Banner Estrella
Medical Center

MEDICAL STAFF BYLAWS

Adopted: May 20, 2004
Last Amended: 05/14/2015

BANNER ESTRELLA MEDICAL CENTER

Phoenix, Arizona
BYLAWS OF THE MEDICAL STAFF

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ARTICLE FOURTEEN: ADOPTION AND AMENDMENT

Glossary:

Telemedicine: use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. *Source: American Telemedicine Association.* Distant Site: site where the practitioner providing the telemedicine service is located.

PREAMBLE

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

INDEMNIFICATION

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

ARTICLE ONE: NAME

1.1 The organizational component of Banner Health to which these Bylaws are addressed is called "The Medical Staff of Banner Estrella 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 function of the organized medical staff is to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges, and to approve and amend 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 Estrella Medical Center.

2.1-3 To provide a mechanism for accountability to the Board for the review of the appropriateness of patient care services, professional and ethical conduct, and teaching and research activities of each practitioner appointed to the Medical Staff, so that patient care provided at the Medical Center facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

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

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

2.1-5 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.

2.1-6 To provide an orderly and systematic means by which staff members can advise the Board and CEO on medical staff matters and on Medical Center policy-making and planning processes.

2.2 **RESPONSIBILITIES**

Licensed independent practitioner members of the organized Medical Staff are designated to perform the oversight activities of the organized medical staff. 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 to assess, maintain, and improve the quality and efficiency of care provided in the Medical Center, including:

(a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria;

(b) Engaging in the ongoing monitoring of patient care practices;

(c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and

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

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

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

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

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

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

ARTICLE THREE: MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

Every practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as set forth in these Bylaws, department rules and regulations, credentialing procedures manual, or privilege delineation forms:

3.1-1 LICENSURE

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

3.1-2 PROFESSIONAL EDUCATION AND TRAINING

(a) Applicants must have graduated from an approved medical, osteopathic, dental, or podiatric school or attainment of a PhD degree in psychology. Foreign Medical Graduates must be certified 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 ("ACGME"), by the American Osteopathic Association ("AOA"), by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, the Council on Podiatric Medical Education ("CPME"), the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing.

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

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

(d) Applicants who are psychologists must possess a PhD degree in psychology from a program approved by the American Psychological Association, possess certification by the American Board of Professional Psychologists, be currently listed in the National Register of Health Services Providers in Psychology, and meet the educational requirements for licensure in the State of Arizona. Applicants must also demonstrate at least one year full-time experience or its equivalent in an inpatient setting (either pre- or post-doctoral) or in a mental health care setting.

3.1-3 **BOARD CERTIFICATION**

(a) Membership on the Medical Staff does not require board certification. However, except as specially provided below, having Medical Staff privileges to practice at the Medical Center requires the applicant and Members to either be board certified or board qualified in the specialty for which privileges are being requested by one of the following:

1. Physician: The American Board of Medical Specialties or the American Osteopathic Association
2. Podiatrist: The American Board of Podiatric Surgery or The American Board of Podiatric Orthopedics and Primary Podiatric Medicine
3. Dentist: The American Dental Association
4. Psychologist: The American Board of Professional Psychologists

(b) For purposes of this section, "Board certification" or "Board certified" means certified by a board approved by the American Board of Medical Specialties or the Advisory Board for of 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, has applied for and has 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 the applicant has met all training requirements for qualification by the appropriate board.

(c) 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 the American Board of Medical Specialties (ABMS) or the American Osteopathic Board (AOS). Failure to become certified within the time allowed under these Bylaws, or Rules and Regulations of the applicant's department or section, or failure to pass the Board certification exam on the third attempt shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

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

(e) The Medical Executive Committee will consider grandfather privileging (privileging without subspecialty board certification) requests from individual departments according to the following guidelines. This is for the purpose of providing highly sub-specialized care to BEMC patients who otherwise may not have access to this care at Banner Estrella.

Grandfather privileging will be considered only for Level 3 privileges, which these guidelines define as a subspecialty board requiring two antecedent board certifications (Levels 1 and 2). For sub-specialties where multiple paths to board certification exist, if any of the paths involve only one antecedent board certification prior to subspecialty board certification, the privilege will be considered Level 2 and grandfathering will not be available.

Individual departments wishing to grant privileges following these guidelines must submit a proposal for approval by the MEC and the Banner Health Board. Proposals must include the following:

1. The practitioner is certified by the two antecedent boards;
2. The practitioner is not Level 3 Board eligible, and eligibility expired prior to January 2005;
3. The practitioner currently has the requested privileges at another Banner hospital;
4. The practitioner has actively exercised those privileges for at least one year, with sufficient activity to evaluate competence.

(f) Members are required to remain board certified if they wish to maintain their privileges.

(g) The Medical Executive Committee may consider extending membership within the current appointment term, under the following circumstances for initial certification or maintenance of certification:

- a practitioner has taken the exam, and is awaiting results or has exam scheduled and provides evidence of this; or

- 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.

3.1-4 **CLINICAL PERFORMANCE**

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

3.1-5 **PROFESSIONALISM**

Demonstrated ability and willingness to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care, and patient and employee satisfaction. It is the policy of Banner Estrella 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. Members/applicants who participate in activities constituting "disruptive conduct" as described in the Professional Conduct Policy shall be considered to lack the qualifications required by this Section 3.1-5. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken.

3.1-6 **SATISFACTION OF MEMBERSHIP OBLIGATIONS**

Satisfactory compliance with the basic obligations accompanying appointment to the staff and equitable participation, as determined by Medical Staff and Board authorities, in the discharge of staff obligations specific to staff category.

3.1-7 **SATISFACTION OF CRITERIA FOR PRIVILEGES**

Evidence of satisfaction of the criteria for granting of, and maintenance of, clinical privileges in at least one department.

3.1-8 **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.

3.1-9 **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. Documentation of influenza vaccination is required for members of the Active, Associate, Federally Employed Military, and Allied Health staffs by December 1st of each year or approved exemption per Banner Health policy. Members of the Telemedicine and eICU practitioners will be exempt from this documentation if they do not otherwise practice at the hospital.

3.1-10 **ABILITY TO PARTICIPATE IN FEDERAL PROGRAMS**

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

3.1-11 **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.

3.1-12 **PROFESSIONAL LIABILITY INSURANCE**

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

3.1-13 **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 a Medical Center.

3.1-14 **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' purposes, needs and capabilities, or to community need.

3.1-15 **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 Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department chairman. The member must submit written notice to the Chief of Staff at least two weeks in advance of the regular meeting;
(b) The right to initiate a recall election of a Medical Staff Officer and/or a department chairman 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 Executive Committee by presentation to the Executive Committee of a petition signed by 40% of the Active Staff. Upon receipt of such a petition, the 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 a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;
(f) The right to request conflict resolution of any issue by presentation to the Executive Committee a petition signed by 30% of the Active Staff. Upon receipt of such a petition, the Executive Committee will schedule a meeting to discuss the issue;
(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 a review by the Executive Committee in the event that nonreviewable corrective action is taken.

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

3.3 **BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP**

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

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

(b) Abide by the Banner Health Bylaws, these Bylaws, department rules and regulations, and all other standards and policies of the Board, the Medical Staff and Medical Center;

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

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

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

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

(g) Participate in continuing education programs as requested;

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

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

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

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

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

(m) Disclose to a patient any direct financial interest that the practitioner, his/her group or his/her employer has in a separate diagnostic or treatment facility prior to transferring the patient to such facility.

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

(o) 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.

(p) Participate in the BEMC orientation program as required by the Medical Executive Committee.

(q) Physicians shall provide the Medical Staff Services office with their preferred method of communication and shall be deemed to know information that has been sent via that method.

3.4 **TERM OF APPOINTMENT**

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

3.4-1 **EXPIRATION**

(a) The appointment of each staff member shall expire every two years on the last day of the birth month of the practitioner, except as provided below. An interim reappointment may be necessary to align the practitioner with the two-year birth month reappointment cycle.

(b) The Board, after considering the recommendations of the Executive Committee, may set a more frequent reappraisal period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability, has been the subject of disciplinary action, or is under investigation or where further evaluation is pending.

3.5 **EXHAUSTION OF ADMINISTRATIVE REMEDIES**

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

3.6 **LIMITATION OF DAMAGES**

Every applicant to and member of the Medical Staff agrees that his or her sole remedy for any adverse or corrective action for failure to comply with these Bylaws shall be the right to seek injunctive relief pursuant to ARS 36-445 et. seq. An alleged breach of any provision of these Bylaws and/or Fair Hearing Plan shall provide no right to monetary relief from the Medical Staff, the 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 **RESIGNATIONS**

All bylaws, rules and regulations, policies and obligations, including Emergency Department on-call assignments, shall continue to apply until the date the resignation is accepted the Medical Executive Committee.

