



# Banner Heart Hospital

## **MEDICAL STAFF BYLAWS**

### **PREAMBLE**

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Heart Hospital 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 applicants to, and members of, the Medical Staff. These Bylaws of Banner Heart Hospital provide a recognized structure for Medical Staff activities and document the binding relationship between the Medical Staff and the Board.

### **ARTICLE ONE: NAME**

The organizational component of Banner Heart Hospital to which these Bylaws are addressed is called “The Medical Staff of Banner Heart Hospital.”

### **ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF**

#### **2.1 PURPOSES**

The purposes of this Medical Staff are:

to continually seek to provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Heart Hospital.

to provide a mechanism for accountability to the Board, through defined organizational structures, for the review of the appropriateness of patient care services, professional and ethical conduct, and research activities of each practitioner appointed to the Medical Staff, so that patient care provided at the Hospital facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

to serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Hospital and through which they fulfill the obligations of staff appointment.

to provide an orderly and systematic means by which staff members can give input to the Board and Chief Executive Officer on medico-administrative issues and on Hospital policy-making and planning processes.

#### **2.2 RESPONSIBILITIES**

The responsibilities of the Medical Staff through its departments, committees, and officers include:

**2.2-1** To participate in the performance improvement and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided in the Hospital, 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, including assessing processes, conducting Sentinel Clinical Event root cause analyses to improve patient care practices, and monitoring the effectiveness of improvements;
  - (c) Evaluating practitioners' credentials for appointment and reappointment to the Medical and Allied Health Professional Staffs and for the delineation of clinical privileges; and;
  - (d) Promoting the appropriate use of Hospital 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, and corrective action;
- 2.2-3** To participate in the development, conduct, and monitoring of clinical research activities;
- 2.2-4** To develop and maintain Medical Staff Bylaws, a Fair Hearing Plan, General Medical Staff Rules and Regulations and Medical Staff Service Policies and Procedures that are consistent with sound professional practices, and to enforce compliance with them;
- 2.2-5** To participate in the Hospital'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;
- 2.2-7** To participate in the planning, implementation, and evaluation of hospital plans for a safe, accessible, effective, and efficient environment consistent with quality patient care, and;
- 2.2-8** To assist Banner Heart Hospital in improving patient satisfaction.

### **ARTICLE THREE: MEMBERSHIP**

#### **3.1 GENERAL QUALIFICATIONS**

Every practitioner who seeks or enjoys staff membership shall, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws or in department rules and regulations. The medical staff enforces and complies with, and takes action as necessary, to enforce the Medical Staff Bylaws, Rules and Regulations and policies.

##### **3.1-1 LICENSURE**

Evidence of a current, valid license, issued by the State of Arizona to practice medicine, psychology, podiatry, or dentistry.

##### **3.1-2 PROFESSIONAL EDUCATION AND TRAINING**

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

For purposes of this section, an "approved" or "accredited" school or university is one fully accredited during the time of the practitioner's attendance by the Accreditation

Council for Graduate Medical Education, by the American Osteopathic Association, by the American Psychological Association, or by a successor agency to any of the foregoing or by an accrediting agency on file with the U.S. Secretary of Education.

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

### **3.1-3 BOARD CERTIFICATION**

- (a) Board certified or qualified for Board certification: Where membership and privileges are granted on the basis of Board qualification, initial certification shall be obtained prior to the expiration of Board qualification or sooner as required by the department or section. Failure to become certified within the time allowed by the applicant’s specialty Board shall be considered a voluntary relinquishment of his/her medical staff membership and privileges.

For purposes of this section, “Board certification” or “Board certified” means has been/is certified by a board approved by the American Board of Medical Specialties, by the American Osteopathic Association, by the Royal College of Physicians and Surgeons of Canada or a board determined by the Executive Committee to be equivalent. For purposes of this section, “Board qualification” or “Board qualified” means the applicant has applied for and been accepted to become an active candidate for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the applicant shall be deemed qualified during this time period if the director of his/her training program certifies that he/she has met all training requirements for qualification by the appropriate board.

- (b) Board certification is not required where a particular field or specialty does not have an American Board certification or where the applicant’s privileges are limited to surgical assisting only. Board certification is not required for an applicant applying for membership prior to March 1, 2001 provided that such applicant is an Active member in good standing on the Medical Staff of Banner Baywood Medical Center, Banner Mesa Medical Center and/or Banner Desert Medical Center and was a member of such staff(s) as of October 1, 2000. However, individual departments may require specialty board certification and/or board recertification.
- (c) Maintaining board certification is not required of physicians older than 62 years who were board certified on their 62<sup>nd</sup> birthday.
- (d) As established by Medical Staff Department Rules and Regulations, whenever a practitioner’s time period in which to become board certified expires, the practitioner is deemed to have immediately and voluntarily relinquished his/her medical staff appointment and clinical privileges.
- (e) To applicant members where there is a shortage of qualified Medical Staff members in the practitioner’s specialty necessary to meet the Hospital’s demand for services, where

the Executive Committee has determined that the practitioner's training and experience approximate as nearly as possible those assured by board certification.

- (f) Members are required to remain board certified. Recertification must be obtained within 3 years from the expiration of Board certification or recertification or within the timeframe specified by certain specialty boards. Failure to become recertified within the time frame allowed under these Bylaws shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges. The Board recertification requirement shall not apply to existing staff members in good standing whose board certification lapsed prior to February 9, 2012.

**3.1-4 CLINICAL PERFORMANCE**

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

**3.1-5 COOPERATIVENESS**

Demonstrated ability 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. It is the policy of Banner Heart Hospital and this Medical Staff that all individuals within its hospital be treated courteously, respectfully, and with dignity. The Medical Staff of Banner Heart Hospital prohibits and shall not tolerate abuse or harassment by medical or allied health professional staff. This includes verbal or physical behavior that a reasonable person would regard as hostile, intimidating, disrespectful, or offensive. Should claims about such behavior occur the situation shall be investigated. If inappropriate behavior is determined to have occurred, the situation shall be judged on the nature and severity of the behavior, as well as patterns of behavior, by the Practitioner Conduct Committee.

In order to effectively and expeditiously address complaints from hospital staff concerning practitioner conduct/behavior (other than sexual harassment and quality of care issues), each complaint shall be submitted on a Complaint Form C, and shall be processed in accordance with the Medical Staff Services Policy entitled "Complaints About Practitioners." The Medical Staff and hospital will, to the extent permitted by law, protect the identity of complainants and the confidentiality of the information, ensuring an environment of fairness for all involved.

As appropriate, administration and other hospital departments shall adopt policies and procedures consistent with this policy and these Medical Staff Bylaws, to inform hospital personnel about the mechanisms and processes for lodging complaints about practitioner conduct.

Complaints of sexual harassment shall be handled in accordance with the Banner Health "Sexual Harassment Policy and Procedure".

**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 the granting of clinical privileges in at least one department or section.

**3.1-8 PROFESSIONAL ETHICS AND CONDUCT**

Demonstrated high moral character and adherence to generally recognized standards of medical and professional ethics which include: seeking appropriate consultation when medically indicated; providing or arranging for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; obtaining appropriate informed patient consent for treatments; placing the patient's welfare above one's own financial interests; refraining from paying or accepting commissions or referral fees for professional services; and delegating the responsibility for diagnosis or care to a practitioner or allied health professional not qualified to undertake that responsibility.

