

**ALLIED HEALTH PROFESSIONALS
RULES and REGULATIONS**

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ARTICLE I. DEFINITIONS AND CATEGORIES

1.1 Definition

Allied health professionals (AHPs) are individuals who:

- (a) are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital; and
- (b) function in a medical support role to physicians who have agreed to be responsible for such AHPs. AHPs are not members of the medical staff.

1.2 Categories

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

ARTICLE II. QUALIFICATIONS

2.1 Statement of Qualifications

A statement of qualifications for each category of allied health professionals shall be developed by the department to which the AHP would be assigned, subject to approval by the Medical Executive Committee and the Board. Each statement must:

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

ARTICLE III. PREROGATIVES, OBLIGATIONS, TERMS AND CONDITIONS

3.1 Prerogatives

The prerogatives of an AHP are to:

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

3.2 Obligations

Each AHP shall:

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

3.3 Terms and Conditions

An AHP shall be individually assigned appointment to the clinical department appropriate to his or her professional training and subject to formal periodic (biennial) review and disciplinary procedures as determined for the category. Prior to exercising approved privileges, AHPs must receive CPOE/EMR (Computer Physician Order Entry/Electronic Medical Record) training as it applies to their scope of practice. AHPs must receive an orientation to the Medical Center.

Any questions concerning the function of an AHP shall be referred to the department of the sponsoring physician.

ARTICLE IV. ADVERSE ACTION REVIEW AND APPELLATE REVIEW, AUTOMATIC AND NONREVIEWABLE ACTIONS

4.1 Adverse Action Review and Appellate Process

4.1.1 Initiation of Adverse Action Review and Appeal Process

AHPs who are subject to Adverse Action (other than Nonreviewable or Automatic Actions defined in Sections 4.2 and 4.3) shall be afforded an Adverse Action Review and appeal process in accordance with these Rules & Regulations. Adverse Actions include: denial of a request to provide any patient care services within the applicable Scope of Practice or revocation, suspension, reduction, limitation or termination of privileges within the applicable Scope of Practice. AHPs are not entitled to due process rights set forth in the Medical Staff Bylaws, and none of the procedural rules set forth therein shall apply.

- 4.1.2 **Notice of Adverse Recommendation or Action**
Within fifteen (15) days after Adverse Action is taken against an AHP, the AHP and his/her supervising physician shall be notified in writing of the specific reasons for the Adverse Action and the AHPs rights per these Rules and Regulations.
- 4.1.3 **Request for Review of Adverse Recommendation or Action**
The AHP may request an Adverse Action Review following the procedure set forth in these Rules and Regulations. If the AHP does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) days following the receipt of the notice of the Adverse Action, the Adverse Action shall be final and non-appealable.
- 4.1.4 **Composition of the Review Committee**
The Medical Staff Department to which the AHP is assigned or departmental committee consisting of at least three members of the Department and a Nursing Administration representative will consider the request and serve as the Review Committee.
- 4.1.5 **Notice of Time and Place for Review**
The AHP shall be given ten (10) days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, who will be called to support the Adverse Action.
- 4.1.6 **Statements in Support**
The Medical Staff Representative and the AHP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Medical Staff Services Office at least five (5) days prior to the review.
- 4.1.7 **Rights of Parties**
During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. The AHP, the Hospital and the Medical Staff Representative shall not be entitled to legal counsel at the Adverse Action Review or Appellate Review.
- 4.1.8 **Burden of Proof**
The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.
- 4.1.9 **Action on Committee Review**
Upon completion of the review, the Review Committee shall consider the information and evidence presented, make a recommendation, which shall include the basis therefore, and forward it to the Chief of Staff. The AHP and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.
- 4.1.10 **Duty to Notify of Noncompliance**
If the AHP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan/Allied Health Professionals Rules and Regulations or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation. The AHP will be deemed to waive any procedural deviation that he/she has not raised promptly with the Chief of Staff pursuant to this section.
- 4.1.11 **Request for Appellate Review**
If the AHP is dissatisfied with the Committee's recommendation, he/she may submit a written request for an Appellate Review, provided that the Chief Executive Officer receives such request within ten (10) days following the AHP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with these Rules and Regulations or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by

substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable. For appeals based upon procedural errors, notice of noncompliance must have been properly given.