3.8 **PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT**

3.8-1 **QUALIFICATIONS**

A practitioner, who is or who will be providing professional 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.

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

(b) Termination of such employment or contracts shall result in automatic termination of Medical Staff membership and privileges unless the practitioner meets the qualifications for privileges under a non-employed/non-contracted specialty, or if otherwise provided in the contract for professional services or the exclusive contract.

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

3.9 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. No reporting is required under federal or state law when privileges or membership is limited because an Exclusive Agreement is entered into, and no such reports shall be made.

3.9-1 REVIEW OF POSITIONS

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

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

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

3.10 MEDICAL DIRECTORS

3.10-1 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 to carry out its peer review and quality improvement activities. Medical Directors shall serve as ex-officio appointee with vote on all committees of the Medical Staff consistent with the scope of their responsibilities. Medical Directors must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1

3.10-2 MEDICAL DIRECTOR, CARE COORDINATION

The Medical Director of Care Coordination shall automatically be granted Active Staff membership and serve as an ex-officio member on Medical Staff Committees consistent with the scope of his or her responsibilities as related to care coordination and/or utilization management. For the MDCC to exercise privileges at the Facility s/he must apply for membership and privileges in the manner described in these Bylaws and must continuously satisfy the qualifications and complete the requirements set forth in Sections 3.1 and 5.2.

3.10-3 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall automatically be granted Active Staff membership and serve as an ex-officio member on all Medical Staff Committees. 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. For the Chief Medical Officer to exercise privileges at the Facility, s/he must apply for membership and privileges in the manner described in these Bylaws. The Chief Medical Officer shall have Medical Staff leadership and peer review responsibilities as delegated by the Medical Executive Committee including, but not limited to, responsibility for reviewing care, conducting investigations, identifying trends and resolving issues.

3.11 GRADUATE MEDICAL EDUCATION

A participant in approved training programs in the role of a medical student, intern, resident and/or fellow is not credentialed as a member of the Medical Staff and provides patient care/services within the scope of his/her prescribed program structure. Each participant shall be supervised by the assigned members of the Medical Staff.

3.12 CREDENTIALING PROCESS

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

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.1 CATEGORIES

There will be five categories of appointment to the staff: active, associate, federally employed military, telemedicine and honorary. Members of the Medical Staff may be elevated to the Active Staff at or following appointment upon the recommendation of the Executive Committee and approval of the Board.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS FOR ACTIVE STAFF

The active staff shall consist of physicians, dentists, podiatrists and psychologists who demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center or are regularly involved in the care of patients in the Medical Center facilities. The volume of annual patient

contacts and involvement in the affairs of the Medical Staff or Medical Center necessary to achieve and maintain active staff shall be established by the Executive Committee.

4.2-2 **PREROGATIVES OF ACTIVE STATUS**

An active staff member may:

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

4.2-3 **OBLIGATIONS OF ACTIVE STATUS**

An active staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

(a) Contribute to organizational, administrative, quality and patient safety reviews, and utilization management activities of the Medical Staff, and faithfully perform the duties of any office or position to which elected or appointed;
(b) Provide oversight in the process of analyzing and improving the patient experience;
(c) Pay all staff dues and assessments as required.

4.2-4 **FAILURE TO SATISFY QUALIFICATIONS**

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

4.3 **ASSOCIATE STAFF**

4.3-1 **QUALIFICATIONS**

The Associate Staff shall consist of physicians, dentists, podiatrists and psychologists who admit patients to the Medical Center only on an occasional basis or are only occasionally involved in the affairs of the Medical Staff or Medical Center.

4.3-2 **PREROGATIVES**

An Associate Staff member may:

(a) Admit patients, except as set forth in department rules and regulations; privilege criteria and Medical Center admission policies;
(b) Exercise such clinical privileges as have been granted by the Board;
(c) Demonstrate his/her continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers;
(d) Be appointed to committees unless otherwise provided by these Bylaws; and
(e) Vote on matters presented at committees to which he or she has been appointed and at department meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.3-3 **OBLIGATIONS**

An Associate Staff member must meet the basic obligations set forth in these Bylaws, including in Section 3.3, and pay staff dues and assessments as required.

4.3-4 **CHANGE IN STAFF CATEGORY**

Associate members will be advanced to the active staff category at the time of reappointment, or sooner upon request, if the qualifications set forth in 4.2-1 are satisfied.

4.4 **HONORARY STAFF**

4.4-1 **QUALIFICATIONS**

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

4.4-2 **PREROGATIVES**

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

4.5 **FEDERALLY EMPLOYED MILITARY STAFF**

4.5-1 **QUALIFICATIONS**

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

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

4.5.2 **PREROGATIVES**

The Federally Employed Military Staff member may:

(a) Admit patients who are eligible for care at military health facilities; or if covering emergency room call, may admit civilian patients provided adequate arrangements for follow-up care are in place.
(b) Exercise such clinical privileges as are granted by the Board;
(c) Be appointed to committees;
(d) Vote on matters presented at committees to which he or she has been appointed;
(e) Participate in education programs.

4.5-3 **OBLIGATIONS**

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

4.6 **TELEMEDICINE STAFF**

4.6-1 **QUALIFICATIONS FOR TELEMEDICINE STAFF**

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

4.6-2 **PREROGATIVES**

A telemedicine staff member may:

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

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

4.6-3 **OBLIGATIONS**

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

(a) Contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff; and
(b) Pay all staff assessments.

4.6-4 **FAILURE TO SATISFY QUALIFICATIONS**

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

ARTICLE FIVE: PROCESS FOR CREDENTIALING AND DELINEATION OF PRIVILEGES

5 .1 **PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES**

Completed applications for membership and privileges are submitted at the time of initial appointment to the Credentials Committee, Department, Section as appropriate, and Executive Committee, subject to final approval by the Board. Completed applications for reappointment are submitted to the Department, Section as appropriate, and 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 Credentialing Procedures Manual.

5.2 The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Allied Health Policy. Completed applications for allied health membership for initial appointment and scopes of practice will be submitted to the Credentials Committee, Department, and Executive Committee for review and action prior to submission to the Board. Completed applications for reappointment are submitted to the respective Department Chairman and Medical Executive Committee, subject to final approval by the Board.

5.2 **PROCEDURE FOR DELINEATING PRIVILEGES**

5.2-1 **REQUESTS**

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. In some instances, staff membership may be granted to a practitioner who desires not to request clinical privileges. Specific

requests must be submitted for modifications of privileges in the time frame between reappointment periods. All requests for clinical privileges will be processed in accordance with the procedures set forth in the Credentialing Manual and according to relevant privilege criteria. Privilege requests submitted after the initial granting of membership shall not require review by the Credentials Committee, and will be recommended by the Department Chairman to the Medical Executive Committee and the Board. Requests for clinical privileges are acted on in a reasonable timeframe, upon receipt of complete application from the CVO, generally within 60 days.

5.2-2 **SUPERVISION**

Whenever a practitioner is required by the Medical Staff to be supervised, the practitioner is responsible for making these arrangements. Supervision must be completed within one year of date privilege is granted. Otherwise, supervised privilege will be voluntarily withdrawn. Request for extension to supervision time frame may be submitted in writing prior to expiration of the supervision period for consideration by the Medical Executive Committee and must include reason for request.

5.2-3 **ADVANCEMENT FROM SUPERVISION**

Whenever a practitioner completes supervisory requirements, the supervisory reports and other required documentation will be submitted to the appropriated department/committee for review. Where the practitioner has successfully completed the requirements, the chairman may grant unsupervised privileges, subject to ratification by the Medical Executive Committee and the Board.

5.3 **BASIS FOR PRIVILEGES DETERMINATIONS**

Clinical privileges shall be granted in accordance with education and training, experience, current licensure, utilization practice patterns, current health status, 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. Review of data from other hospitals may also serve as the basis for privileges determination(s). As part of reappointment review and privilege determinations, results of quality and performance improvement, utilization review, supervised cases (if applicable), and where appropriate, practice at other hospitals will be considered. Requests for modification of privileges require evidence of appropriate training, experience and current clinical competency. The criteria for granting or denial of privileges are applied consistently for each practitioner.

5.4 **EXERCISE OF PRIVILEGES**

5.4-1 **IN GENERAL**

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

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

5.4-2 **PRIVILEGES IN EMERGENCY SITUATIONS**

In an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to the degree permitted by the practitioner's license, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of department affiliation, staff category, or privileges. A practitioner providing such emergency services outside the

scope of granted privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

5.4-3 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 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 weeks of the Board's action. In the case of privilege denial, the applicant is informed of the reason for denial. The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and/or external persons or entities.

5.6 PRIVILEGES FOR NEW PROCEDURES

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

Prior to developing new criteria for privileges not previously established, the medical staff will work with hospital staff to determine whether sufficient space, equipment, staffing, and financial resources will be in place or available within a specified time frame to support each requested privilege.

