

7.4-3 By the August meeting of the Medical Executive Committee, the list of nominations will be presented to the Medical Executive Committee and the Chief Executive Officer.

7.5 ELECTIONS, VACANCIES, AND REMOVALS

7.5-1 ELECTION PROCESS

The Medical Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto. The candidate receiving the highest number of votes via electronic and/or mail ballot vote of members of the Active Staff and Advanced Practice Providers as applicable by facility is elected. Voting by proxy shall not be permitted. In the case of a tie, a majority vote of the Medical Executive Committee shall decide the election.

7.5-2 VACANCIES IN ELECTED OFFICES

In the event of a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve for the remainder of the unexpired term in addition to their succession two-year term. When a vacancy occurs in the office of the Vice Chief of Staff, the Secretary/Treasurer shall serve for the remainder of the unexpired term. The Medical Executive Committee shall appoint an interim officer to fill an office until the next regular election.

7.5-3 RESIGNATIONS AND REMOVAL FROM OFFICE

(a) Resignations: any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified in the notice.

(b) Removals: any officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal for cause. Grounds for removal shall include failure to maintain qualifications of the office as outlined in Bylaws Section 7.1-2 and/or uphold the duties of the office as outlined in Bylaws Section 7.6. The individual shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on removal.

7.6 DUTIES OF OFFICERS

7.6-1 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 medical staff meetings, including meetings of the Medical Executive Committee;
(c) serve as an ex officio member of all other staff committees without vote. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;
(d) appoint, with the consultation of the Medical Executive Committee, members for all standing and special Medical Staff or multidisciplinary committees, and designate the chair of these committees;
(e) interact with the Chief Executive Officer 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 Chief Executive Officer;
(g) be a spokesman for the Medical Staff in external professional affairs;
(h) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Medical Executive Committee;
(i) receive and act upon requests of the Board to the Medical Staff; and
(j) report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated functions to promote quality patient care;
(k) serve on the Banner Peer Review Council;
(l) meet and discuss with the Board Subcommittee any matters of concern to the Medical Staff.

7.6-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in his or her absence. The Vice Chief of Staff shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

7.6-3 SECRETARY/TREASURER

The Secretary/Treasurer shall be responsible for oversight of the Medical Staff finances and present a financial report at the annual Medical Staff meeting. The Secretary/Treasurer shall assume all duties and authority of the Vice Chief of Staff in his or her absence and may perform such other duties as the Chief of Staff may assign or delegate.

7.6-4 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff may be an ex officio member (with vote) 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.

ARTICLE EIGHT: RESIDENTS (IF APPLICABLE)

8.1 RESIDENT PHYSICIANS ENROLLED IN GRADUATE MEDICAL EDUCATION PROGRAM

Resident physicians who are currently enrolled in a graduate medical education program and under the supervision of qualified Medical Staff members, shall not be considered Independent practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. Residents shall abide by the provisions outlined in the *Resident Physician Scope of Activities Policy*. Resident physicians enrolled with a graduate medical education program which is conducted by Banner will not require an affiliation agreement with the Medical Center (Banner Residents). All other resident physicians shall be credentialed by the sponsoring training program in accordance with provisions in a written affiliation agreement between the Medical Center and the program; credentialing information shall be made available to the Medical Center upon request.

8.2 RESIDENT AFFILIATION

Resident Affiliation is for senior residents who are moonlighting at the Medical Center within the scope of privileges granted.

8.2-1 QUALIFICATIONS FOR RESIDENT AFFILIATION

Resident Affiliation physicians are not members of the Medical Staff but do have clinical privileges at the Medical Center Resident Affiliation physicians must submit an application for request of privileges and must be enrolled and in good standing in a residency program, approved by the Medical Executive Committee. Resident Affiliation physicians are required to gain approval from the Residency Director to function in a moonlighting capacity. Residents must provide evidence of a currently valid license issued by the State Medical Board to practice, DEA and professional liability insurance in the amount required by the Board.