4.1.12 **Interview with Medical Executive Committee**

Upon a proper and timely request for an Appellate Review, the AHP shall be given an interview with the Medical Executive Committee or a subcommittee thereof consisting of at least three (3) members. The AHP shall be given at least five (5) days prior written notice of the time, place and date of the Appellate Review. At the appeal, the parties shall be allowed to present written and/or oral arguments as to why the Committee's recommendation should be reversed or modified.

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

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

The final decision will be submitted to the Medical Staff Subcommittee of the Board.

4.2 **Automatic Suspension or Limitation**

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

4.2.1 **License**

Whenever a practitioner's license is revoked, restricted, or suspended, or has expired, the practitioner's AHP appointment and clinical privileges are similarly revoked, restricted, or suspended.

4.2.2 **Controlled Substances Registration**

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

4.2.3 **Professional Liability Insurance**

A practitioner's appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Banner Board. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned and must reapply for AHP membership and privileges.

4.2.4 **Exclusion from Medicare/State Programs**

The CEO, with notice to the Chief of Staff, will immediately and automatically suspend an Excluded Practitioner. An "Excluded Practitioner" is a practitioner whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or Tricare (formerly CHAMPUS) program.

4.2.5 **Failure to Satisfy Special Appearance Requirement**

A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, shall automatically be suspended. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership and clinical privileges. Thereafter, the affected practitioner must reapply for AHP membership and privileges.

4.2.6 **Failure to Pay Staff Dues**

A practitioner who fails to pay staff dues shall automatically be suspended from the AHP staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have

- resigned voluntarily from the staff and must reapply for AHP membership and privileges.
- 4.2.7 **Failure to Execute Releases and/or Provide Documents**
A practitioner who fails to execute a general or specific release and/or provide documents during a term of appointment when requested by the Chief of Staff, department chairman, section chief, or designee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.
- 4.2.8 **Failure to Establish Freedom from Infectious TB**
A practitioner's staff membership and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious TB whenever such evidence is requested as required by law and Hospital policy. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of freedom from infectious TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.
- 4.2.9 **Failure to be Vaccinated or to Obtain Exemption**
A practitioner's clinical privileges shall be immediately suspended for failure to provide evidence of flu vaccination or an approved exemption granted by Banner or, where granted an exemption, for failure to wear a mask as required by Banner policy. Privileges will be reinstated at the end of flu season.
- 4.2.9 **Failure to Participate in an Evaluation**
A practitioner who fails to participate in an evaluation of his/her qualifications for AHP Staff membership and/or privileges shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.
- 4.2.10 **Failure to Complete Assessments and Provide Results**
A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.
- 4.2.11 **Failure to Maintain a Supervising Physician**
A practitioner who fails to maintain a supervising physician, shall automatically be suspended. If, within 30 calendar days of notification of suspension, another physician with appropriate privileges on the BGFMC Medical Staff agrees to serve as the supervising physician and is approved by the appropriate licensing agency, if so required, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for AHP membership and privileges.

4.3 **Nonreviewable Actions**

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

- 4.3.1 Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
- 4.3.2 Issuance of a warning or a letter of admonition or reprimand.
- 4.3.3 Imposition of monitoring of professional practices, other than direct supervision, for a

- period of 6 months or less.
- 4.3.4 Termination or limitation of temporary privileges.
- 4.3.5 Any recommendation voluntarily imposed or accepted by a practitioner.
- 4.3.6 Denial of membership for failure to complete an application for membership or privileges.
- 4.3.7 Removal of membership for failure to complete the minimum supervisory requirements.
- 4.3.8 Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
- 4.3.9 Any requirement to complete an educational assessment or training program.
- 4.3.10 Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
- 4.3.11 Retrospective chart review.
- 4.3.12 Termination of any contract with or employment by the Medical Center.
- 4.3.14 Removal or limitation of the ability to see patients in the Emergency Department.
- 4.3.15 Denial, removal or limitation of AHP membership or permission to provide patient care services as a result of 1) the decision of the CEO to enter into, terminate or modify an exclusive contract for clinical services; or 2) the termination or modification of the practitioner's relationship with the exclusive provider.
- 4.3.16 Grant of conditional appointment or appointment for a limited duration.