5.7 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES

5.7-1 REQUEST FOR PRIVILEGES

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

5.7-2 DETERMINATION OF APPROPRIATENESS

The Chief of Staff, with the approval of the Executive Committee, will establish an interdisciplinary Ad Hoc Committee or request the Professional Review Committee to evaluate the request. The Chairman of the Committee shall be a disinterested party currently not performing these procedures. The Committee shall give the affected practitioner and other interested persons an opportunity for an interview. After receipt of the Committee's report, the Executive Committee will recommend to the Board whether inter-disciplinary privileges are appropriate and, if applicable, the criteria and process for granting such privileges.

5.8 SPECIAL CONDITIONS

5.8-1 ORAL SURGEONS AND DENTISTS

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

5.8-2 PODIATRISTS

Surgical procedures performed by a podiatrist are under the overall supervision of the Chairman of the Department of Orthopedics. A podiatrist may write orders and co-admit patients with a physician member of the Medical Staff who must perform a basic medical appraisal for each patient immediately after admission, be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization, and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.

5.8-3 CLINICAL PSYCHOLOGY PRIVILEGES

Clinical psychologists shall not have privileges to admit patients to the Medical Center, but may see patients upon the request and recommendation of physician members of the Medical Staff.

5.9 TEMPORARY PRIVILEGES

5.9-1 CONDITIONS

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

5.9-2 CIRCUMSTANCES

Upon the recommendation of the Chief of Staff, department chairman, and Credentials Committee chairman or their respective designees, the CEO or designee may grant temporary privileges in the following circumstances:

(a) Pendency of Application: Temporary privileges may be granted to an applicant who has submitted a complete application that has been verified and raises no concerns, has been approved by the Credentials Committee and Department Chairman, and is awaiting review and approval of the Medical Executive Committee and the Board.

Temporary privileges may be granted to an applicant for an initial period not to exceed 60 days. One extension may be granted for an additional period not to exceed 60 days. Any such renewal shall be made by the department chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. Under no circumstances may such privileges be granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Specific Patient Care Need:

1. *One Time Request*: Temporary privileges may be granted to a practitioner for the care of a specific patient. The request for specific privileges and the patient care need must be documented and the following information must be verified prior to the granting of privileges: appropriate and current licensure, adequate professional liability insurance, DEA Registration, if applicable, documentation to meet privilege criteria, evidence of board certification or eligibility with certification as required, identification verification (verification may be shared from another Banner facility if current within the past six months) and review of the National Practitioner Data Bank (NPDB) report. Such temporary privileges may not be granted to a practitioner more than three (3) times in any 12 month period after which the practitioner must apply for staff appointment. Such privileges shall be in effect for a specific period of time, but in no case for a time to exceed sixty (60) days or beyond the date of the patient's discharge, whichever comes first. The practitioner must agree to abide by the provisions of the Bylaws, Rules and Regulations Policy Manual, as well as the appropriate Department Rules and Regulations.

2. *Coverage of Service*: In special circumstances where a service is not adequately covered to meet patient care needs, temporary privileges may be granted upon receipt of application and verification of the following information: appropriate and current licensure, adequate professional liability insurance, DEA Registration, if applicable, one current competency reference, adequate education and training (via AMA or AOA profiles), NPDB, evidence of board certification or eligibility with certification as required, identification verification (verification may be shared from another Banner facility if current within the past six months) and documentation required to meet privilege criteria. Temporary privileges granted under these circumstances constitute the exception rather than the norm, and cannot be utilized for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 60 days. One extension may be granted for an additional period not to exceed 60 days. Such temporary privileges may not be granted to a practitioner more than three (3) times in any 12 month period after which the practitioner must apply for staff appointment.

(c) Locum Tenens

To a practitioner who will be serving as a locum tenens to fulfill an important patient care need, but only after receipt of a complete application for appointment as a locum tenens and evidence of the following information: appropriate and current licensure that is not currently being challenged or previously had a successful challenge, board certification requirements, adequate professional liability insurance, DEA registration (if applicable), acceptable education and training (via AMA or AOA profile, criminal background check, National Practitioner Data Bank report, one current competency reference, documentation required to meet criteria for any special privileges being requested and identification verification (verification may be shared from another Banner facility if current within the past six months). The locum tenens lasts for 90 days in length upon approval of the Department Chairman. A locum tenens may not be granted privileges more than

once (plus one 90 day extension) in any 12 month period. The individual must fully and completely agree to abide by the provisions of the Bylaws, Rules and Regulations Policy Manual, as well as the appropriate Department Rules and Regulations.

5.9-3 **ADDITIONAL PROCEDURES**

Temporary privileges to perform additional specific procedures which have been approved to be performed at Banner Estrella Medical Center may be granted, but only after the member has applied for the privileges and the Medical Executive Committee has recommended that the privileges be granted. Temporary privileges for specific additional procedures may not be granted for a period of more than 60 days.

5.9-4 **TERMINATION**

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

5.9-5 **RIGHTS OF THE PRACTITIONER**

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

5.10 **DISASTER PRIVILEGES**

5.10-1 Temporary disaster privileges may be granted by the CEO or designee only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. In order for volunteers to be considered eligible to act as licensed independent practitioners, the following information will be obtained: a valid government-issued photo ID from a state or federal agency, such as a driver's license or passport, and at least one of the following:

- Current picture hospital ID card from a health care organization that clearly identifies professional designation
- Current license to practice (primary source verified)
- Identification indicating the volunteer is a member of a 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 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 Hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

5.10-2 Primary source verification of licensure will begin as soon as the immediate situation is under control, and must be completed within 72 hours from the time the volunteer practitioner presents to the organization. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed practitioner's license cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible and the following is documented: 1) reason(s) it could not be performed within 72 hours of the practitioner's arrival; 2) evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and

3) evidence of the hospital's attempt to perform primary source verification as soon as possible.

5.10-3 Oversight of the professional performance of volunteer practitioners who receive disaster privileges (e.g. direct observation, mentoring, clinical record review) will be the responsibility of the Chief of Staff or Appropriate Department Chairman, or other designee.

5.10-4 The CEO or designee will decide within 72 hours whether continuation or renewal of the disaster privileges is indicated. This decision is based upon information regarding the professional practice of the volunteer. Temporary privileges may last for the duration of the disaster or 60 days, whichever occurs first.

5.10-5 Volunteer practitioners functioning under disaster privileges will be identified as such by wearing an identification badge provided upon the granting of privileges.

5.10-6 Such privileges may be terminated in accordance with Section 5.9-4. A Practitioner is not entitled to the procedural rights afforded by these Bylaws because a request for temporary disaster privileges is refused or because such privileges are terminated or otherwise limited.

5.11 TELEMEDICINE AND TELERADIOLOGY PRIVILEGES

5.11-1 The Medical Executive Committee shall determine which patient care, treatment, and services may be provided by practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine and Teleradiology services may be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand. Under such circumstances, the requirements in 5.9(1-6) above shall apply.

5.11-2 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of BEMC. The practitioner may be privileged at BEMC using credentialing information from another Banner facility. BEMC will re-verify licensure and perform a query of the National Practitioner Data Bank and Criminal Background Screening. The information will be used for decision making in regard to granting of telemedicine privileges. The application approval process outlined in the Credentialing Procedures Manual will apply.

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

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 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 PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

(a) A request for an investigation and/or corrective action may be submitted to the Chief of Staff by any member of the Medical Staff, the CEO, or the Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request. The Chief of Staff shall refer the request to the Professional Review Committee, which shall notify the practitioner of the general nature of the request.

(b) The Professional Review Committee or subcommittee thereof ("Professional Review Committee") shall consider the request and determine if an investigation is warranted. The Professional Review Committee may use one or more "evaluation tools" described below to determine if an investigation is warranted, or where an investigation is undertaken, these evaluation tools may be used to determine whether corrective action is necessary. The use of evaluation tools does not constitute an investigation. Evaluation tools include an interview with the practitioner, concurrent or retrospective chart review, concurrent observation consultation requirements, or other means of evaluating a provider's competency or performance. A practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension pursuant to Section 6.6-10 of these Bylaws. The practitioner has the right to an interview if he/she believes the Professional Review Committee should reconsider the use of any such evaluation tool. However, the practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such tools.

(c) Certain matters that may lead to corrective action are routinely considered by each Medical Staff department and/or the Professional Review Committee as a part of their ongoing quality and performance improvement, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the department or the Professional Review Committee, the Professional Review Committee shall conduct a review as set forth herein.