8.2-2 **PREROGATIVES**

The prerogatives of Resident Affiliation physicians are to:
(a) Practice within the scope defined in their Delineation of Privileges;
(b) Access Medical Center information, via Clinical Connectivity, for their own patients;
(c) Attend Committee meetings when invited by the Committee leadership;
(d) Attend Continuing Medical Education programs at the Medical Center;
(e) Receive Medical Staff Newsletters and other facility publications.

8.2-3 Resident Affiliation physicians do not have the right to vote or attend meetings other than those to which they have been invited.

8.2-4 Resident Affiliation physicians will be subject to the requirements for focused professional practice evaluation as established by the Medical Executive Committee.

8.2-5 Resident Affiliation privileges will expire 60 days after completion of the residency program

8.2-6 A Resident Affiliation physician will become a member of the medical staff as a change in category with a request for medical staff membership and privileges to continue practicing at the medical center and pending completion of verification of stat license, verification of residency training and confirmation of enrollment in the National Practitioner Data Bank continuous query, completion of an updated privilege form and approval by the Board.

ARTICLE NINE: COMMITTEES

9.1 **DESIGNATION**

The committees described in this Article shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, the descriptions of which will be contained in a committee charter. 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, the Chief Executive Officer or their respective designees and Medical Directors as consistent with their contract duties are ex officio members without vote of all standing and special committees of the Medical Staff. Professional Review Committee members may serve as ex-officio appointee(s) with vote on committees of the Medical Staff if and as requested by the Chief of Staff or Chief Executive Officer.

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 parent committee. Any such subcommittee may include individuals appointed by the committee chair who are not members of the standing committee.

9.2-3 **SPECIAL OR STANDING INTERDICIPLINARY COMMITTEES**

When a procedure or group of procedures is performed on a regular basis by members of more than one clinical specialty, the Medical Executive Committee may create a committee to recommend privileges and develop regulations in regard to the performance of those procedures. The formed committee may carry out peer review and make recommendations to the Professional Review Committee.

9.2-4 **APPOINTMENT OF MEMBERS AND CHAIR**

Except as otherwise provided, the Chief of Staff shall appoint, in consultation with the Medical Executive Committee, the members and chair of any Medical Staff committee formed to accomplish Medical Staff functions. The chair of all committees shall be members of the Active Staff.

9.2-5 **TERM, PRIOR REMOVAL, AND VACANCIES**

(a) Except as otherwise provided, committee members and chairs shall be appointed by the Chief of Staff for a term of two years or until the member's successor is appointed, unless such member or chair 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.
(c) A vacancy in any committee may be filled for the unexpired portion of the term in the same manner in which the original appointment was made.

9.2-6 VOTING RIGHTS

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

9.3 MEDICAL EXECUTIVE COMMITTEE

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

9.3-1 COMPOSITION

The Medical Executive Committee includes physicians and may include other licensed independent practitioners. Membership shall consist of:
(a) Chief of Staff, as Chair
(b) Vice-Chief of Staff
(c) Immediate Past Chief of Staff (ex officio, with vote)
(d) Department Chairs
(e) Secretary/Treasurer
(f) Member at Large
(g) Credentials Committee Chair
(h) Chief Medical Officer (ex officio with vote)
(i) Chief Executive Officer (ex officio without vote)
(j) Chief Nursing Officer (ex officio without vote)
(k) Other representation as necessary, may be appointed by the Chief of Staff and approved by majority vote of the Medical Executive Committee (ex officio, without vote)

Chairs of standing committees may be invited to meetings of the Medical Executive Committee as necessary (without vote).

9.3-2 ELECTIONS, TERMS, VACANCIES, AND REMOVALS

(a) ELECTIONS

The Medical Staff officers shall be elected in the manner prescribed in Section 7.5.

(b) TERMS OF OFFICE

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

(c) REMOVALS AND VACANCIES

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

9.3-3 DUTIES

The duties and authority of the Medical Executive Committee are to:
(a) Act on all matters of Medical Staff business, except for the election or removal of medical staff officers and for the approval of Medical Staff Bylaws. The Medical Executive Committee may act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its authority as set forth herein;
(b) Receive and act upon reports and recommendations from Medical Staff committees, and other assigned activity groups;
(c) Make recommendations to the Board of Directors regarding the organized medical staff structure, and the process used to review credentials and delineate privileges;
(d) Coordinate and implement the professional and organizational activities and policies of the Medical Staff, including but not limited to the review of department and committee policies and procedures, the review of committee reports, the determination of dues and assessments of

members; responsibility for the investment and expenditure of Medical Staff funds which shall be exclusively for purposes permitted by the IRS and consistent with the responsibilities of the Medical Staff.