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

ARTICLE V. SCOPE OF SERVICE

5.1 Description

The scope of service that may be provided by any group of AHPs shall be developed by the appropriate department and representatives of management, if applicable, and subject to the recommendation of the Executive Committee and the approval of the Board. For each group, guidelines must include at least:

- 5.1.1 specifications of categories of patients to whom services may be provided.
- 5.1.2 a description of the services to be provided and procedures to be performed, including any special equipment, procedures, or protocols that specific tasks may involve, and responsibility for documenting the services provided in the medical record.
- 5.1.3 a description of the scope of assistance that may be provided to a physician and any limitations thereon, including the degree of physician supervision required.
- 5.1.4 the services provided by AHPs who are not Banner employees must be commensurate with the qualifications and competencies required of medical center employees who perform the same or similar services.

ARTICLE VI. CREDENTIALING

6.1 General

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

A physician assistant, nurse practitioner or certified nurse anesthetist who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Medical Center, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as a non contracted/employed AHP staff member.

6.2 Processing the Application

6.2.1 Applicant's Burden

The applicant has the burden of producing adequate information for a proper evaluation of his or her qualifications and of resolving any doubts about any of the qualifications required for AHP membership, department or section assignment, or clinical privileges, and of satisfying any requests for information or clarification. Applications not demonstrating compliance with the requirements for allied health staff membership and privileges will be deemed to be incomplete. Incomplete applications will not be processed.

6.2.2 APPLICATIONS UPON OPENING

Applications submitted prior to the opening of BGFMC will be reviewed as follows: For current Allied Health members of the Banner Ironwood Medical Staff, the Banner Health Credentials Verification Office (CVO) will accept updated applications and delineation of privileging forms. The CVO will verify all expirables and forward a copy of the application and all supporting information to Banner Goldfield Medical Center's Medical Staff Office. Clean applications will be submitted for review by the CMO, then submitted to the Board for approval. Other applications will be processed as set forth below.

6.2.2 Verification of Information

An Initial Pre-Application Request Form shall be submitted to the CVO which shall forward a copy to the BGFMC's Medical Staff Office to determine eligibility. If the applicant meets minimum established eligibility criteria, the CVO office will be notified and the applicant will be mailed a more detailed application for completion. Representatives of the Banner Health CVO shall collect and verify the references, licensure, and other qualification evidence submitted and notify the applicant of any problems in obtaining the required information. Upon such notification, it is the applicant's obligation to obtain the required information. The references obtained by the CVO do not become part of the credentials file. Where concerns are identified, a current competency verification and privilege checklist will be sent to the professional who completed the CVO reference form. When collection and verification is accomplished, the application shall be presumed to be complete and shall be transmitted with all supporting materials to the BGFMC Medical Staff Office which will then submit the application to the Credentials Committee and to the chairman of each department and the chief of each section, if applicable, in which the applicant seeks permission to provide patient care services. If the application is subsequently found to be incomplete, the applicant will be notified that the application is incomplete and the information that must be submitted will be requested.

6.2.3 Credentials Review

6.2.3.1 Advanced Practice Nurses, Surgical First Assistants, Certified Nurse Anesthetists

Nursing Administration shall review the completed application, the supporting documentation, and any other relevant information and determine if the applicant meets all of the necessary qualifications for staff membership and department and section requested. Nursing Administration shall transmit its recommendation(s) regarding staff appointment and prerogatives to Medical Staff Services for committee review.

6.2.3.2 Physician Assistants, Pathology Assistants, Private Scrubs/Surgical Technologists

Upon receipt of all necessary documentation, the Credentials Committee at its next regularly scheduled meeting shall review the completed application, the supporting documentation, and any other relevant information and determine if the applicant meets all of the necessary qualifications for staff membership and department and section requested. The Credentials Committee shall transmit its recommendations regarding staff appointment and privileges to the clinical department or section in which privileges have been requested.