6.3 **DEFINITION OF INVESTIGATION**

(a) Any time a physician is under targeted review because of concerns about competence or conduct.
(b) Focused Professional Practice Evaluation (FPPE) applied to an individual provider because of concerns.
(c) An investigation does not include routine FPPE as part of an initial appointment to the Medical Staff or addition of privileges.
(d) An investigation does not include routine peer review activities.
(e) The investigation begins as soon as the Medical Staff begins an inquiry.
(f) The investigation ends when the Medical Staff renders a final action or a decision not to pursue the matter further.

6.4 **PROCEDURE FOR PROFESSIONAL REVIEW**

(a) Within 60 days of the determination by the Professional Review Committee that corrective action may be warranted, the Professional Review Committee shall conclude an investigation and document its findings. If the findings warrant that corrective action be taken, the affected practitioner shall have an opportunity for an interview with the Professional Review Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. A record of such interview shall be made and included with its report. In certain instances, an investigation by the Professional Review Committee 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. A sixty (60) day interim report from the Professional Review Committee Chairman must be made to the Department Chairman and the Medical Executive Committee stating the estimated completion date.

(b) After its deliberations, the Professional Review Committee will make its recommendation, and if adverse, shall forward it to the Executive Committee. The Executive Committee shall review the recommendation to determine whether it is supported by substantial evidence and whether the Bylaws were followed. If the 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 SUMMARY SUPERVISION

6.5-1 INITIATION

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

(a) Chief of Staff or designee, acting as a member of and on behalf of the Executive Committee;
(b) Chief Medical Officer;
(c) Member of the Professional Review Committee, acting on behalf of the Professional Review Committee;
(d) Applicable department chairman or designee, acting as a member of and on behalf of the applicable department committee;
(e) Chief Executive Officer;
(f) Executive Committee member, acting as a member of and on behalf of the Executive Committee;
(g) Chairman of the Banner Board of Directors

6.5-2 REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE

A practitioner whose clinical privileges have been placed under summary supervision by any two individuals identified in Section 6.4-1 shall be entitled to request a review of the summary supervision, by the Professional Review Committee or subcommittee thereof, having no less than three (3) members.

This right to a review does not apply to supervision imposed by a department committee under Section 5.2-2. The review must be requested, if at all, within 15 business days of the practitioner's receipt of notice of the supervision. Such review shall take place within 15 days of the request for review. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary supervision be terminated or continued.

6.6 SUMMARY SUSPENSION

6.6-1 INITIATION

Whenever immediate action must be taken in the best interest of patient care in the Medical Center or to prevent imminent danger to the health of any individual, any two of the following 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 Executive Committee;
(b) Chief Medical Officer;
(c) Member of the Professional Review Committee, acting on behalf of the Professional Review Committee;
(d) Applicable department chairman or designee, acting as a member of and on behalf of the applicable department committee;
(e) Chief Executive Officer;
(f) Executive Committee member, acting as a member of and on behalf of the Executive Committee;
(g) Chairman of the Banner Board of Directors

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

6.6-2 **REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE**

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Professional Review Committee or a subcommittee thereof having no less than three (3) members. The review must be requested within 15 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 15 business days of the request for review. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary suspension be terminated or continued.

6.6-3 **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 an expedited hearing pursuant to the Fair Hearing Plan.

6.6-4 **ALTERNATIVE COVERAGE**

Immediately upon imposition of summary suspension, the Chief of Staff, Chairman of the Professional Review Committee, the department chairman or their respective designees shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the Medical Center. Patient's wishes shall be considered in the selection of an alternative practitioner.

6.7 **AUTOMATIC SUSPENSION OF PRIVILEGES**

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

6.7-1 **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 of License: Whenever a practitioner's license to practice in this state expires, the practitioner's Medical Staff appointment and clinical privileges shall immediately be suspended and the practitioner will be considered to have voluntarily resigned if the license is not renewed within 30 days of the license expiring.

6.7-2 **CONTROLLED SUBSTANCES REGISTRATION**

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

6.7-3 **MEDICAL RECORDS**

Privileges to admit new patients or schedule new procedures will be temporarily suspended for failure to complete medical records as required by the Rules and Regulations. Such suspension shall not apply to care of patients admitted or already scheduled for surgery at the time of the suspension, to emergency patients, or to imminent deliveries. Temporary suspension shall be lifted upon completion of the delinquent records. If a provider accumulates 60 days of temporary suspension for delinquent medical records within a year, he/she will be required to pay a fee as outlined in Section 4.36 of the Medical Staff Rules and Regulations.

6.7-4 **PROFESSIONAL LIABILITY INSURANCE**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under Section 3.1-11 of these Bylaws. Affected practitioners may request reinstatement during a period of 60 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-5 **FREEDOM FROM INFECTIOUS TUBERCULOSIS**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious tuberculosis as required by law and Hospital policy. Affected practitioners may request reinstatement during a period of 30 calendar days following suspension upon presentation of evidence of freedom from TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-6 **FAILURE TO OBTAIN INFLUENZA VACCINATION**

A practitioner who fails to provide evidence of annual influenza vaccination or approved exemption as required by Section 3.1-9 of these Bylaws shall automatically be suspended. Privileges shall be reinstated when evidence of vaccination is provided or when influenza season is deemed to have ended. Members of the Telemedicine and eICU practitioners will be exempt from this documentation if they do not otherwise practice at the hospital.

6.7-7 **EXCLUSION FROM MEDICARE/STATE PROGRAMS**

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

6.7-8 **FAILURE TO RESPOND TO REQUESTS FOR INFORMATION OR TO SATISFY SPECIAL APPEARANCE REQUIREMENT**

A practitioner who fails without good cause to respond when contacted by an officer of the medical staff, department chairman, or Professional Review Committee member, after three attempts by the physician's preferred method of communication, or to appear at a meeting where his or her special appearance is required, in accordance with Section 10.3-3, may be automatically suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Privileges may be reinstated upon response or appearance as determined by the Chief of Staff or designee. Failure to appear within 90 days of the request to respond or appear shall result in revocation of staff membership and

privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.7-9 **FAILURE TO PAY STAFF DUES**

A practitioner who fails to pay staff dues as set forth in Section 12.3 shall automatically be suspended from the Medical Staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-10 **FAILURE TO EXECUTE RELEASES AND/OR PROVIDE DOCUMENTS**

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

6.7-11 **FAILURE TO PARTICIPATE IN AN EVALUATION**

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges as required by Section 11.1 shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-12 **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.

6.7-13 **REMOVAL FROM CALL FOR FINANCIAL CONFLICTS**

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

6.8 **NONREVIEWABLE ACTION**

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

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

(d) Termination or limitation of temporary privileges or disaster privileges.
(e) Termination of any contract with or employment by the Medical Center(s).
(f) Any recommendation voluntarily imposed or accepted by a practitioner, including an agreement to refrain from practicing at the Medical Center.
(g) Denial of membership and privileges for failure to complete an application for membership or privileges.
(h) Removal of membership and privileges for failure to complete supervision when required by the Medical Executive Committee or the Medical Staff department in which privileges are granted.
(i) Removal of membership and privileges for failure to complete supervision as may be required by the Medical Executive Committee or the Medical Staff department in which privileges are granted.
(j) Reduction or change in staff category.
(k) Refusal of credentials committee, department, or Executive Committee to consider a request for appointment, reappointment, staff category, department assignment, or privileges within one year of a final adverse decision regarding such request.
(l) Removal or limitation of Emergency Department call obligations.
(m) Any requirement to complete an educational assessment or training program.
(n) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(o) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
(p) Retrospective chart review.
(q) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the Medical Center to enter into, terminate or modify an exclusive contract for certain clinical services; or (2) the termination or modification of the practitioner's relationship with the exclusive provider.
(r) Grant of conditional appointment/reappointment **or** appointment/reappointment for a limited duration.
(s) Automatic suspension of Allied Health Staff membership and privileges due to loss of sponsoring physician.
(t) Termination of membership and privileges due to the failure to become Board Certified or to maintain Board Certification as specified by these Bylaws.

Where an action that is not reviewable under these Bylaws or the Fair Hearing Plan has been taken against a practitioner, the affected practitioner may request review of the action and may submit information demonstrating why the action is unwarranted. Depending upon the nature of the action and the Committee or individual who took the action, the Executive Committee, the Professional Review Committee or the CEO shall consider the request and decide, in its/his/her sole discretion, whether to review the submission and whether to take or recommend any action. The affected practitioner shall have no appeal or other rights in connection with the Executive Committee's, Professional Review Committee's, or CEO's decision.

6.9 **HEARING AND APPEAL RIGHTS**

6.9-1 **HEARINGS AND APPEALS**

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

6.9-2 **FAIR HEARING PLAN**

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

6.9-3 **HEARING PANEL**

When a hearing is requested, the hearing will be conducted by a committee composed of at least three members. No person in direct economic competition with the practitioner or

who has participated in the adverse recommendation shall participate. Members of the hearing committee shall be physicians and may, but need not, be members of the medical staff.