**3.1-9 HEALTH STATUS**

Freedom from or adequate control of any significant physical or mental health impairment, freedom from tuberculosis 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.

**3.1-10 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.

**3.1-11 PROFESSIONAL LIABILITY INSURANCE**

Evidence of professional liability insurance of a kind, in an amount and with an insurance company that is satisfactory to the Banner Board.

**3.1-12 EFFECTS OF OTHER AFFILIATIONS**

No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:

- (a) licensure to practice;
- (b) completion of a postgraduate training program at a Banner Health Hospital;
- (c) certification by any clinical Board;
- (d) membership on a medical school faculty;
- (e) staff appointment or privileges at another hospital or in another practice setting; or
- (f) prior staff appointment or any particular privileges at this Hospital or any other Banner Health Hospital.

**3.1-13 NON-DISCRIMINATION**

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 Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, or to community need.

### **3.1-14 EXEMPTIONS FROM QUALIFICATIONS**

Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the honorary or affiliate staff.

### **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 Chair. The member must submit written notice to the President of the Medical Staff at least two weeks in advance of a regular meeting;
- (b) The right to initiate a recall election of a Medical Staff Officer and/or a Department Chair by following the procedures set forth in these Bylaws;
- (c) The right to initiate the scheduling of General Staff meetings by following the procedures set forth in these Bylaws;
- (d) The right to challenge any rules or policy established by the Executive Committee by presentation to the Executive Committee of a petition signed by 20% of the Active Staff. Upon receipt of such a petition, the Executive Committee shall provide information clarifying the intent of the rules or policy or schedule a meeting to discuss the issue;
- (e) The right to request conflict resolution of any issue by presentation to the Executive Committee of a petition signed by 20% of the Active staff. Upon receipt of such a petition, the Executive Committee will schedule a meeting to discuss the issue.
- (f) The right to request a department meeting when a majority of members in the department or a specialty believe that the department has not acted appropriately;
- (g) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken;
- (h) The right to request review by the Executive Committee in the event that non-reviewable corrective action is taken, and
- (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 Chief Executive Officer and Senior Management or Banner Board.

### **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 Medical Staff Bylaws, General Medical Staff Rules and Regulations, Medical Staff Department Rules and Regulations, and all other standards and policies and procedures of the Medical Staff and Hospital;

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- (c)** discharge such staff, committee, department, section, and Hospital functions for which he or she is responsible;
  - (d)** prepare and complete in timely fashion, according to these Bylaws and Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, services, or departments;
  - (e)** 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;
  - (f)** participate in continuing education programs;
  - (g)** participate in call coverage and supervisory or consultation panels as may be determined by the Executive Committee;
  - (h)** treat as confidential, any information discussed in executive session and use confidential information only as necessary for treatment, payment and healthcare operations in accordance with HIPPA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For the 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 to ensure confidential information is not disclosed;
  - (k)** comply with the drug testing policy if required by the Executive Committee, and submit to urine and/or blood testing as requested;
  - (l)** comply with requests from any two of the following to confirm current physical and mental capacity to practice medicine and freedom from, or adequate control of, any physical, mental, or behavioral impairment, including substance and alcohol abuse: President, Medical Staff; Chair, Department of Medicine; Chair, Department of Surgery; Chief Executive Officer;
  - (m)** demonstrate the ability to work cooperatively and professionally with the hospital, its professional staff and the Medical Staff and refrain from disruptive behavior which could interfere with patient care or the operation of the hospital and its Medical Staff;
  - (n)** prepare and complete, in a timely fashion and according to these Bylaws and the hospital's policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, services or departments;
  - (o)** abide by the ethical principles of the profession, including arranging for appropriate and timely medical coverage and caring for patients for whom he/she is responsible and obtaining consultation when necessary for the safety of those patients;
  - (p)** immediately notify the Chief Executive Officer and the President of the Medical Staff of the revocation or suspension of his/her professional license, the imposition of terms of probation or limitation of his/her practice by any state licensing agency, including any stipulation; the

cancellation or restriction of his/her professional liability coverage; or the revocation, suspension, or voluntary relinquishment of his/her DEA certificate;

- (q) immediately notify the Chief Executive Officer and the President of the Medical Staff of his/her denial or loss of staff membership or denial, loss, curtailment, restriction of privileges at any hospital or other healthcare institution; any adverse determination by a peer review organization concerning his/her quality of care; the commencement of a formal investigation or the filing of charges by the Department of Health and Human services, any law enforcement agency, regulatory agency of the United States, the state of Arizona, or any other state; or the denial or loss of his/her right to participate in any Federal or State program, including the Medicare and Medicaid programs, and,
- (r) provide the Medical Staff Services Department, on or before the expiration date of the practitioner's appointment to the staff, written documentation evidencing such practitioner's current licensure, controlled substances registration, and professional liability insurance.

Failure to meet these obligations may result in non-reappointment or the imposition of corrective action as provided in these Bylaws.

### **3.4 TERM OF APPOINTMENT**

Appointments to the Medical Staff and grants of clinical privileges are for a period of two years, except that:

- (a) new members of the staff are subject to an initial provisional period and upon satisfactory conclusion of that period, are placed in the appropriate reappointment cycle as determined by the Hospital's system of staggered reappointment; and,
- (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 or has been the subject of disciplinary action.

#### **3.4-1 EXPIRATION**

The appointment of each staff member shall expire every two years from the previous appointment date, unless a shorter appointment date has been specified.

### **3.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT**

#### **3.5-1 QUALIFICATIONS AND SELECTION**

A practitioner, who is or who will be providing specified professional services pursuant to a contract or employment with the Hospital, shall meet the same appointment qualifications, shall be evaluated for appointment, reappointment, and clinical privileges in the same manner, and shall fulfill all of the obligations of the assigned category as any other staff member.

- (a) Practitioners rendering professional services pursuant to employment or contracts with the Hospital shall be required to maintain Medical Staff membership and privileges.
- (b) Unless otherwise provided in the contract for professional services, termination of such employment or contracts shall not result in automatic termination of Medical Staff membership or clinical privileges.



### **3.6 CHIEF MEDICAL OFFICER'S ROLE**

- (a) A Chief Medical Officer is a practitioner engaged by the hospital or Medical Staff, either full or part-time; in an administrative capacity whose activities may include clinical responsibilities such as direct patient care, research, or supervision of the patient care activities of other practitioners under the Chief Medical Officer's direction.
- (b) When provided for by contract, a Chief Medical Officer's responsibilities shall include assisting the Medical Staff and/or the Banner Health Care Management Council to carry out its peer review and quality improvement activities. Such Chief Medical Officer shall serve as an ex-officio appointee to all committees of the Medical Staff consistent with the scope of his/her responsibility. The Chief Medical Officer shall automatically be granted active staff membership.
- (c) The Chief Medical Officer shall be exempt from paying dues and/or assessments.
- (d) The Chief Medical Officer shall be automatically granted Active Staff and does not have to meet all of the qualifications under 3.1.
- (e) The Chief Medical Officers of BHH and BBMC provide administrative coverage for each other.

### **3.7 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 prior to initiating litigation.

### **3.8 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 shall provide no right to monetary relief from the Medical Staff, the Hospital or any third party, including any employee, agent or member of the Medical Staff or the Hospital and any person engaged in peer review activities.