(e) Review aggregate quality performance data and make recommendations for quality improvement;
(f) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;
(g) 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; and for the other responsibilities delegated by the Board to the Staff;
(h) Represent the views of the Medical Staff to the Board and make recommendations to the Chief Executive Officer and to the Board on Medical Center medico-administrative matters;
(i) Review the qualifications, credentials, performance, delineation of privileges and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding such matters;
(j) Review quality issues regarding contracted services and make recommendations to the Chief Executive Officer as necessary.
(k) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
(l) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees; and
(m) Assist in obtaining and maintaining regulatory compliance of the Medical Center.
(n) Review and act on information derived from Risk Management, incident reports, and trend analysis, concurrent and retrospective, to effectively maintain a safe patient environment and reduce liability;
(o) Make recommendations to the Medical Staff for the approval of, use of, and material changes in format of the medical record;
(p) Declare a medical record complete for purposes of filing after reasonable attempts to contact the responsible physician have failed;
(q) Provide oversight for the Utilization Review process, including review and approval of the annual Utilization Review Plan; and
(r) Act on behalf of the organized medical staff.

9.3-4 MEETINGS

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

9.3-5 ATTENDANCE REQUIREMENTS

All members of the Medical Executive Committee are required to attend.

9.4 PEER REVIEW COMMITTEE

9.4-1 COMPOSITION

The Medical Executive Committee may function as the Peer Review Committee as applicable by facility. For facilities with a separate committee, the Peer Review Committee (PRC) shall consist of at least three members, including the Chief Medical Officer who shall serve as Chair. The Chair shall designate a member of the Committee as Vice-Chair. Members shall be members of the medical staff engaged to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities. The Chief Executive 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. For the initial term, members may be appointed for a term less than three years.

9.4-2 QUALIFICATIONS

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

9.4-3 SELECTION AND REVIEW PROCESS

New members shall be appointed by the Chief of Staff, subject to approval by the Medical Executive Committee. The Medical Executive Committee will periodically review the performance of PRC members and may remove any member for failure to maintain qualifications as outlined in Bylaws Section 9.4-2 and/or uphold the duties of the position as outlined in Bylaws Section 9.4-4 or for any other reason.

9.4-4 **DUTIES**

The duties of the Professional Review Committee are to:

(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 of member of the Medical and Advanced Practice Provider/Allied Health Professional Staff;
(f) Serve as a resource for moral and ethical issues;
(g) Monitor and evaluate the quality and appropriateness of patient care and professional performance;
(h) Seek peer review assistance from external sources if and when the PRC determines that such assistance is appropriate and/or necessary.
(i) Review aggregate quality performance data of individual physicians and make recommendations for quality improvement in the context of peer review;
(j) Share information with the Departments and Committees to provide opportunities for learning and process improvement;
(k) Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative and educational functions as well as issues referred from a department chair, Medical Director or Chief Medical Officer;
(l) Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, consultation and suspension as warranted
(m) Recommend to the Medical Executive Committee as required the limitation, revocation or termination of Medical Staff membership and/or privileges;
(n) Establish a subcommittee or subcommittees as are necessary to perform its duties. Members of subcommittees may include practitioners who are not members of the PRC and/or who are not members of the Medical Staff; and
(o) Serve as ex officio appointee(s) with vote on committees of the Medical Staff if and as requested by the Chief of Staff or Chief Executive Officer.

9.4-5 **MEETINGS**

The Peer Review Committee shall meet as often as necessary, but at least (monthly) and shall maintain a record of its proceedings and actions.