6.9-4 **SCHEDULING THE HEARING**

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

6.9-5 **HEARING PROCESS**

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

6.9-6 **SCHEDULING THE APPEAL**

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

6.9-7 **APPEAL PROCESS**

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

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 **GENERAL OFFICERS OF THE STAFF**

7.1-1 **IDENTIFICATION**

The general officers of the staff are:

(a) Chief of Staff
(a) Vice Chief of Staff
(b) Immediate Past Chief of Staff (ex officio)
(c) Secretary-Treasurer

7.1-2 **QUALIFICATIONS**

Each general officer must:

(a) Be a member of the active staff at the time of nomination and election and remain a member in good standing during his or her term of office.
(b) Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
(c) Have demonstrated a high degree of interest in and support of the Medical Staff and the Medical Center.
(d) Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general and department officers of the Medical Staff, the CEO, and the Board.

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

7.2 **TERM OF OFFICE**

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

7.3 **ELIGIBILITY FOR RE-ELECTION**

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

7.4 **NOMINATIONS**

7.4-1 **NOMINATING COMMITTEE**

(a) The General Officers of the Staff shall serve as the nominating committee. The Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each office. Nominees must disclose interests that potentially compete with the interests of the Medical Staff and/or the Medical Center, including ownership and financial interests in competing facilities or employment or contractual relationships with the Medical Center. At the July meeting of the Executive Committee, the Nominating Committee shall present for information the list of nominations to the Executive Committee and the CEO. The Secretary shall give written notice of the nominations to all active staff members of the Medical Staff, by mail or e-mail 30 days days prior to the annual general staff meeting.

(b) Further nominations may be made by any voting member of the Medical Staff within 14 days following distribution of the original list of nominations–provided that evidence is presented that the potential nominee meets the qualifications for office and consents to the nomination. Such nominees must also disclose potential conflicts of interest.

7.5 **ELECTIONS, VACANCIES, AND REMOVALS**

7.5-1 **ELECTION PROCESS**

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

(a) The Secretary or designee shall electronically mail one official ballot, with instructions, to each active staff member of the Medical Staff within 14 days after nominations are completed. Potential conflicts of interest shall be noted on the ballot or in a notice enclosed with the ballot. The instructions shall state the deadline by which the ballot must be returned electronically to the Medical Staff Services Department in order to be valid, which shall be no more than 14 days after the mailing of the ballots. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

(b) The Secretary, or designee, shall verify the voter's name as a qualified voter. On the date designated in the ballot instructions, the ballots shall be counted by the Medical Staff Services Department and verified by the Secretary.

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

(d) In the case of a tie, a majority vote of the Executive Committee shall decide the election.

7.5-2 **VACANCIES IN ELECTED OFFICES**

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

7.5-3 **RESIGNATIONS AND REMOVAL FROM OFFICE**

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

(b) Removals: removal from office, or membership on the Medical Executive Committee, may be initiated only by the Executive Committee or by petition signed by at least one-third of the active staff members, for failure to maintain qualifications of the office as outlined in Bylaws Section 7.1-2 and/or uphold the duties of the office as outlined in Bylaws Section 7.6 or for any other reason. Such removal shall be considered at a meeting of the Medical Executive Committee if initiated by the Medical Executive Committee. If initiated by petition, removal shall be considered by the Medical Staff at a special meeting as provided in Section 10.1-2, for the purpose of considering and acting upon the request for removal. Removal shall require a two-thirds vote of the voting members present and shall be effective immediately upon tabulation of the vote by the CEO or his designee.

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 general staff meetings and meetings of the 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 Executive Committee, members for all standing and special Medical Staff or multi-disciplinary committees, and designate the chairman of these committees;
(e) interact with the CEO and Chief Medical Officer in all matters of mutual concern within the Medical Center;
(f) represent the views and policies of the Medical Staff to the CEOs;
(g) be a spokesman for the Medical Staff in external professional affairs; and
(h) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Executive Committee.
(i) receive and act upon requests of the Medical Staff from the Board;
(j) at the Board's request, report on the performance and maintenance of quality and patient safety as delegated by the Board to the Medical Staff;
(k) 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 be a member of the Executive Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Executive Committee.

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

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

7.6-4 **SECRETARY-TREASURER**

The secretary-treasurer shall be a member of the Executive Committee. As secretary, he/she shall determine that accurate and complete minutes of all Executive Committee and Medical Staff meetings are maintained. Secretary-Treasurer or designee will oversee the Election Process and notify nominees of results. As treasurer, he/she shall safeguard all funds of the Medical Staff. The secretary-treasurer shall perform all such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Executive Committee.

ARTICLE EIGHT: CLINICAL DEPARTMENTS

8.1 **CLINICAL DEPARTMENTS**

The Medical Staff shall be divided into clinical departments. 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 Executive Committee may recommend the creation, elimination, modification, or combination of departments or sections. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws. The current clinical departments are:

(a) Anesthesiology
(b) Cardiology/CVT
(c) Emergency Medicine
(d) Medicine
(e) Obstetrics/Gynecology
(f) Orthopedics
(g) Pediatrics
(h) Surgery
(i) Radiology

8.2 **ASSIGNMENT TO DEPARTMENTS**

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

8.3 **FUNCTIONS OF DEPARTMENTS**

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

(a) develop and approve clinically relevant quality indicators that identify variances which trigger evaluation of the care by a physician reviewer; review and approve criteria/indicators annually which include but are not limited to:
- medication use
- blood use
- operative/invasive review
- unexpected deaths
- identification of known or potential problems that have an adverse effect on patient care.

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

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

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

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

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

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

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

(i) Provide oversight in the process of analyzing and improving the patient experience.

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

(k) assure adequate on-call coverage for emergency patients consistent with the physician resources available within the department. Departments have the responsibility to determine whether a mandatory or voluntary Emergency Department (E.D.) On Call is adequate to serve the needs of the community. If the Department recommends a mandatory E.D. call, they must forward the recommendation to the Medical Executive Committee for approval.

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

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

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

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

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

8.4 **SECTIONS**

Departments, with the approval of the Executive Committee, may form Sections, as needed, to conduct business designated by the department. Chiefs of Sections will be appointed by the Department Chairman who shall be a member of the Active Staff and will serve a two-year term, however will not be entitled to serve as a member of the Executive Committee based solely on serving as a Section Chief. The Section Chief will assist the Department chairperson with any quality management activities related to the specialists of that section. Sections are optional, and will have no work other than that assigned by a Department chairperson.

8.5 DEPARTMENT OFFICERS

8.5-1 QUALIFICATIONS

Each department shall have a chairman who shall be and remain, during his or her term, a member in good standing of the active Medical Staff; shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department; shall be and remain Board Certified by an appropriate specialty board or have comparable competence that has been affirmatively established through the credentialing process; and shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center. Departments may have a vice-chairman or other officers as defined in the department's rules and regulations.

8.5-2 SELECTION

The Department Chairman shall be elected in the manner prescribed in Section 7.5-1. A department chairman shall be elected every two years by the active staff members of the department. For this election, a request for nominations will be sent to department members prior to October of odd-numbered years. Nominations may also be made at the department meeting, so long as the nominee is qualified and has consented to the nomination. At the adjournment of the Department meeting where nominations are reviewed, the slate will be deemed finalized and ballots mailed out. Vacancies in elected department offices due to any reason shall be filled for the unexpired term through a special election held for that purpose at a meeting of the department.

8.5-3 TERM OF OFFICE

Elected department chairmen and other department officers, if any, shall serve a two-year term terminating on December 31 of odd-numbered years or until their successors are chosen, unless a vacancy occurs for any reason. Department officers shall be eligible to succeed themselves. The term of office of a contract department chairman is as specified in the contract or employment arrangement with the Medical Center.

8.5-4 RESIGNATION

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

8.5-5 VACANCIES

The Vice Chairman will automatically assume the Chairmanship for a period of up to 45 days during which the respective Department will hold an election for purposes of filling the vacancy for the remaining time period. If the Department does not have a Vice Chairman, the Medical Executive Committee will temporarily appoint an acting Chairman, and the Department will conduct a Departmental election.