## **ARTICLE FOUR: MEDICAL STAFF CATEGORIES**

### **4.1 CATEGORIES**

There shall be seven categories of appointment to the staff: active, courtesy, consulting, affiliate, provisional, community-based, and honorary.

### **4.2 ACTIVE STAFF**

#### **4.2-1 QUALIFICATIONS**

The active staff shall consist of physicians who:

- (a) demonstrate a genuine concern, interest, and activity in the Hospital through substantial involvement in the affairs of the Medical Staff or Hospital and regularly admit patients to, or are regularly involved in the care of patients in the Hospital facilities. Twenty-five patient contacts during the previous two 2 years, are necessary to achieve and maintain active staff. Patient contacts are determined utilizing the following reports for patient activity statistics: histories and physicals, discharge

summaries, consultation reports, and/or operative or procedure reports; patient contacts for radiologists are defined as either twenty-five interventional procedures performed at Banner Heart Hospital or film reads for one-hundred Banner Heart Hospital patients. Patient contacts for pathologists are defined as twenty-five tissue/biopsy reports for Banner Heart Hospital patients. Patient contacts for emergency medicine physicians are defined as the referral of twenty-five Banner Baywood Medical Center emergency department patients for admission at Banner Heart Hospital; and;

(b) satisfy the meeting attendance requirements established by the Executive Committee.

#### **4.2-2 PREROGATIVES**

An active staff member may:

(a) admit patients, except as set forth in these Bylaws and the Medical Staff General Rules and Regulations, department rules and regulations, and Hospital 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, section, and committees of which he or she is a member; and,

(d) hold office at any level in the Medical Staff organization and be Chair or a member of 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**

An active staff member shall, in addition to meeting the basic obligations set forth in Section 3.2:

(a) contribute to the organizational, administrative and medico-administrative, quality review, and utilization management activities of the Medical Staff; be willing to serve in medical staff, department, and section offices and on Hospital and Medical Staff committees, and faithfully perform the duties of any office or position to which elected or appointed;

(b) participate equitably and appropriately in the discharge of staff functions such as training, research, and continuing education programs; serve when necessary on the on call roster, fulfill such other staff functions as may be reasonably required;

(c) satisfy the meeting attendance and special appearance requirements of the Medical Staff and the assigned department and section; and

(d) pay all staff dues and assessments, unless waived by the Executive Committee.

#### **4.2-4 CHANGE IN STAFF CATEGORY**

Active members who have twenty-five patient contacts during the previous two years, as defined in 4.2-1(a) above, shall be maintained on the Active Staff at the time of reappointment. Active members, who do not meet the qualifications for Active Staff during the previous two years, shall be transferred to the Courtesy Staff.

#### **4.2-5 FAILURE TO SATISFY QUALIFICATIONS**

Failure of an Active staff member to satisfy the qualifications or obligations of the Active staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been moved from the Active staff category may request reconsideration of the change by the Executive Committee.

### **4.3 COURTESY STAFF**

#### **4.3-1 QUALIFICATIONS**

The Courtesy staff shall consist of physicians who utilize the Hospital only on an occasional basis and who have less than twenty five patient contacts but at least 1 patient contact during the previous two years, as defined in 4.2-1(a) above.

#### **4.3-2 PREROGATIVES**

A Courtesy staff member may:

- (a) admit patients, except as set forth in department rules and regulations and Hospital admission policies;
- (b) exercise such clinical privileges as have been granted by the Board;
- (c) be appointed to committees unless otherwise provided by these Bylaws; and
- (d) vote on matters presented at committees to which he or she has been appointed and at department and section meetings unless otherwise limited by these Bylaws or by department rules and regulations.

#### **4.3-3 OBLIGATIONS**

A Courtesy staff member shall, in addition to meeting the basic obligations set forth in Section 3.2:

- (a) Satisfy special appearance requirements of the Medical Staff and the assigned department and section;
- (b) serve when necessary on the on call roster for charity, unassigned, and emergency patients; and,
- (c) pay all staff dues and assessments, unless waived by the Executive Committee.

#### **4.3-4 CHANGE IN STAFF CATEGORY**

Courtesy members who have twenty-five patient contacts during the previous two years, as defined in 4.2-1(a) above, shall be transferred to the Active Staff at the time of reappointment. Courtesy members who meet the qualifications set forth in Section 4.2-1 may request elevation to the Active staff during the appointment period.

#### **4.3-5 FAILURE TO SATISFY QUALIFICATIONS OR OBLIGATIONS**

Failure of a Courtesy staff member to satisfy the qualifications or obligations of the Courtesy staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been moved from the Courtesy staff category may request reconsideration of the change by the Executive Committee.

#### **4.4 CONSULTING STAFF**

##### **4.4-1 QUALIFICATIONS**

The Consulting staff shall consist of physicians who do not admit patients but who consult or otherwise provide service to patients in the Hospital only on an occasional basis.

##### **4.4-2 PREROGATIVES**

A Consulting staff member may:

- (a) exercise such clinical privileges, excluding the privilege to admit, as have been granted by the Board;
- (b) be appointed to committees unless otherwise provided by these Bylaws; and
- (c) vote on matters presented at committees to which he or she has been appointed and at department and section meetings unless otherwise limited by these Bylaws or by department rules and regulations.

##### **4.4-3 OBLIGATIONS**

A Consulting staff member shall, in addition to meeting the basic obligations set forth in Section 3.2:

- (a) Satisfy the special appearance requirements of the Medical Staff and the assigned department and section, and
- (b) Pay all staff dues and assessments, unless waived by the Executive Committee.

##### **4.4-4 CHANGE IN STAFF CATEGORY**

Consulting staff members may be transferred to another Staff category if the qualifications for that staff category are met and if admitting privileges are requested and granted.

##### **4.4-5 FAILURE TO SATISFY QUALIFICATIONS OR OBLIGATIONS**

Failure of a Consulting staff member to satisfy the qualifications or obligations of the Consulting staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been moved from the Consulting staff category may request reconsideration of the change by the Executive Committee. Failure to utilize the hospital during an entire reappointment period may result in a practitioner being dropped from the Medical Staff. Consulting Staff members, in under-served specialties identified by the Executive Committee, shall not be dropped from the Medical Staff due to failure to utilize the hospital during the previous reappointment period.

#### **4.5 AFFILIATE STAFF**

##### **4.5-1 QUALIFICATIONS**

The Affiliate staff shall consist of dentists, psychologists, podiatrists and other doctoral degree professionals who meet the basic qualifications for staff membership as stated in Section 3.1 and who provide services to patients in the Hospital, but who can never be solely responsible for managing a patient. Affiliate staff members are not eligible for advancement to other staff categories.

##### **4.5-2 PREROGATIVES**

An Affiliate staff member may:

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- (a) attend General Staff and department meetings;
  - (b) be appointed to committees unless otherwise provided by these Bylaws;
  - (c) 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; and,
  - (d) exercise such privileges as have been granted by the Board.

**4.5-3 OBLIGATIONS**

An Affiliate staff member shall, in addition to meeting the basic obligations set forth in Section 3-2:

- (a) satisfy the special appearance requirements of the Medical Staff and the assigned department and section, and,
- (b) pay all staff dues and assessments, unless waived by the Executive Committee.