9.5 CREDENTIALS COMMITTEE (if applicable)

9.5-1 **COMPOSITION**

The Credentials Committee shall consist of at least three voting members who shall be Active Staff members in good standing and will be appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chair. The Chief Executive Officer and the Chief Medical Officer shall be ex-officio members without vote.

9.5-2 **DUTIES**

The duties of the Credentials Committee are to perform the key function of credentialing as described in these Bylaws under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or clinical privileges.

In addition, the following functions shall also be performed by the Credentials Committee:

(a) Oversee a mechanism to ensure that all providers with clinical privileges maintain required credentials ongoing:
(b) Through recommendations made related to clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments and between members and non-members of the Medical Staff who have clinical privileges;
(c) Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted; and
(d) Make recommendations to the Medical Executive Committee with regard to any revisions on the proves for appointment, reappointment or delineation of clinical privileges.

9.5-3 **MEETINGS**

The Credentials Committee shall meet monthly and shall report their recommendations and activities to the Medical Executive Committee.

9.6 BYLAWS COMMITTEE (if applicable)

9.6-1 **COMPOSITION**

The Medical Executive Committee may function as the Bylaws Committee as applicable by facility. For

facilities with a separate committee, the Bylaws Committee shall be composed of a Chair, who shall be the Vice Chief of Staff, and at least two (2) other members who shall be appointed by the Chief of Staff. Banner Health legal counsel shall be an Ex-officio member of the Bylaws Committee, without vote.

9.6-2 **DUTIES**

The duties of the Bylaws Committee are to:

(a) conduct a review of the Bylaws when deemed necessary, but at least biennially;
(b) submit to the Medical Executive Committee recommendations for changes in the Bylaws; and
(c) receive and evaluate, for recommendation to the Medical Executive Committee, suggestions for modifying the Bylaws.

9.7 **PROFESSIONAL WELLNESS COMMITTEE**

The Professional Wellness Committee shall be composed of a Chair and at least two other members appointed by the Chief of Staff. The Chair shall be appointed by the Medical Executive Committee to serve a two (2) year term with the option of serving additional two (2) year terms as approved by the Chief of Staff and Medical Executive Committee. Each facility Chief of Staff and Vice Chief of Staff will serve as ex officio members with a vote.

The Committee will facilitate the wellness of credentialed physicians, advanced practice providers, and allied health professionals. This will be accomplished by leading educational opportunities, participating in the western region leadership development program for physicians and advanced practice providers, participating in the Talk2ME program, and partnering with the Peer Review Committee and Medical Executive Committee to help with physicians in need or crisis as applicable.

9.8 **ETHICS PROGRAM (if applicable)**

The Ethics Program at the facility 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.

The Ethics Program is comprised of physicians from a variety of specialties if possible and associates including but not limited to social work, chaplaincy, nursing, risk management and administration. The members of the Ethics Program are convened on an ad hoc basis. The Medical Executive Committee will serve as the oversight committee for the Ethics Program.

ARTICLE TEN: MEETINGS

10.1 **MEDICAL STAFF MEETINGS**

10.1-1 **REGULAR MEETINGS**

General staff meetings will be held at least annually and may be held more frequently.

10.1-2 **SPECIAL MEETINGS**

A special meeting of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, or the Board. The Chief of Staff will call for such a meeting upon petition signed by 40% of the members of the active staff.

10.2 **DEPARTMENT COMMITTEE MEETINGS**

10.2-1 **REGULAR MEETINGS**

Clinical committees may, by resolution, provide the time for holding regular meetings. A committee must meet as often as necessary to conduct department business.

10.2-2 **SPECIAL MEETINGS**

A special meeting of any committee may be called by the chair thereof and must be called by the chair 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 committee. Advanced notice of at least two days of such special meeting will be given to all members of the committee.

10.2-3 **EXECUTIVE SESSION**

Any committee may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group and other individuals who have a legitimate reason to be present including the Chief Executive Officer or his/her designee may remain during such 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 facility PRC to present the case. If the

practitioner has been so notified, the Medical Executive Committee or the Chief of Staff will inform the practitioner that his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to appear may result in automatic suspension under Section 6.6.

10.4 **QUORUM**

10.4-1 **GENERAL MEDICAL STAFF MEETINGS**

A minimum of 3 voting members present at any regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws.