8.5-6 REMOVAL

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

8.5-7 DUTIES

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

(a) Act as presiding officer at department meetings;

(b) Be a member of the Executive Committee, and account to the Executive Committee for administrative (unless mutually agreed upon to be provided by the hospital) and clinically related activities within the department;
(c) Maintain quality control programs, as appropriate, and provide continuous assessment and improvement of the quality of care, treatment, and services provided within the department;
(d) Recommend to the Executive Committee and implement the following: department rules and regulations, criteria for clinical privileges that are relevant to the care provided in the department, programs for orientation for new members of the department, and programs for continuing medical education of members of the department.
(e) Provide guidance on overall medical policies of the Medical Center, and recommend strategies for integrating department services into the primary functions of the medical center, and coordinating interdepartmental and intradepartmental services.
(g) Recommend the clinical privileges and staff category of practitioners who are members of or applying to the department;
(h) Provide continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, and refer to the Professional Review Committee issues relating to professional conduct and the quality and appropriateness of patient care and professional performance.
(i) Enforce the Bylaws, rules and regulations; and develop, implement, and enforce policies of the department and the Medical Center that support care and services;
(j) Implement, within the department, actions directed by the Executive Committee or the Board;
(k) Participate in every phase of administration of the department, including cooperation with the nursing service and Medical Center administration;
(l) Appoint such committees as are necessary to conduct the functions of the department;
(m) Appoint such chairmen or committee members as required by these Bylaws and department rules and regulations; and
(n) Assess and recommend to the Executive Committee and the CEO off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center.
(o) Assess and recommend to the Executive Committee and the CEO a sufficient number of qualified and competent persons to provide care, treatment, and services.
(p) Ascertain the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
(q) Recommend space and other resources needed by the department/service.
(r) Perform such other duties as may, from time to time, be reasonably requested by the Chief of Staff or the Executive Committee.

ARTICLE NINE: COMMITTEES

9.1 **DESIGNATION**

The committees described in this Article or in the Medical Staff Rules and Regulations shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, and when appropriate, the 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 Executive Committee.

9.2 GENERAL PROVISIONS

9.2-1 EX OFFICIO MEMBERS

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

9.2-2 SUBCOMMITTEES

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

9.2-3 APPOINTMENT OF MEMBERS AND CHAIRMEN

Except as otherwise provided, the Chief of Staff shall appoint, in consultation with the Executive Committee, the members and chairman of any Medical Staff committee formed to accomplish Medical Staff functions. The chairman of all standing committees shall be members of the active staff. Chairmen of special or ad hoc committees may be appointed from the associate or honorary staff.

9.2-4 TERM, PRIOR REMOVAL, AND VACANCIES

(a) Except as otherwise provided, committee members and chairmen shall be appointed by the Chief of Staff for a term of two years which shall coincide with the term of the Chief of Staff or until the member's successor is appointed, unless such member or chairman sooner resigns or is removed from the committee.

(b) A Medical Staff member serving on a committee, except one serving ex officio, may be removed by the Chief of Staff from the committee for failure to remain as a member of the staff in good standing, and by action of the Executive Committee. A committee member removed by Executive Committee action shall have the right to an appearance before the Executive Committee to request reconsideration of the removal.

(c) A vacancy in any committee may be filled for the unexpired portion of the term following appointment by the Chief of Staff and approval by the Executive Committee.

9.2-5 VOTING RIGHTS

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

9.3 MEDICAL EXECUTIVE COMMITTEE

The organized medical staff authorizes the Medical Executive Committee to carry out medical staff responsibilities, in accordance with law and regulation. All active members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee.

9.3-1 COMPOSITION

The Medical Executive Committee includes physicians and may include other licensed independent practitioners or individuals as determined by the organized medical staff. Membership shall consist of the following:

a) Chief of Staff, as chairman
b) Vice-Chief of Staff
c) Secretary/Treasurer
d) Immediate Past Chief of Staff (ex-officio, with vote)
e) Chairmen of the Departments
f) Two (2) Members at Large

g) One (1) Hospitalist Representative*****
h) Chairman of the Credentials Committee*****
i) A member of Professional Review Committee*****
j) Chief Medical Officer (ex officio with vote)
k) Chief Executive Officer (ex officio, without vote)
l) Other representation as necessary (ex-officio, without vote)*****

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

9.3-2 **ELECTIONS, TERMS, VACANCIES, AND REMOVALS**

(a) **Elections**

The Medical Staff officers, and members at large shall be elected in the manner prescribed in Section 7.5. Department chairmen shall be selected in the manner prescribed in Section 8.5-2 and elected in the manner prescribed in Section 7.5.

(b) **Terms of office**

With the exception of ex officio members, all members of the Executive Committee shall serve a two year term. General staff officers shall serve terms that terminate December 31 in even numbered years. Department chairmen shall serve terms that terminate December 31 in odd-numbered years. Members serving on the Executive Committee by virtue of appointment by the Chief of Staff shall serve two year terms that terminate on December 31 of even-numbered years. The Chief of Staff may appoint these members to subsequent two-year terms with approval of the Executive Committee, or appoint new members, with approval of the Executive Committee.

(c) **Removals and vacancies**

Removals and vacancies of general staff officers, department chairmen, and other Medical Executive Committee members, will be handled in the manners prescribed in Section 7.5 and Section 8.5. Vacancies among at-large members may be filled by appointment by the Chief of Staff with approval of the Executive Committee.

9.3-3 **DUTIES**

The duties and authority of the Executive Committee are to:

(a) Act on all matters of Medical Staff business, except for the election or removal of general staff officers and for the approval of Medical Staff Bylaws. The 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 departments, committees and other assigned activity groups;
(c) Make recommendations to the Board of Directors regarding the organized medical staff structure, and the process used to review credentials and delineate privileges;
(d) Make recommendations directly to the governing body on medical staff membership;
(e) Make recommendations directly to the governing body on the delineation of privileges for each practitioner privileged through the medical staff process;
(f) Coordinate and implement the professional and organizational activities and policies of the Medical Staff;
(g) Review aggregate quality performance data and make recommendations for quality improvement;
(h) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;
(i) Make recommendations to the CEO and to the Board on Medical Center medico-administrative matters;
(j) Review the qualifications, credentials, performance, and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding such matters;

(k) 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;
(l) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
(m) 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
(n) Assist in obtaining and maintaining regulatory compliance of the Medical Center;
(o) Act on behalf of the organized medical staff between meetings of the organized medical staff within the scope of its responsibilities as defined by the organized medical staff.
(p) Appoint a subcommittee to make credentialing recommendations directly to the governing body on behalf of the Medical Executive Committee for months when there is no meeting of the Medical Executive Committee.

9.3-4 **MEETINGS**

The Executive Committee shall meet as often as necessary, but at least six times per year and shall maintain a record of its proceedings and actions. Special meetings of the Medical Executive Committee may be called at any time by the Chief of Staff or the CEO.

9.3-5 **ATTENDANCE REQUIREMENTS**

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

9.4 PROFESSIONAL REVIEW COMMITTEE

9.4-1 **COMPOSITION**

The Professional Review Committee shall consist of at least five members, including the Chief Medical Officer who shall serve as Chairman. A co-chairman will also be appointed by the Chief Medical Officer with input from the PRC members. The co-chairman will serve in the Chief Medical Officer's absence and will attend the Medical Executive Committee when the Chief Medical Officer is unable. Members shall be physicians engaged to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities. The Chief of Staff and a representative of Medical Center administration shall serve as ex-officio members of the PRC (without vote). Members shall be appointed for staggered terms of three years and may be appointed for successive terms.

9.4-2 **QUALIFICATIONS**

PRC members 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**

The Chief of Staff and the CEO shall assemble a committee of seven individuals to select the PRC members. The Chief of Staff and CEO shall serve, and shall each select two other individuals to serve on the selection committee. The Chief Medical Officer will also serve on the selection committee as the seventh representative. A majority decision is required to select any PRC member. The Executive Committee will periodically review the performance of PRC members and may remove any member from the committee 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.

9.4-4 **DUTIES**

The duties of the Professional Review Committee include:

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

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

(c) Review sentinel events, near misses, and complex clinical issues;

(d) Review potential conflicts of interest and recommend actions to address actual conflicts;

(e) Investigate, review and resolve complaints of disruptive conduct by any member of the Medical Staff or Allied Health 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 of Medical Staff and Allied Health Staff members;

(h) Seek peer review assistance from external sources if and when the PRC determines that such assistance is appropriate and/or necessary;

(i) Review aggregate quality performance data of individual physicians and make recommendations for quality improvement in the context of peer review;

(j) Share information with the Departments and Committees to provide opportunities for learning and process improvement;

(k) Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative and educational functions as well as issues referred from a department chair or medical director;

(l) Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, consultation and suspension as warranted;

(m) Recommend to the Medical Executive Committee, as required, the limitation, revocation or termination of Medical Staff membership and/or privileges;

(n) Establish a subcommittee or subcommittees as are necessary to perform its duties. Members of subcommittees may include practitioners who are not members of the PRC and/or who are not members of the Medical Staff.

(o) Serve as ex-officio appointee(s) with vote on committees of the Medical Staff if and as requested by the Chief of Staff or CEO.

9.5 CANCER COMMITTEE

9.5-1 COMPOSITION

The Cancer Committee shall consist of at least seven active staff members, with representation from medical oncology, radiation oncology, pathology, surgery, radiation safety, and gynecology, as well as representatives appointed by Medical Center administration, including representatives from administration, nursing, social services, cancer registry, pastoral care, quality management and pharmacy. Medical Staff Members shall be appointed by the Chief of Staff, who shall also designate one member as chairman. The CEO will appoint the non-physician members.