**4.5-4 FAILURE TO SATISFY QUALIFICATIONS**

Failure to utilize the Hospital during an entire reappointment period may result in a practitioner being dropped from the Medical Staff.

**4.6 PROVISIONAL STAFF**

**4.6-1 QUALIFICATIONS**

All physicians except Community-Based providers and members of the Affiliate and Allied Health Professional Staffs shall be initially appointed to the Provisional Staff and may be eligible for transfer to other staff categories as defined in these Bylaws.

**4.6-2 PREROGATIVES**

Provisional Staff members may:

- (a) attend General Staff and Department meetings;
- (b) be appointed to Committees unless otherwise provided by these Bylaws;
- (c) vote on matters presented at Committees to which he/she has been appointed and at department meetings unless otherwise limited by these Bylaws or by Department Rules and Regulations, and
- (d) exercise such privileges as have been granted by the Board.

**4.7 HONORARY STAFF**

**4.7-1 QUALIFICATIONS**

Membership on the Honorary staff is by invitation and is restricted to staff members for whom, upon retirement from practice, the Executive Committee recommends and the Board approves this status in recognition of long-standing service to the Hospital or other noteworthy contributions to its activities.

**4.7-2 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

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.

#### **4.8 COMMUNITY-BASED PROVIDER STAFF**

The Community-Based Provider Staff shall consist of physicians who request Banner Heart Hospital services for their patients and wish to be affiliated with the Hospital. Community-Based Provider Staff physicians are not members of the medical staff. They are not required to pay annual dues or fees.

##### **4.8-1 QUALIFICATIONS**

Physicians seeking to affiliate with Banner Heart Hospital must apply for Community-Based Provider Staff and provide evidence of the following:

- a) Arizona license 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 Banner Heart Hospital staff and physicians, and,
- d) Professional ethics and conduct.

##### **4.8-2 PREROGATIVES**

The Community-Based Provider Staff member may:

- (a) order outpatient diagnostic services for patients;
- (b) make courtesy visits to patients;
- (d) attend General Staff meetings;
- (e) attend Banner Heart Hospital medical education programs, and;
- (f) access Banner Heart Hospital information, including computer access for their patients.

##### **4.8-3 OBLIGATIONS**

Community-based Provider Staff members must agree to utilize Banner Heart Hospital patient information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations.

##### **4.8-4 CHANGE IN STAFF CATEGORY**

The Community-Based Provider Staff member who wishes to exercise privileges at Banner Heart Hospital must request a change in staff category and make initial application for processing through the routine credentialing process.

##### **4.8-5 DENIAL OR TERMINATION OF MEMBERSHIP**

Community-Based Provider Staff or physicians seeking Community-Based Provider Staff status are not entitled to due process rights under the Fair Hearing Plan. A physician who believes he/she was wrongly denied Community-Based Provider Staff 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 review the submission and make a final determination. The physician has no appeal or other rights in connection with the Executive Committee's decision.

#### **4.9 FEDERALLY EMPLOYED MILITARY STAFF**

##### **4.9-1 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 the 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.

##### **4.9-2 PREOGATIVES**

The Federally Employed Military Staff member may:

- a. Admit patients who are eligible for care at military health facilities;
- 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

##### **4.9-3 OBLIGATIONS**

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

#### **ARTICLE FIVE: APPOINTMENT, REAPPOINTMENT AND RESIGNATION**

##### **5.1 APPLICATIONS**

An application for Banner Heart Hospital staff membership must be submitted by the applicant in writing or electronically and on the form designated by the Executive Committee and approved by the Banner Health Board. When notification has been received by the Medical Staff Services Department by the Banner Health Centralized Verification Office that an application has been received, the applicant will be provided copies of the Medical Staff Bylaws, Medical Staff General Rules and Regulations and a copy of the Rules and Regulations of the appropriate department.

##### **5.1-1 APPLICATION CONTENT**

The Medical Staff Services Department, or the Banner Health CVO, shall collect relevant information regarding the applicant's professional activities, performance, and behavior, quality of care, health status, and clinical and technical skills. Every applicant must furnish complete information regarding:

- (a) undergraduate, medical school, and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended, and for all postgraduate training, names of those responsible for monitoring the applicant's performance;
- (b) all currently valid medical, dental, or other professional licensures or certifications, and a full schedule Drug Enforcement Administration registration, when applicable, with the date and number of each. Pathologists and teleradiologists are not required to have a DEA certificate;

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- (c)** specialty or sub-specialty board certification, recertification, or eligibility status;
  - (d)** health status, (including freedom from infectious pulmonary tuberculosis), and any health impairments (including alcohol and/or drug dependencies) which may affect the applicant's ability to perform professional and medical staff duties fully;
  - (e)** professional liability insurance coverage, in the amount acceptable to the Board, including the names of present and past insurance carriers, and complete information on malpractice claims history and experience including claims, suits, and settlements made, concluded, and pending;
  - (f)** any pending or completed action involving the withdrawal of an application or the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary relinquishment (by resignation or expiration of license or certificate) to practice in any state or country; DEA of other controlled substances registration; specialty or sub-specialty Board certification or eligibility or professional liability Insurance;
  - (g)** voluntary or involuntary termination, limitation, reduction, or loss of staff membership status, prerogatives, or clinical privileges at any hospital, clinic, or health care institution;
  - (h)** department and section assignment, and specific clinical privileges requested;
  - (i)** any current felony criminal charges pending against the applicant and any past charges including their resolution;
  - (j)** names and addresses of all hospitals or health care organizations where the applicant had or has had any association, employment, privileges, or ppractice with the inclusive dates of each affiliation. All time intervals since graduation must be accounted for;
  - (k)** additional information from other databanks, including the National Practitioner Data Bank (NPDB), may be gathered by the Medical Staff Services Department staff or the Banner Health CVO, as required by the Executive Committee and/or regulatory bodies;
  - (l)** names of members of the Banner Heart Hospital staff that will provide coverage in the absence of the practitioner, except for those specialties who only come to the hospital on a limited basis and are not cardiologists, CVT surgeons or vascular surgeons, and;
  - (m)** evidence of the applicant's agreement to abide by the provisions of the Medical Staff Bylaws, General Rules and Regulations, appropriate Departmental Rules and Regulations, and Banner Health and hospital policies and procedures, and;
  - (n)** a criminal background screening conducted by Banner Health Secure Hire.



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- (o) all applicants must present to a Banner Health facility with a government-issued photo identification to allow the hospital representative to copy the ID and document that the individual presenting him/herself is, in fact, the same individual who is identified in the credentialing documents. This photo ID may include a valid driver's license, a passport, or other government-issued photo ID card.
  - (p) The application must include the names of three medical or health care professionals who have personal knowledge of the applicant's qualifications and who will provide specific written comments on these matters. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance and clinical competence over a reasonable period of time and, at least one should have had organizational responsibility for supervision of the applicant's performance (e.g., department chair/service chief, or training program director). The use of partners, associates, members or employees of the applicant's current or prospective employer as references raises the question of bias, while the use of these individuals is not prohibited, it should be avoided or minimized where practical. In addition, the completed application shall include one letter of current clinical competence from the practitioner's peer. Peer is defined as a practitioner within the member's same specialty. However, surgeons and anesthesiologists may submit the name of one surgeon and one anesthesiologist as peers.