10.4-2 **COMMITTEE MEETINGS**

The presence of 50% of the voting members of the Credentials Committee, Medical Executive Committee and the Peer Review Committee shall constitute a quorum for that respective committee. The presence of 2 voting members shall constitute a quorum at any other committee meeting.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY, RELEASES AND INDEMNIFICATION

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 or terminated;

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

(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 about the practitioner in accordance with the Banner Sharing of Peer Review Information Policy.

11.2 **CONFIDENTIALITY OF INFORMATION**

Information obtained or prepared by any representative for the purpose of evaluating qualifications, 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 facilities or organization's activities concerning, but not limited to:

(a) applications for appointments, reappointment, clinical privileges, or specified services;
(b) appraisals and/or periodic reappraisals of care or professional conduct;
(c) corrective or disciplinary actions;
(d) hearings and appellate reviews;
(e) quality review 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, 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 execute general and specific releases and provide documents when requested by the Chief of Staff or chair of the applicable committee 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 6.6-8.

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 state 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.

11.6 **INDEMNIFICATION**

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

ARTICLE TWELVE: GENERAL PROVISIONS

12.1 **MEDICAL STAFF RULES AND REGULATIONS**

Subject to approval by the Board, the Medical Executive Committee shall adopt and amend 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 Staff Rules and Regulations may not conflict with the Banner Health Bylaws.

12.2 **STAFF DUES**

The Medical Executive Committee shall establish the amount of annual dues. The process for assessing annual dues is defined in the Medical Staff Dues Policy.

12.3 **SPECIAL NOTICE**

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

12.4 **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.

12.5 **PARLIAMENTARY PROCEDURE**

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

12.6 **CONFLICT RESOLUTION**

12.6-1 **STAFF MEMBER CHALLENGE**

Any member of the Medical Staff may challenge any rule or policy established by the Medical Executive

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

12.6-2 **MEDICAL EXECUTIVE COMMITTEE REVIEW**
The Medical Executive Committee will consider the challenge at its next meeting and will determine what changes will be made to the rule or policy or may, at its discretion, appoint a subcommittee to review the challenge and recommend potential changes to address the concerns. The Medical Executive Committee may use internal or external resources to assist in resolving the conflict. The Medical Executive Committee will review subcommittee recommendations and take final action on the rule or policy, subject to Board approval as required. The Medical Executive Committee will communicate all changes to the Medical Staff.

12.6-3 **CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY**
A recommendation to use either internal or external resources to resolve the conflict may be made by the Board, the Chief Executive Officer, or 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 differences between the Medical Staff and the Executive Committee.

12.7 **HISTORIES AND PHYSICALS**
A history and physical examination (H&P) in all cases shall be completed by a physician, oral surgeon, podiatrist and dentist within the scope of their training or Advanced Practice Provider who is approved by the medical staff to perform admission H&Ps within 24 hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedure or a pre-procedural assessment for any procedure in which moderate sedation will be administered; or the case will be cancelled unless the responsible practitioner documents in writing that such delay would constitute a hazard to the patient. A legible H&P performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The content of complete H&P is delineated in the Medical Staff Medical Records Policy.

12.8 **TREATING FAMILY MEMBERS**
Unless deemed appropriate by the Chief of Staff or the Chief Medical Officer, practitioners may not treat immediate family members within Banner Hospitals except in an emergency or when another qualified practitioner is not available timely. Immediate family members are defined as parents, children, siblings or spouse.

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 Chief Executive Officer, the Board and the community. These Bylaws may not conflict with the Banner Health Bylaws. In the event that a law or regulatory requirement changes, such change will govern these Bylaws as legally required by operation of law.

13.2 **BYLAW REVIEWS**

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

13.2-1 The Bylaws of the Medical Staff are adopted by the Medical Staff and approved by the Board prior to becoming effective. Amendments to these Bylaws may be adopted upon approval of the Medical Executive Committee and approval by a majority electronic and/or ballot vote of members of the Active Staff voting. Ballots shall be sent to the Active Staff member by mail or email. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing/emailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

13.2-2 Upon recommendation of the Bylaws Committee, the Medical Executive Committee shall have the power to adopt legal modifications or clarifications and such amendments shall be effective immediately upon Board approval. The Medical Executive Committee shall also have the power to adopt such amendments to the Bylaws as are technical, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, without the requirement for Board approval.