9.5-2 DUTIES

The duties of the Cancer Committee shall be to promote a coordinated, multidisciplinary approach to patient management; to assure that a comprehensive, active supportive care system is in place for patients and families; to monitor and improve cancer care received by Medical Center/campus patients; to develop and evaluate annual goals for clinical educational and programmatic activities related to cancer; to supervise the cancer registry and ensure accurate and timely abstracting, staging, follow up reporting; to ensure content of the annual report and ensure that it is published timely; to review administrative matters relating to cancer care and to review policies that affect cancer care at the Medical Center.

9.6 CREDENTIALS COMMITTEE

9.6-1 COMPOSITION

The Credentials Committee shall consist of at least five active staff members appointed by the Chief of Staff. The immediate past Chief of Staff shall serve as Chairman or appoint a designee with the approval of the Executive Committee, and past Chiefs of Staff may continue to serve on the committee.

9.6-2 DUTIES

The duties of the Credentials Committee shall be to examine the qualifications of each applicant to determine whether all qualifications for staff membership have been met. It shall forward applications recommended for privileges to the clinical departments or sections in which privileges have been requested.

9.6-2 ALLIED HEALTH APPLICATION REVIEW

The Credentials Committee may appoint a subcommittee or an individual within a discipline that is responsible to review the qualifications of applicants to the Allied Health Staff. The Chief Nursing Officer, or designee, would participate in the credentialing, privileging, and ongoing evaluation of advanced practice registered nurses.

9.7 BYLAWS COMMITTEE

9.8-1 COMPOSITION

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

9.7-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a review of the Bylaws at least once each calendar year or more frequently when deemed necessary;
(b) submitting to the Executive Committee recommendations for changes in the Bylaws; and
(c) receiving and evaluating, for recommendation to the Executive Committee, suggestions for modifying the Bylaws.

9.8 PROFESSIONAL PEER SUPPORT COMMITTEE

9.8-1 COMPOSITION

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

9.8-2 DUTIES

The Professional Peer Support Committee will:

(a) Provide ongoing education to the Medical Staff, Hospital Staff and Administrative leadership regarding physician and allied practitioner health, impairment recognition, types and levels of impairment, problems associated with impairment, resources available for the prevention, diagnosis, treatment and rehabilitation of impairment, and the process for referral to the committee, while maintaining informant confidentiality if requested and whenever possible;
(b) Evaluate the credibility of a complaint, allegation, or concern;
(c) Maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened;
(d) Recommend available resources for diagnosis and/or treatment of physicians and allied health professionals experiencing possible illness and impairment issues;
(e) Serve as a resource for physicians and allied health professionals experiencing illness and impairment issues;

(f) Assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
(g) Assist Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee;
(h) Recommend to the affected practitioner that either a psychological, psychiatric and/or physical examination is obtained;
(i) Ensure the recommendations of the committee/subcommittee are followed;
(j) Monitor the practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required;
(k) Require the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the Professional Peer Support Committee or appropriate department chairman; and
(l) Advise the appropriate Department Chairman/Executive Committee of instances in which a practitioner is providing unsafe treatment or if an affected practitioner fails to adhere with the committee's recommendations;
(m) Initiate appropriate actions when a practitioner fails to complete the required rehabilitation program.

9.9 BIOETHICS COMMITTEE

9.9-1 COMPOSITION

The Bioethics Committee shall consist of physicians from a variety of specialties and associates representing Med/Surg, Social Work, Chaplaincy, Nursing, Risk Management, Administration, and a lay member from the community.

9.9-2 DUTIES

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

(a) developing guidelines for consideration in cases having bioethical implications.
(b) developing and implementing procedures for the review of such cases.
(c) developing and/or reviewing institutional policies regarding care and treatment of such cases.
(d) retrospectively reviewing cases for quality review purposes.
(e) consulting with concerned parties to facilitate communication and aid conflict resolution.
(f) educating the Medical Center staff and Medical Staff on bioethical matters.

9.10 PHARMACY & THERAPEUTICS COMMITTEE (P&T)

9.10-1 COMPOSITION

The Pharmacy and Therapeutics Committee should consist of a chairperson, at least 4 members of the medical staff, the director of pharmacy, the clinical pharmacy coordinator or designee, and a representative from administration, nursing and quality management or as otherwise noted in specific facility bylaws. This is a multidisciplinary committee in which the physician members, one pharmacy representative, and one nursing representative shall have a vote.

9.10-2 DUTIES

Pharmacy and Therapeutics committee recommends the adoption or assists in the formulation of policies regarding evaluation, selection, procurement, distribution, use, safe

practices, and other matters pertinent to medications in both the hospital and any associated ambulatory department.

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

1. Serve in an advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the safe use of medications.
2. Serve in an advisory capacity to the Medical Staff and Pharmacy Department in the selection or choice of medications which meet the most effective therapeutic quality standards.
3. Evaluate objectively the clinical data regarding new medications or agents proposed for use in the hospital.
4. Develop a formulary of accepted medications for use in the hospital and provide for continued review.
5. Participate in the formulation and analysis of Medication Use Evaluations.
6. Review and approve pharmacy policies and procedures.
7. Review adverse drug reactions reports and make appropriate recommendations.
8. Review medication occurrence reports and make appropriate recommendations.
9. Review pharmacy intervention activities and make appropriate recommendations
10. Present recommendations from the Pharmacy and Therapeutics Committee to the appropriate medical staff committee and/or the Medical Executive Committee.

9.11 TUMOR BOARD

9.11-1 COMPOSITION

Practitioners of this Committee shall consist of all disciplines of the Medical Staff.

9.11-2 RESPONSIBILITIES

The Tumor Board will review and discuss the medical condition of and treatment options for patients. The Tumor Board will improve the quality of cancer care and provide educational opportunities for members by focusing on problem cases, pretreatment evaluation, staging, treatment strategy and rehabilitation.

9.12 UTILIZATION MANAGEMENT COMMITTEE

9.12-1 COMPOSITION

The Utilization Management Committee shall consist of members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as Chairman. The UM Committee is a multidisciplinary committee consisting of physicians and representatives from quality management, case management, nursing, administration, and as needed from HIMS and other ancillary services. The committee shall meet at least quarterly and shall report to the MEC.

9.12-2 DUTIES

The duties of the Utilization Management Committee shall include:

a) Implement a proactive and concurrent process to ensure appropriate and efficient use of health care resources.
b) Develop and enforce a Utilization Review Plan that guides the review of services provided by hospital staff and members of the medical staff for Medicare/Medicaid beneficiaries. The plan shall include scope and frequency of review with respect to medical necessity of services, e.g. admission, length of stay, and professional services and medications provided.
c) Determine education and training needs for members of the medical staff and hospital staff in regard to utilization management.

ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 REGULAR MEETINGS
General staff meetings will be held at least annually.

10.1-2 SPECIAL MEETINGS
A special meeting of the Medical Staff may be called by the Chief of Staff, the Executive Committee, or the Board. The Chief of Staff will call for such a meeting upon petition signed by 10% of the members of the active staff.

10.2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

10.2-1 REGULAR MEETINGS
Clinical departments and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. A department will meet at least three (3) times per year.

10.2-2 SPECIAL MEETINGS
A special meeting of any department or committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Chief of Staff, or the Executive Committee. A notice of such special meeting will be sent to all members of the department or committee.

10.2-3 EXECUTIVE SESSION
All quality review activities undertaken by a department, section or committee, including but not limited to recommendations regarding Medical Staff membership, delineation of clinical privileges, and corrective action, shall be undertaken in Executive Session. "Executive Session" means portions of a meeting designated by the Chair as involving confidential information. Any department or committee may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group and other individuals who have a legitimate reason to be present may remain during such session. Separate minutes must be kept of any executive session. When other Medical Staff Committees or the Board act on or review discussion or action taken in Executive Session, such action or review shall be undertaken in Executive Session. All Executive Session minutes and activities shall be maintained confidentially as required by law.

10.3 ATTENDANCE REQUIREMENTS

10.3-1 CHART REVIEW
A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the department or committee to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to attend will result in automatic suspension under Section 6.6-8.

10.3-2 CLINICAL CONFERENCE
Whenever a department perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified by the department chairman of the time, date, place of the program, the subject matter to be covered, and its special applicability to their practice.

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

10.3-3 **SPECIAL APPEARANCE**

Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the Chief of Staff, the chairman of the Professional Review Committee or the applicable department chairman may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefore. Absent good cause, failure to attend will result in automatic suspension under Section 6.6-8.

10.4 **QUORUM**

10.4-1 **GENERAL STAFF MEETINGS**

A quorum is not required.