## 5.2 **EFFECT OF APPLICATION**

5.2-1 The applicant must sign the application and, in so doing:

- (a) attests to the correctness and completeness of all information furnished and in so doing acknowledges that any material misstatement in or omission from the application may constitute grounds for denial or revocation of appointment;
- (b) signifies his/her willingness to appear for interviews in connection with the application;
- (c) signifies his/her willingness to undergo a physical or mental health evaluation upon the request of the President of the Staff, Vice President of the Staff, Chair of the Credentials Committee, or department chair;
- (d) agrees to abide by the terms of these Bylaws, the Medical Staff General Rules and Regulations, the rules and regulations of the assigned department and section, the Medical Staff Services Policies And Procedures, the Banner Health and Banner Heart Hospital Policies and Procedures, regardless if membership and/or clinical privileges, are granted;
- (e) agrees to maintain an ethical practice to provide continuous care to his or her patients;
- (f) authorizes and consents to representatives of the medical staff and Banner Heart Hospital consulting with any individual who or entity which may have information bearing on the applicant's qualifications, and consents to

the inspection of all records and documents that may be material to evaluation of such qualifications, and

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

### **5.3 APPLICATION FEE**

If so required, an application fee, in the amount established by the Executive Committee and the Chief Executive Officer or designee must be submitted by the applicant prior to the processing of the application.

### **5.4 PROCESSING THE APPLICATION**

#### **5.4-1 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 staff membership, department or section assignment, or clinical privileges, and of satisfying any requests for information or clarification (including health examinations). Applications not demonstrating compliance with the requirements for medical staff membership and privileges will be deemed to be incomplete. Incomplete applications will not be processed.

#### **5.4-2 VERIFICATION OF INFORMATION**

The application shall be submitted to the Banner Health CVO which shall notify the hospital's Medical Staff Services Department of its receipt. The Banner Health CVO, working with the Medical Staff Services Department, shall collect and verify the references, licensure, and other qualification evidence submitted and notify the applicant of any problems in obtaining the required information. The Medical Staff Services Department, working with the Credentials Committee, shall collect and verify any other pertinent information to complete the application. Upon such notification, it is the applicant's obligation to obtain the required information. When collection and verification is accomplished, the application shall be deemed to be complete and shall be transmitted with all supporting materials to the next regularly scheduled meeting of the Credentials Committee and to the Chair of each department and/or the Chief of each section in which the applicant seeks privileges.

#### **5.4-3 CREDENTIALS COMMITTEE ACTION**

The Credentials Committee shall review the completed application, the supporting documentation, and any other relevant information to determine if the applicant meets all of the necessary qualifications for staff membership and department and/or section requested. The Credentials Committee shall forward applications recommended for privileges to the clinical department chair and/or section chief in which privileges have been requested. The Credentials Committee may conduct an interview with the applicant or may designate a committee to conduct such interview.

#### **5.4-4 DEPARTMENT CHAIR AND/OR SECTION CHIEF ACTION**

The Chair of each department and/or Chief of each section in which the applicant seeks privileges shall review the application and its supporting documentation and

forward to the next regularly scheduled meeting of the Executive Committee the recommendations as to the scope of clinical privileges to be granted.

A department Chair and/or section Chief may conduct an interview with the applicant or designate a committee to conduct such interview.

Where the applicant maintains that his/her postgraduate training program is equivalent to a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or that his/her board certification or eligibility is equivalent to that granted by the appropriate board approved by the American Board of Medical Specialists, the appropriate department shall assess the supporting documentation to determine equivalency.

**5.4-5 TEMPORARY PRIVILEGES PENDING EXECUTIVE COMMITTEE AND BANNER HEALTH BOARD APPROVALS**

Where the application demonstrates that the applicant meets the qualifications for membership and all requested privileges and contains no unresolved adverse information (e.g., no significant malpractice claims, no reports of disciplinary action or pending investigations, no licensing restrictions or pending investigations, no unfavorable evaluations), and has been reviewed and approved by the department Chair or section Chief and the Credentials Committee, the Chair of the Credentials Committee and the Department Chair may recommend to the Chief Executive Officer, that the applicant be granted temporary privileges, pending approval of the application by the BHH Executive Committee and the BH Board.

**5.4-6 EXECUTIVE COMMITTEE ACTION**

The 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, and any other relevant information available to it. The Executive Committee shall prepare a written report with recommendations as to approval or denial of, or any special limitations on, staff appointment, category of staff membership, and prerogatives, department and section affiliation, and scope of clinical privileges, or defer action for further consideration.

**5.4-7 EFFECT OF EXECUTIVE COMMITTEE ACTION**

- (a) Favorable Recommendation: An Executive Committee recommendation that is favorable to the applicant in all respects shall be forwarded to the next regularly scheduled meeting of the Board.
- (b) Adverse Recommendation: An adverse Executive Committee recommendation shall entitle the applicant to the procedural rights provided in these Bylaws.
- (c) Deferral: Action by the Executive Committee to defer the application for further consideration shall be followed up at its next regular meeting or upon receipt of adequate information with its recommendations as to approval or denial of, or any special limitations on, staff appointment, staff category, prerogatives, department and section affiliation, and scope of clinical privileges.

**5.4-8 BOARD**

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- (a)** At its next regularly scheduled meeting, the Board may adopt or reject, in whole or in part, a recommendation of the Executive Committee or refer the recommendation back to the 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 Chief Executive Officer shall, by special notice, promptly inform the applicant who is then entitled to the procedural rights provided in these Bylaws. Board action after completion of the procedural rights provided in the Bylaws or after waiver of these rights is effective as its final decision.
- (b)** The Board shall act upon all credentials File of independent healthcare professionals requesting medical staff membership and privileges. The Board has delegated to its medical staff subcommittee, the authority to take action on all files that qualify for recommendations on routine and all other files that require board action.
- (c)** A routine application is an application that contains evidence of any of the following at the time of appointment or at any time since the beginning of the last appointment period:
1. where the application is incomplete;
  2. where the applicable Executive Committee has made a final recommendation to deny, terminate, revoke, suspend, limit, or otherwise restrict the membership or privileges of any medical staff member or applicant;
  3. where there is a current challenge or has been a successful challenge to an applicant's licensure or registration;
  4. where there has been a final judgment adverse to the applicant in a professional liability action; and/or,
  5. where the applicant's medical staff membership or clinical privileges have been involuntarily terminated or restricted at any hospital or healthcare facility.
- (d)** An expedited application is an application that has been recommended for approval by the Executive Committee and which, at the time of appointment or since the beginning of the last appointment period, does not contain any if the adverse information identified above.
1. Prior to submitting the Executive Committee report to the Medical Staff Subcommittee, it shall be determined whether an application I is an expedited or a routine application. Expedited applications shall be submitted to the Medical Staff Subcommittee on a report requesting Medical Staff Subcommittee expedited action. Routine applications shall be submitted on a report requesting that the Medical Staff Subcommittee make a recommendation to the Banner Health Quality and Care Management Committee and the Banner Health Board.

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2. The Medical Staff Subcommittee will review, evaluate, and take action on expedited applications for appointment and reappointment to the BHH Medical Staff and on all requests for clinical privileges. Actions of the Subcommittee in approving expedited applications for appointment and reappointment and requests for clinical privileges shall be effective as the action of the Quality and Care Management Committee, upon written communication of the action of the Subcommittee to the Chief Executive Officer. Actions of the Subcommittee shall be presented to the Banner Board Quality and Care Management Committee and the Board for review and ratification.
  3. The Medical Staff Subcommittee will make recommendations to the Quality Committee of the Board regarding routine requests for membership and/or clinical privileges. Actions of the Medical Staff Subcommittee on routine applications and requests for clinical privileges shall not be effective until final action is taken by the Banner Health Board.