13.3 **PERIODIC REVIEW**

13.3-1 The Medical Staff and Allied Health Rules and Regulations, Medical Staff Policies, Credentials Manual and Fair Hearing Plan shall be reviewed at least every two (2) years and shall be revised as needed. Reviews shall also be conducted upon request of the Board.

13.3-2 **ADOPTION AND AMENDMENT**

The Medical Staff Rules and Regulations, Medical Staff Policies, Credentials Manual and Fair Hearing Plan are adopted by the Medical Executive Committee and approved by the Board prior to becoming effective. Amendments to these documents may be adopted upon approval of the Medical Executive Committee and the Board, subject to Active Staff notification as described below.

13.3-3 **COMMUNICATION TO THE MEDICAL STAFF**

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

(b) Urgent matters. In cases of a documented need for urgent amendment, the Medical Executive Committee and Board may provisionally adopt an urgent amendment without prior notification of the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If concerns are not received within 10 days, the amendment stands. If there is a conflict and a majority of the Active Staff oppose the amendment, the Medical Executive Committee will utilize the conflict resolution process set forth in Section 12.3. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

13.4 MEDICAL STAFF DIRECT COMMUNICATION TO THE BOARD PROCESS

The Medical Staff may propose amendments to the Bylaws, Medical Staff Rules and Regulations, Medical Staff policies, Credentials Manual and Fair Hearing Plan directly to the Medical Executive Committee or directly to the Board. To submit an amendment directly to the Board, a petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendments at its next meeting and may meet with the applicable Medical Staff members representing the Medical Staff recommendations in the petition and determine whether to recommend language that is acceptable to the Medical Staff and the Medical Executive Committee. The Medical Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Medical Executive Committee. If the Medical Executive Committee proposes revised language, the members of the Medical Staff who proposed the challenge can decide to recommend its original language to the Active Staff for vote. Ballots shall be sent to each Active Staff member, by mail or email, along with the revised language and comments of the Medical Executive Committee and the applicable Medical Staff members. The ballots must be returned within 14 days after their mailing at which time they will be tallied with approval by a majority electronic and/or ballot vote of members. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the vote. If a proposed amendment is approved by the Active Medical Staff, it shall be submitted to the Board for final approval.

13.5 BOARD OF DIRECTORS ACTION

13.5-1 Medical Staff recommendations regarding proposed amendments to the Bylaws, Medical Staff Rules and Regulations and Medical Staff policies or thereto shall be effective upon the affirmative vote of the Board.

13.5-2 In the event the Board has concerns regarding any provision or provisions of the proposed amendments to the Bylaws, Medical Staff Rules and Regulations or policies, the Board shall advise the Medical Staff of its concerns. The Medical Staff 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 JOINT CONFERENCE COMMITTEE

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

13.7 UNILATERAL BOARD AMENDMENTS

Neither body may unilaterally amend the Medical Staff Bylaws, except the Board may take action if the Medical Staff fails to act within sixty (60) days 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 hospital, 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. Such action may be taken only after consideration of the matter by a Joint Conference Committee as specified in Section 13.6.

ARTICLE FOURTEEN: CLINICAL DEPARTMENTS

14.1 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments and shall be responsible to the Medical Executive Committee. The two clinical departments shall include the Department of Medicine and the 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. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws.

14.2 ASSIGNMENT TO DEPARTMENTS

Each member with privileges shall be assigned membership in one department. 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.