10.4-2 **COMMITTEE MEETINGS**

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

10.4-3 **DEPARTMENT MEETINGS**

Each department shall establish what constitutes a quorum for the transaction of business before the department as a whole.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 **AUTHORIZATIONS AND RELEASES**

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

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

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

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

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

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

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

11.2 **CONFIDENTIALITY OF INFORMATION**

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

11.3 **ACTIVITIES COVERED**

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

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

11.4 **RELEASES AND DOCUMENTS**

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

11.5 **CUMULATIVE EFFECT**

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

ARTICLE TWELVE: GENERAL PROVISIONS

12.1 **CONFLICT RESOLUTION**

12.1-1 **STAFF MEMBER CHALLENGE**

Any member of the Medical Staff may challenge any rule or policy established by the Executive Committee by submitting to the Chief of Staff written notification of the challenge, with a petition signed by 10% of the members of the ACTIVE Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

12.1-2 **EXECUTIVE COMMITTEE REVIEW**

The 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 Executive Committee may use internal or external resources to assist in resolving the conflict. The Executive Committee will review subcommittee recommendations and take final action on the rule or policy, subject to Board approval as required. The Executive Committee will communicate all changes to the Medical Staff.

12.1-3 **CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY**

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

12.2 **MEDICAL STAFF RULES AND REGULATIONS**

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

12.3 **DEPARTMENT RULES AND REGULATIONS**

Each department and section will formulate written rules and regulations for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with the Bylaws and Medical Center policies. These department rules and regulations must be reviewed and approved by the Executive Committee and the Board as needed, but must be reviewed at least every two (2) years; any changes affecting qualifications, privileges, supervision, and call coverage must be approved by the Executive Committee and the Board.

12.4 **HISTORIES AND PHYSICALS**

A history and physical examination ("H&P") in all cases shall be completed by a physician, oral surgeon, or Allied Health Professional who is approved by the medical staff to perform admission H&Ps within 24 hours after registration or admission. The completed H&P must be on the medical record prior to surgery or invasive procedure or any procedure in which conscious sedation will be administered or the case will be cancelled unless the responsible practitioner documents in writing that such delay would constitute a hazard to the patient. A legible H&P performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. The content of complete H&P is delineated in the General Rules and Regulations of the Medical Staff.

12.5 **STAFF DUES**

Notice of dues shall be given to the staff at the time of reappointment at which time dues for two years must be paid. All new staff members must pay one year's worth of dues with the application and will be billed for the second year one year later. Failure to render payment shall result in non-processing of a new application or reappointment. Special assessments may be levied by a majority vote of the active staff, and rules of payment similar to those described above in terms of time frame shall apply. The Honorary, community-based and Federally Employed Military staffs shall be exempt from payment of dues and assessments. Medical Staff dues are non-refundable.

12.6 **SPECIAL NOTICE**

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

12.7 **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.

12.8 **PARLIAMENTARY PROCEDURE**

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

12.9 **COMMUNICATION**

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

12.10 **SUPPORT STAFF**

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

ARTICLE THIRTEEN: COMMUNITY-BASED PRACTITIONERS

Community-based practitioners (including physicians, physician assistants and advance practice nurses) are those who request Medical Center services for their patients and wish to be affiliated with the Medical Center. Community-based practitioners are not members of the Medical Staff and do not have clinical privileges at the medical center.

13.1 **QUALIFICATIONS**

Practitioners seeking to affiliate with the Medical Center must apply for community-based status and provide evidence of the following qualifications:

(a) Arizona licensure in good standing;

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

(c) Ability to relate in a professional manner with Medical Center staff and physicians;
(d) Professional ethics and conduct.

13.2 **PREROGATIVES**

The prerogatives of Community-Based practitioners are to:
(a) Order Medical Center outpatient diagnostic services for patients;
(b) Access Medical Center information, via Clinical Connectivity, for their own patients;
(c) Attend Continuing Medical Education programs at the Medical Center.
(d) Receive Medical Staff Newsletters and other BEMC Publications.

13.3 **OBLIGATIONS**

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

13.4 **DENIAL OR TERMINATION OF COMMUNITY-BASED STATUS**

Community-based practitioners or practitioners seeking Community-Based status are not entitled to due process rights under the Fair Hearing Plan. A practitioner who believes he or she was wrongly denied community-based status or whose status was terminated may submit information to the Executive Committee, demonstrating why the denial or termination was unwarranted. The Executive Committee, in its sole discretion, shall decide whether to review the submission. The practitioner has no appeal or other rights in connection with the Executive Committee's decision.

ARTICLE FOURTEEN: ADOPTION AND AMENDMENT

14.1 **MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

The Medical Staff shall be responsible for the development, adoption, and periodic review of these Bylaws which must be consistent with Medical Center policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community. These Bylaws may not conflict with the Banner Health Bylaws. In the event that a law or regulatory requirement changes, such change will govern these Bylaws as legally required by operation of law.

14.2 **BYLAWS REVIEW**

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.

14.3 **MEDICAL EXECUTIVE COMMITTEE PROCESS**

The Bylaws of the Medical Staff are adopted by the Medical Staff and approved by the Board prior to becoming effective. Amendments to these Bylaws may be adopted upon approval of the Executive Committee and approval by a majority electronic and/or ballot vote of members of the Active Staff voting. Ballots shall be sent to each Active Staff member by mail or email. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 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.

14.4 **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 14.7.

14.5 **MEDICAL STAFF PROCESS**

The Medical Staff may propose Bylaws or amendments thereto directly to the Board, including amendments to remove authority given to the Medical Executive Committee. A petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Executive Committee. The Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Executive Committee. The Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Active Medical Staff for vote in accordance with Section 15.3. The comments of the Executive Committee shall be sent with the ballots. If the proposed amendment is accepted by the Medical Staff by a majority of those voting, the amendment, along with the Medical Executive Committee comments, will be forwarded to the Board for action.

14.6 **BOARD OF DIRECTORS ACTION**

14.6-1 **WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION**

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

14.6-2 **BOARD CONCERNS**

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

14.7 **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.

14.8 **TECHNICAL AND EDITORIAL AMENDMENTS**

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

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

14.9-1 **PERIODIC REVIEW**

The Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, and Allied Health Rules and Regulations 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.

14.9-2 **COMMUNICATION TO THE MEDICAL STAFF**

(a) Routine matters. Absent a documented need for urgent action, before acting, the Executive Committee will communicate to the Staff by email proposed changes to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations and Allied Health Rules and Regulations before approving such changes. Members may submit comments and concerns to the Chief of Staff c/o Medical Staff Services within 10 days. If concerns are not received within 10 days, the Executive Committee's recommendation relating to the proposed changes will be submitted to the Board for approval. If concerns are received, the 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 Executive Committee and Board may provisionally adopt an urgent amendment without prior notification of the Medical Staff. The 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 *40%* of the Active Staff oppose the amendment, the Executive Committee will utilize the conflict resolution process set forth in Section 12.1. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

14.9-3 **MEDICAL STAFF AMENDMENTS**

The Medical Staff may propose amendments to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations and Allied Health Rules and Regulations to the Bylaws Committee or directly to the Board. To submit the amendments directly to the Board, a petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Executive Committee. The Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Executive Committee. The Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Board, along with the recommendation of the Executive Committee. If the Executive Committee determines a medical staff vote is necessary, ballots shall be sent to each Active Staff member by mail or email, along with the comments of the Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

14.9-4 **ADOPTION AND AMENDMENT**

The Credentials Procedure Manual, Fair Hearing Plan, Allied Health Rules and Regulations and Medical Staff Rules and Regulations must be adopted by the Medical Executive Committee and approved by the Board prior to becoming effective. Amendments to the Fair Hearing Plan, Medical Staff Rules and Regulations, and/or Allied Health Rules and Regulations may be adopted upon approval of the Medical Executive Committee and the Board.

ADOPTION AND APPROVAL: **5/20/04**
Amendments Approved: 6/17/04; 11/17/05; 6/15/06; 10/19/06; 04/18/07; 10/18/07; 11/13/08; 10/15/09; 11/12/09; 10/14/10; 10/13/11; 2/9/12; 5/9/13, 07/21/14, 11/13/14, 03/12/15; 05/14/15

REVISED: Bylaws Committee – 01/06/2016
Medical Executive Committee – 01/06/2016
Out to Active Medical Staff for vote- 01/07/2016
Board – 2/11/16

REVISED: Bylaws Committee – 02/15/16
MEC – 3/2/16
Out to Active Staff for vote – 3/2/16
Board – 4/14/16

REVISED: Bylaws Committee -5/23/16
MEC – 6/1/16
Out to Active Staff for vote – 6/3/16
Board – 7/14/16

REVISED: MEC – 7/6/16
Out to Active Medical Staff for Vote – 7/15/16
Board – 8/11/16