6.2.4 Department and Section Action

The chairman of the respective department and chief of the section, if applicable, in which the applicant seeks privileges shall review the application and its supporting

documentation and forward to the Medical Executive Committee the recommendation as to the privileges to be granted.

Prior to submitting a recommendation to the Medical Executive Committee, the chairman of the department and section chief, if applicable, shall determine whether an application is expedited or routine. Applications meeting any of the following criteria may not be eligible for expedited review:

- a) Where the application is incomplete.
- b) Where there is a current challenge or previously successful challenge to an applicant's licensure or registration.
- c) Where the applicant has received an involuntary termination of allied health staff membership at another organization.
- d) Where the applicant has received involuntary limitation, reduction, denial or loss of clinical privileges.
- e) Where the Credentials Review determines that there has been either an unusual pattern of liability actions brought against the applicant, or an excessive number of professional liability actions resulting in a final judgment against the applicant.
- f) Where the applicant has been convicted of, or pleads guilty or no contest to, a felony related to the practice of medicine.
- g) Where there is adverse information on reference letters or comments suggesting potential problems.

Applications determined to be eligible for expedited review shall be forwarded to the Medical Executive Committee; those determined to be routine, according to the above criteria, shall be reviewed at the next regularly scheduled meeting of the department prior to being forwarded to the Medical Executive Committee.

A department chairman or section chief may conduct an interview with the applicant or designate a committee to conduct such interview.

6.2.5 **Medical Executive Committee Action**

The Medical Executive Committee, at its next regular meeting, shall review the application, the supporting documentation, the reports and recommendations from the department chairmen, section chiefs, and Credentials Committee/subcommittee, and any other relevant information available to it. The Medical Executive Committee shall prepare a written report to the Board with recommendations as to approval or denial of, or any special limitations on, staff appointment and privileges, department and section affiliation, scope of service, or defer action for further consideration.

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

6.2.5.2 **Limited Period of Appointment:** From time to time, the Medical Executive Committee may recommend a period of appointment of less than two years. A limited appointment may be extended without completion of a new application and review required by these Bylaws provided that a reappointment application is completed and processed within two years. The practitioner will submit a supplemental application and any other requested information, which will be reviewed, along with any additional information deemed appropriate, by the Department.

6.2.6 **Board**

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

6.3 **Temporary Privileges**

6.3.1 **Conditions**

Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately certified/licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has provided evidence of satisfactory professional liability insurance. Special requirements of supervision and reporting may be imposed by the Chief of Staff, department chairman, or section chief. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Rules and Regulations and the policies of the Medical Center.

6.3.2 **Circumstances**

Upon recommendation of the Chief of Staff, department chairman, the CEO or his/her designee may grant temporary privileges in the following circumstances:

- 6.3.2.1 **Pendency of Application:** to an applicant who has submitted a complete application that has been verified and raises no concerns, has been approved by the Credentials Subcommittee or the Credentials Committee and the department chairman, and is awaiting review and approval of the Medical Executive Committee and the Board. Upon completion of CPOE/EMR (Computer Physician Order Entry/Electronic Medical Record) training, 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. During the first three months of opening, 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 Department Chairman or the Chief Medical Officer, and is awaiting review and approval of the Medical Executive Committee and the Board. The Chief Nursing Officer must review and approve applications of advanced practice nurses.
- 6.3.2.2 **Care of Specific Patient:** to a practitioner for the care of a specific patient but only after receipt of a request for the specific privileges desired and confirmation of appropriate licensure, adequate professional liability insurance coverage and favorable results of the National Practitioner Data Bank query. Such temporary privileges may not be granted in more than (3) three instances in any 12 month period after which the practitioner must apply for staff appointment, and are restricted to the care of specific patients for which they are granted.
- 6.3.2.3 **Coverage of Services:** Where a service is not adequately covered to meet patient care needs, temporary privileges may be granted to an applicant for staff membership upon receipt of application and verification of the following information: appropriate licensure, certification (if applicable), adequate professional liability insurance, DEA registration (if applicable), current clinical

competency, education and training, and NPDB query responses. Privilege criteria for the requested privilege(s) must be met. Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of practitioner convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 60 days upon completion of CPOE/EMR training. One extension may be granted for an additional period not to exceed 60 days.