14.3 FUNCTIONS OF DEPARTMENTS

Departments shall continually seek to improve quality of care for all patients and shall perform the following functions:

(a) develop, approve and review annually clinically relevant quality and appropriateness parameters and criteria/indicators including medication use, blood use, operative/invasive review, unexpected deaths and identification of known or potential problems that have an adverse effect on patient care and recommend appropriate action to the Medical Executive Committee;

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

(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) 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;

(f) adopt 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;

(g) meet as necessary to carry out the duties of the Department and to provide a forum for discussion of matters of concern to its members;
work with the Medical Executive Committee and Chief Executive Officer to assure adequate on-call coverage for emergency patients consistent with the physician resources available within the department;

(h) coordinate the professional services of its members with those of other departments and with Medical Center nursing and support services;
participate in budgetary planning pertaining to department activities including but not limited to space and resources with Medical Center administration, including the review of new technologies;

(i) 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.

14.4 DEPARTMENT OFFICERS

14.4-1 QUALIFICATIONS

Each department shall have a chair who shall be and remain, during his/her term:

1. A member in good standing of the active Medical Staff;
2. Be board certified by an appropriate specialty board or demonstrate comparable competence as established through the credentialing process and shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center.

14.4-2 **SELECTION**

A department chair shall be elected every two years by the active and advanced practice provider staff members of the department.

Nominations will be solicited and submitted by Department members with an electronic vote process. Ballots will be sent out electronically to be returned in person, by mail, facsimile, or email within 14 days. Voting by proxy shall not be permitted.

Vacancies in elected department offices due to any reason shall be filled for the unexpired term through appointment by the Chief of Staff. Selection of any additional officers shall follow this same procedure.

14.4-3 **TERM OF OFFICE**

Elected department chairs shall serve a two- year term unless a vacancy occurs for any reason. Department officers may be re-elected in succeeding terms not to exceed a total of two successive two-year terms.

14.4-4 **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~~ with a referral to the Medical Executive Committee. The Medical Executive Committee will determine whether there is sufficient evidence to consider grounds for removal for cause. Grounds for removal shall include failure to maintain qualifications of the office as outlined in Bylaws Section 8.4-1 and/or uphold the duties of the office as outlined in Bylaws Section 8.4-5. The individual shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote for removal. Removal shall occur with the majority vote of the Medical Executive Committee.

14.4-5 **ROLES AND RESPONSIBIITIES**

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

- Participate in every phase of administrative related activities of the department, including cooperation with the nursing service and Medical Center administration; act as presiding officer at department meetings and be a member of the Medical Executive Committee and account to the Medical Executive Committee for all administrative and clinically related activities within the department;
- Provide continuing surveillance of the professional performance of all individuals in the department with delineated clinical privileges;
- Recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommend the clinical privileges and staff category of practitioners who are members of or applying to the department
- Recommend to the Medical Executive Committee and implement department rules and regulations, criteria for credentials review and privileges delineation, programs for orientation and continuing medical education, and improvement in quality of care, treatment, services and utilization management;
- Provide guidance on overall medical policies of the Medical Center, and make specific recommendations regarding the department;
- Assess and recommend to the Medical Executive Committee and the Chief Executive Officer off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center;
- Integrate the department into the primary functions of the Medical Center;
- Coordinate and integrate interdepartmental and intradepartmental services
- Provide guidance on overall medical policies of the Medical Center; develop and implement policies and procedures that guide and support the provision of care, treatment and service;

- Assess and recommend to the Medical Executive Committee and the Chief Executive Officer a sufficient number of qualified and competent persons to provide care, treatment, and services;
- Ascertain the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- Monitor and evaluate the quality and appropriateness of patient care, treatment and services and professional performance rendered by practitioners with clinical privileges in the department and maintain quality control programs as appropriate;
- Recommend to the Medical Executive Committee and Chief Executive Officer, space and other resources as needed by the department;
- Recommend to the Medical Executive Committee and implement department rules and regulations, criteria for credentials review and privileges delineation, programs for orientation and continuing medical education;
- Refer to the Peer Review Committee issues relating to professional conduct and the quality and appropriateness of patient care and professional performance;
- Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
- Implement, within the department, actions directed by the Medical Executive Committee or the Board;
- Appoint such committees as are necessary to conduct the functions of the department;
- Appoint such chairmen or committee members as required by these Bylaws and department rules and regulations; and
- Perform such other duties as may be reasonably requested by the Chief of Staff or the Medical Executive Committee.