## **5.5 APPLICANTS FOR REMOTE PRIVILEGES**

Applicants for remote privileges shall meet the same appointment qualifications, shall be evaluated for appointment, reappointment, and clinical privileges in the same manner, and shall fulfill all of the obligations as any other staff members.

## **5.6 REAPPOINTMENT PROCEDURES**

### **5.6-1 INFORMATION COLLECTION AND VERIFICATION**

#### **(a) FROM STAFF MEMBER**

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

Failure to return the satisfactorily completed forms shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the current term. Upon receipt of a completed reappointment within six months of the voluntary resignation described above, a practitioner may request reinstatement to the Executive Committee and the Banner Board.

The Medical Staff Services Department or its agent, as approved by the Executive Committee, shall verify the information provided on the reappointment form and notify the staff member of any specific information inadequacies or verification problems. The staff member has the burden of producing adequate information and resolving any doubts about it.

At the time of reappointment, the office-based practitioner with no hospital activity during the preceding two years, shall, because of the practitioner's lack of clinical activity documentation, provide the medical staff with the following documentation to provide for assessment of the practitioner's performance and current clinical

competency: the name and contact information of a peer who can attest to the practitioners current clinical competence.

**(b) FROM INTERNAL SOURCES**

The Medical Staff Services Department, or its agent, shall collect relevant information since the time of the member's last appointment regarding the individual's professional activities, performance, behavior, quality of care, and clinical or technical skills in Banner Heart Hospital. Such information may include:

- (1) Findings from the performance review and utilization management activities;
- (2) Participation in relevant continuing education activities or other training or research programs;
- (3) Level of clinical activity at Banner Heart Hospital;
- (4) Attendance at medical staff, department, and section meetings;
- (5) Service on medical staff department, section and committees;
- (6) Timely, legible, and accurate completion of medical records;
- (7) Cooperativeness in working with other practitioners and hospital personnel;
- (8) General attitude toward patients and Banner Heart Hospital Staff; and,
- (9) Compliance with all applicable Medical Staff Bylaws, General Rules and Regulations, department rules and regulations, and policies and procedures of the Medical Staff and Banner Heart Hospital.

**(c) FROM EXTERNAL SOURCES**

The Medical Staff Services Department, and/or its agent, shall collect relevant information since the time of the member's last appointment regarding the member's professional and collegial activities, performance, clinical or technical skills, and conduct. Such information may include:

- (1) Peer references. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance and clinical competence. Peer is defined as a practitioner within the member's same specialty. However, surgeons and anesthesiologists may submit the name of one surgeon and one anesthesiologist as peers, for the purpose of obtaining peer references
- (2) National Practitioner Data Bank response;
- (3) Professional Liability Insurance current coverage and any malpractice claims history resulting in settlement or judgments;
- (4) Licensure. Verification of current Arizona license and verification of license to practice in any state or country and any sanctions against license(s), termination, or restriction of licensure and any previously successful or currently pending challenges to licensure, whether voluntary or involuntary;
- (5) Certification, if required;
- (6) Documentation of continuing medical education credits shall be provided as a part of the reappointment process. At least twenty-five percent of the total number of hours required by the practitioner's licensing board for re-licensure shall relate directly to the clinical privileges requested. Determinations regarding applicability of CME to clinical privileges shall be determined by the department chair and/or section chief;
- (7) Other hospital staff memberships and clinical privileges for relevant professional experience and termination, limitation, reduction, or loss of membership or clinical privileges, whether voluntary or involuntary;
- (8) Medicare/Medicaid Sanctions and any previous, pending, or current action against the applicant excluding him/her from participation in Medicare/

Medicaid and/or any other state or federally-supported healthcare program;

- (9) A full schedule Drug Enforcement Administration registration, when applicable, with the date and number of each;
- (10) Health status, including freedom from infectious tuberculosis, and health impairments, including alcohol and/or drug dependencies, which may affect the practitioner's ability to fully perform professional and medical staff duties, and;
- (11) Additional information from other databanks may be gathered by the Medical Staff Services Department or its agent, as required by the Credentials Committee, the department chair and/or section chief, the Executive Committee and/or regulatory agencies.

**5.7 DEPARTMENT AND SECTION EVALUATION**

The Chair of each department and/or Chief of each section in which the staff member requests or has exercised privileges shall review the reappointment application and all supporting information and documentation and evaluate the information for continuing satisfaction of the qualifications for staff appointment, the category of assignment and the privileges requested. The department Chair's and/or section Chief's recommendations shall be forwarded to the Executive Committee.

**5.8 EXECUTIVE COMMITTEE ACTION**

At the next regularly scheduled meeting, the Executive Committee shall review the member's file, the department Chair's and/or section Chair's reports, and any other relevant information available to it and either make a recommendation for reappointment or non-reappointment and for staff category, department and section assignment, and clinical privileges, or defer action for further consideration.

**5.9 FINAL PROCESSING AND BOARD ACTION**

Final processing of reappointments follows the procedure set forth in Sections 5.6-6 and 5.6-7 of these Bylaws. For purposes of reappointment, the terms "applicant" and "appointment," as used in those Sections, shall be read respectively, as "staff member" and "reappointment."

**5.10 TIME PERIODS FOR PROCESSING**

The appointment/reappointment of each staff member shall expire every two years on the last day of the birth month of the practitioner, unless a shorter appointment date has been specified.

**5.11 PROVISIONAL STAFF STATUS**

**5.11-1 SUCCESSFUL CONCLUSION**

**(a) REVIEW AND OBSERVATION REQUIRED**

The requirement for, applicability and duration of, and status of the practitioner in the Provisional Staff membership category is outlined in these Bylaws. Review of the Provisional status consists of a review of case lists and quality management information and, if required by the department, direct observation, consultation, retrospective review of cases, and/or other requirements. Exceptions to supervision requirements may be made by the appropriate departmental committee for those Provisional staff members whose specialty has been designated as underserved or who

practice a low hospital utilization specialty also as defined by the appropriate department committee.

**(b) PRACTITIONER'S OBLIGATIONS**

During the period of Provisional Staff membership, the practitioner shall:

Demonstrate, on the basis of their practice at Banner Heart Hospital and other sources, to the satisfaction of the Medical Staff and the Banner Health Board, current competence, character, ethical behavior, and fulfillment of Medical Staff responsibilities. These requirements must be satisfactorily met prior to the practitioner advancing to another Staff membership category.

Perform at least six admissions, consultations, or procedures that are reasonably representative of the member's specialty, during the first six months of staff membership.

The Department Chair or his/her designee(s) shall review the case list and other information assembled during the Provisional status.

Following favorable review of the listing of required admissions, consultations, or procedures, the Provisional Staff member may be transferred to the appropriate staff membership category, depending upon the member's total patient contacts.

**(c) FAILURE TO SATISFY QUALIFICATIONS**

Provisional Staff members not meeting the above requirements, following their six months of Provisional Staff membership, may request a six month extension. If the above requirements are not met within one year, the member shall be deemed to have voluntarily resigned from the Staff.