6.3.3 **Additional Procedures**

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

6.3.4 **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.

6.3.5 **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.

6.4 **Disaster Privileges**

In the event of an officially declared emergency or disaster, any nurse practitioner, or physician assistant may be granted temporary disaster privileges upon recommendation of the CEO, Chief Medical Officer, Chief of Staff or incident commander handling the disaster provided that the care, treatment, and services provided are within the scope of the individual's license. Such practitioner shall provide evidence of a valid professional license, with the practitioner's license number, or picture identification evidencing that such practitioner is a member of an Arizona hospital's AHP Staff or a member of an AHP Staff at a federal military hospital. Where the practitioner is not a member of an Arizona hospital's AHP Staff, a current Hospital employee or Medical Staff member must recommend the granting of such privileges. Such privileges expire within thirty (30) days or upon the termination of the disaster or completion of inpatient care, whichever occurs first, and may be terminated in accordance with Section 6.3.4. A practitioner is not entitled the procedural rights afforded by these Bylaws because a request for temporary privileges is refused or because such privileges are terminated or otherwise limited.

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

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

6.4.3 The CEO or designee will decide within 72 hours whether continuation or renewal of the disaster privileges is indicated. This decision is based upon information regarding the professional practice of the volunteer.

ARTICLE VII. REAPPOINTMENT

7.1 Information Collection and Verification

7.1.1 From AHP

The Medical Staff Office or its designee shall send each AHP an application for reappointment and notice of the date on which membership and privileges will expire. The application for reappointment must be submitted on the form approved by the Board. The application shall include:

- 7.1.1.1 Information to demonstrate the AHP's continued compliance with the qualifications for allied health membership and to update the member's credentials file.
- 7.1.1.2 Imposed or pending sanctions and any other problems.
- 7.1.1.3 Information regarding health status (including freedom from infectious TB)
- 7.1.1.4 Continuing Education attestation.

Failure to return the satisfactorily completed forms shall be deemed a voluntary resignation from the AHP staff and shall result in automatic termination of membership at the expiration of the current term unless such term.

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

7.1.2 From Internal Sources

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

- 7.1.2.1 Findings from the quality review and utilization management activities;
- 7.1.2.2 Level of clinical activity at BGFMC;
- 7.1.2.3 Timely and accurate completion of medical records;
- 7.1.2.4 Cooperativeness in working with other practitioners and hospital personnel;
- 7.1.2.5 General attitude toward patients and the Medical Center; and
- 7.1.2.6 Compliance with all applicable Bylaws, rules and regulations, and policies and procedures of the medical staff and Medical Center;

7.1.3 From External Sources

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

- 7.1.3.1 Peer references and verification of clinical competency from a physician designated on the reappointment application.
- 7.1.3.2 Professional Liability Insurance – current coverage and any malpractice claims history resulting in settlement or judgments as reported by the National Practitioner Data Bank. Verification from prior malpractice insurance carriers will be sought if concerns are identified which necessitate further investigation.
- 7.1.3.3c Verification of all professional licensures or certifications to practice and sanctions against such license, termination or restriction of licensure and any previously successful or currently pending challenges to licensure, voluntary or involuntary.
- 7.1.3.4 AHP Staff memberships and privileges at other hospitals - for relevant professional experience and termination or restriction of membership or clinical privileges, voluntary or involuntary.
- 7.1.3.5 Medicare/Medicaid Sanctions.
- 7.1.3.6 DEA Registration.
- 7.1.3.7 Additional information from other databanks, including the NPDB, may be gathered by the Medical Staff Office or its agent, as required by the Medical Executive Committee and/or regulatory agencies.