Affected practitioners may request reinstatement during a period of thirty calendar days following the above action, if they have met the Provisional Staff requirements during the thirty calendar days.

**5.12 PROCEDURE FOR DELINEATING PRIVILEGES**

**5.12-1 REQUESTS**

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. Specific additional privilege requests may also be submitted for modifications of privileges in the interim between reappointment periods. These interim requests shall be approved by the appropriate Department Chair and/or Section Chief, the Executive Committee, and the Board.

**5.12-2 PROCESSING REQUESTS**

All requests for clinical privileges will be processed according to the procedures outlined in these Bylaws, as applicable.

**5.13 LEAVE OF ABSENCE**

**5.13-1 LEAVE STATUS**



A staff member may obtain a voluntary leave of absence for personal health, family health, or educational reasons by giving written notice to the President of the Medical Staff through the applicable department Chair and/or Section Chief. The notice must state the approximate period of time of the leave requested and may not exceed one year, unless the request is for educational purposes such as a fellowship, in which case the leave may not exceed 2 years or the length of the fellowship. Reapplication is required beyond one year. The written request for Leave of Absence must include the specific reasons for the leave. During the period of the leave, the staff member's clinical privileges, prerogatives, and responsibilities, including payment of staff dues, are suspended. The request for such leave shall be transmitted to the Executive Committee, which shall forward its recommendation on the request to the Board for final action.

**5.13-2 REACTIVATION**

The staff member must request reactivation by sending a written notice to the Medical Staff Services Department. The staff member must either complete an application for reappointment if the term of appointment has expired or submits a written summary of relevant activities during the leave. The staff member must also provide evidence of current licensure, DEA registration, and professional liability insurance coverage. The procedures in Article 5.4 of the Bylaws shall be followed in evaluating and acting on the reactivation request. Failure to request reactivation of privileges at the end of the approved leave of absence period shall be considered automatic expiration of privileges and a non-reviewable action.

**5.13-3 DELAYS**

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

**5.13-4 REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION**

Except as otherwise provided in the Bylaws or as determined by the Credentials Committee in light of exceptional circumstances, an applicant or staff member who has received a final adverse decision regarding appointment, reappointment, staff category, department or section assignment, or clinical privileges is not eligible to reapply to the medical staff or for the denied category, department or section, or privileges for a period of one year from the date of the notice of the final adverse decision. Any such reapplication will be processed in accordance with the procedures set forth in Section 5.6 of these Bylaws. The applicant or staff member must submit such additional information as the Medical Staff and the Board may require in demonstration that the basis of the earlier adverse action no longer exists. If such information is not provided, the request will be considered incomplete and voluntarily withdrawn.

**5.13-5 REQUESTS WHILE ADVERSE RECOMMENDATION IS PENDING**

No applicant or staff member may submit a new application for appointment, reappointment, staff category change to a particular department or section assignment, or clinical privileges while an adverse recommendation is pending. The Executive Committee shall not submit to the Board any additional recommendations regarding a practitioner while an adverse recommendation is pending.

**5.13-6 REPORTING REQUIREMENTS**

Banner Heart Hospital shall comply with any reporting requirements applicable under the Health Care Quality Improvement Act of 1986 and required under the Arizona Revised Statutes.

## **ARTICLE SIX: DELINEATION OF PRACTICE PRIVILEGES**

### **6.1 EXERCISE OF PRIVILEGES**

#### **6.1-1 IN GENERAL**

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

(b) The following must be successfully completed, as applicable, prior to exercising privileges at the Hospital:

- Banner's electronic medical record/computerized physician order entry (CPOE) training; and,
- Banner's electronic New Provider Orientation

Exceptions may be made for practitioner's granted temporary or disaster privileges. CPOE training may be waived by the President of the Medical Staff or CEO

#### **6.1-2 ADMISSION OF PATIENTS**

A cardiologist, cardiothoracic surgeon, thoracic surgeon, vascular surgeon, and/or pulmonologist shall admit or consult on each patient admitted to Banner Heart Hospital.

#### **6.1-3 EXPERIMENTAL PROCEDURES**

Experimental drugs, procedures, therapies, or tests may be performed upon the approval of and in accordance with Banner Health Research Institute protocols.

### **6.2 BASIS FOR PRIVILEGES DETERMINATIONS**

Clinical privileges shall be granted in accordance with education and training, experience, utilization practice patterns, current health status, and demonstrated competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Additional factors that may be used in determining privileges include those qualifications set forth in Section 3.1. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determination(s). In reappointment determinations, results of quality assurance and utilization review, supervised cases, and where appropriate, practice at other hospitals shall also be considered. In review of requests for changes in privileges, evidence of appropriate training and experience and current clinical competence shall be documented.

### **6.3 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES**

#### **6.3-1 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 shall submit the procedure request, in writing, to the Medical Staff Services Department. The request shall contain the 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.

#### **6.3-2 DETERMINATION OF APPROPRIATENESS**

The President of the Medical Staff, with the approval of the Executive Committee, shall establish an interdisciplinary Ad Hoc Committee and appoint its Chair to evaluate the

request. The Chair of the interdisciplinary Ad Hoc Committee shall be a disinterested party currently not performing these procedures. The Ad Hoc Committee shall give the affected practitioner and other interested persons the right to meet with the Committee. After receipt of the report of the Ad Hoc Committee, the Executive Committee shall recommend to the Board whether interdisciplinary privileges are appropriate and, if applicable, the criteria for granting such privileges.

**6.3-3 DELAYS**

Any practitioner who believes that his or her request for privileges has been improperly delayed may request the President of the Medical Staff to investigate the reason for such delay.

**6.4 SPECIAL CONDITIONS**

**6.4-1 ORAL SURGEONS AND DENTISTS**

Consultations performed by oral surgeons and dentists are under the overall supervision of the Chair of the Department of Surgery. Oral Surgeons and Dentists may write orders.

**6.4-2 PODIATRISTS**

Consultations and/or minor podiatric procedures performed by a podiatrist are under the overall supervision of the Chair of the Department of Surgery. A podiatrist may write orders.

**6.5 PRIVILEGES IN EMERGENCY SITUATIONS**

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

**6.6 TEMPORARY PRIVILEGES**

**6.6-1 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 provided documentation of required professional liability insurance. The President of the Medical Staff, department Chair, or section Chief may impose special requirements of supervision and reporting. Under all circumstances, the practitioner requesting temporary privileges shall agree to abide by these Medical Staff Bylaws, the General Medical Staff Rules and Regulations, Department Rules and Regulations, the Medical Staff Policies and Procedures, the Banner Health Policies and Procedures, and Banner Heart Hospital Policies and Procedures.

**6.6-2 CIRCUMSTANCES**

Upon the recommendation of the Chair of the Credentials Committee, the Department Chair and/or Section Chief, the Chief Executive Officer or designee may grant temporary privileges in the following circumstances:

**Pendency of Application**

To an applicant for staff membership who has requested temporary privileges and whose application has been completed, verified, and reviewed and accepted by the Department Chair, the Credentials Committee, and the Chief Executive Officer. Temporary privileges may be granted to an applicant for a period not to exceed 120 days.