7.2 **Credentials Committee Review**

7.2.1 The Credentials Subcommittee shall review the reappointment application, the supporting documentation, and any other relevant information and evaluate the information for continuing membership and privileges requested. The Credentials Subcommittee shall transmit its recommendation to Medical Staff Office for department review.

7.3 **Department and Section Action**

The chairman of the respective department and chief of the section, if applicable, in which the allied health member requests privileges shall review the reappointment application, the supporting documentation and any other relevant information, and evaluate the information for continuing membership and privileges requested. Applications determined to be eligible for expedited review shall be forwarded to the Medical Executive Committee; those determined to be routine, according to Section 6.2.4, shall be reviewed at the next regularly scheduled meeting of the department prior to being forwarded to the Medical Executive Committee.

7.4 **Medical Executive Committee Action**

The Medical Executive Committee shall review the department and section reports, and any other relevant information available to it and either make a recommendation for reappointment or non-reappointment. The Medical Executive Committee shall prepare a written report to the Board with recommendations as to approval or denial of, or any special limitations on, staff appointment and privileges, department and section affiliation, and scope of service, or defer action for further consideration.

7.5 **Board Action**

Final approval of reappointments rests with the Board of Directors.

7.6 **Time Periods for Processing**

All recommendations for reappointment should be presented to the Board prior to the expiration of the appointment period.

ARTICLE VIII. OPPE/FPPE

8.1 Ongoing Professional Practice Evaluation (OPPE)

As outlined in the Professional Practice Evaluation Policy. OPPE also includes annual sponsoring physician competency evaluation.

8.2 Focused Professional Practice Evaluation (FPPE)

Nurse practitioners, certified nurse anesthetists, crisis counselors and physician assistants.

- 1) A retrospective review of three (3) cases, performed at Banner Goldfield Medical Center, must be completed. The three cases must be cases which represent privileges granted.
 - a) Three to six months after a practitioner's initial appointment or initial granting of privileges, the Medical Staff Office will obtain a list of the practitioner's activity in the hospital. An evaluation form will be generated for three (3) randomly selected cases which will be reviewed and/or assigned for review by the Department Chairman as needed. Results of the review will be reported to the Department Chairman for review and action.
 - b) The reviewer's report is confidential and for use of the Department only. The report, however, may be released to other hospitals if requested in writing, by the reviewed physician for privileges at other hospitals.
 - c) Active staff members of the Department are eligible to serve as reviewers for the retrospective review process.
 - d) The reviewer shall give a candid opinion on the report to the Department Chairman. The reviewer shall immediately notify the Department Chairman should any questions arise concerning an AHP's competency or management of a particular case.

- e) Following review of the completed review forms, additional cases may be required if deemed necessary by the Department Chairman.
- 2) Monitoring of physician-specific data for the FPPE shall include, as available, the use of blood and blood products, medication usage, appropriate utilization of resources, timeliness of the completion of patient records, quality of patient records, outcome information related to morbidity and mortality, all available performance improvement data, outcome information pertaining to operative and other invasive procedures and other matters related to the physician's competency.
 - 3) Clinical competency, technical skill, judgment, adherence to bylaws, cooperativeness and ability to work with others in a professional manner will be evaluated through the peer review process. Generated variance reports shall be reviewed by the Chair or designee.
 - 4) If the practitioner has insufficient activity to adequately evaluate his performance, the FPPE period will be extended for a period not to exceed 12 months in duration.
 - 5) For those practitioners with minimal activity during the initial FPPE period (practitioners who only provide occasional coverage at the hospital) the MEC may, on the recommendation of the department chairman, modify the department specific requirements, 100% of his/her cases during the initial period will be reviewed.

Non-physician first assistants and private scrubs/surgical technologists

A 6 month competency evaluation will be completed by the sponsoring physician and/or peri-operative director.

ARTICLE IX. AMENDMENT AND ADOPTION

9.1 **Amendment**

These General Rules and Regulations of the Allied Health Professional Staff may be amended or repealed, in whole or part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board.

9.2 **Adoption**

Approved and adopted by resolution of the Banner Health Board of Directors on

Revised