#### **Care of Specific Patient**

To a practitioner for the care of a specific patient, when there are important patient care needs, but only after receipt of a completed and signed request for one-time privileges that includes a request for the specific privileges desired. Also required are a current curriculum vitae and documentation of the practitioner's education and training, current state license, (ECFMG (if applicable), board certification or eligibility, current professional liability insurance, current DEA certification, and current hospital affiliation with a local hospital. Additionally, the Medical Staff Services Department shall obtain a peer recommendation and query the NPDB. Such temporary privileges may not be granted in more than two instances in any twelve month period, after which the practitioner shall apply for staff appointment. These temporary privileges are restricted to the care of the specific patients for which they are granted.

Temporary privileges for a specific patient may be granted for more than two instances in any twelve month period for specialists in areas where there is no or insufficient physician membership in the specialty.

#### **Specific Patient Care Need for 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 the application and verification of the following information: appropriate licensure, adequate professional liability insurance, DEA registration, if applicable, three favorable peer references (one of which may be from the training program director), education and training, NPDB, Criminal Background Check 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. Temporary privileges may be extended only once for a maximum of 120 days.

#### **Temporary Privileges to Medical Residents/Fellows**

##### **a) Physician Staff: Qualifying Residency/Fellowship Programs**

Physician residents/fellows may obtain department-specified temporary privileges while in a supervised residency/fellowship training program accredited by the ACGME, the Association of American Medical Colleges, or the Royal College of Physicians and Surgeons of Canada, the successful completion of which would permit the resident to sit for and become certified by the American Board or the Royal College (Canada) or the American Osteopathic Board.

##### **b) Affiliate Staff: Qualifying Residency Programs**

Temporary privileges may be granted to non-physician residents in specialties permitted to practice on the Affiliate Staff while in a supervised residency training program that has been approved by the appropriate professional association as authorized under Arizona law.

##### **c) Permissible Activities of Residents/Fellows**

All of the resident's/fellow's activities at the Hospital must be approved under the qualifying residency/fellowship program and the rules and regulations of the

resident's/fellow's department adopted pursuant to Section 11.1.3.1 and the temporary privileges shall extend only to such activities.

**d) Supervision**

A Medical Staff member must be responsible for supervising the resident's/fellow's patient care activities in accordance with the program and the relevant department's rules and regulations.

**e) Duration of Privileges**

Resident's /fellow's temporary privileges are valid only as long as the resident/fellow satisfies all requirements for participation in the program and insurance coverage.

**f) Scope of Resident's/Fellow's Privileges**

The granting of temporary privileges to residents/ fellows does not confer Medical Staff membership, admitting privileges, the right to vote or hold elected office in the Medical Staff organization, an obligation to pay duties, or Article 9 hearing rights.

**6.6-3 TERMINATION**

The Chief Executive Officer, President of the Medical Staff, department Chair, or section Chief 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 Banner Heart Hospital shall be assigned to another practitioner by the department Chair or section Chief. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

**6.6-4 RIGHTS OF THE PRACTITIONER**

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

**6.7 DISASTER PRIVILEGES**

In the event of an officially declared emergency or disaster in which the hospital Disaster Plan has been activated and the hospital is unable to handle the immediate patient needs, temporary disaster privileges may be granted to a volunteer licensed independent practitioner by the President of the Medical Staff, the Chief Medical Officer (CMO), Incident Commander, or their respective designee(s).

**(a)** 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 of hospital ID card with professional designation;
- Current license to practice (primary source verified);
- Identification indicating the volunteer is a member of a DMAT or other recognized entity;
- Authorization by federal or state entity indicating authority to render care during a disaster;
- Identification by a current hospital employee or medical staff member with personal knowledge of the ability of the volunteer to act independently during a disaster.

**(b)** Family Practitioners and General Internists who do not have hospital privileges shall be permitted to exercise medicine privileges. Pediatricians who do not hold hospital privileges shall be permitted to exercise medicine privileges for children under the age of 18 years. The Medical Staff Services Department personnel shall verify the practitioner's Arizona medical license and shall query the Medicare sanction database and the National

Practitioner Database as well as the practitioner's primary hospital affiliation. Should this not be possible, verification shall occur, as soon as practical after the immediate situation is under control and, except in extraordinary circumstances, shall be completed within 72 hours from the time when the volunteer practitioner presents to the organization. The time the privileges were granted shall be documented and the President of the Medical Staff or designee(s) shall make a decision within 72 hours regarding whether to continue the privileges.

- (c) The granting of disaster privileges shall be handled on a case by case basis and is not an automatic right of the requesting practitioner. Practitioners granted disaster privileges will be issued a temporary hospital identification badge and a listing of these practitioners will be maintained by the Medical Staff Services Department.
- (d) Temporary disaster privileges shall automatically terminate when the hospital no longer requires additional practitioner services or the disaster has ended, whichever occurs first, and as determined by the President of the Medical Staff, CMO, or the Incident Commander, or their respective designee(s).
- (e) Disaster privileges may be revoked at any time. The termination of disaster privileges shall be final and the Medical Staff's Hearing and Appellate Review Procedures/Allied Health Practitioner Appeal Process shall not apply.
- (f) 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 President of the Medical Staff or appropriate department Chair, or other designee.

#### **6.8 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 departments' recommendation to either:

- (a) Conclude that the new technology falls under existing privileging criteria, or,
- (b) 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.

#### **6.9 REMOTE PRIVILEGES**

Remote privileges may be granted physicians who do not come to Banner Heart Hospital but who diagnose hospital inpatients through electronic communications. Physicians providing remote privileges shall be appointed to the Consulting medical staff only.

- (a) **CONDITIONS**  
Remote privileges may be granted only in those specialties where the hospital requires remote services and where the Executive Committee determines that service can be appropriately provided from a remote location.
- (b) **APPLICANTS FOR REMOTE PRIVILEGES**

Applications for Remote privileges shall meet the same appointment qualifications, shall be evaluated for appointment, reappointment, and clinical privileges in the same manner, and shall fulfill all of the obligations as any other Staff members.

#### **6.10 TELEMEDICINE AND TELERADIOLOGY PRIVILEGES**

- (a) The Executive Committee shall determine which patient care, treatment and services may be provided by practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine services may 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. Telemedicine physicians shall meet the disaster privileging revision set forth in these Bylaws.
- (b) Practitioner's providing care, treatment and services of a patient via a telemedicine link are subject to the credentialing and privileging processes of BHH. The practitioner may be privileged at BHH using credentialing information from the distant site if the distant site is a Joint-Commission accredited organization and if the application from the distant site meets quality standards as determined by the BHH Medical Staff. Under this option, BHH would obtain and utilize the distant site's primary source verified information including, but not limited to, licensure, education, training, the ability to perform privileges requested, and health status. BHH 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 telemedicine privileges. The application approval process outlined in these Bylaws, Section 5.6 will apply.
- (c) The 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.
- (d) The provider at the distant site may have total or shared responsibility for patient care, treatment, and services as determined by the patient's attending physician.

### **ARTICLE SEVEN: RESIGNATION**

#### **7.1 RESIGNATION**

Physicians on the Medical Staff who wish to resign their membership may do so by sending or delivering written notice to the Medical Staff Services Department of the Hospital. Such notice should include the date the physician wishes to have his or her resignation become effective. A voluntary resignation from the Medical Staff shall be effective after the physician has completed and signed all available medical records for which he or she is responsible at the time of resignation.

#### **7.2 REINSTATEMENT FOLLOWING RESIGNATION**

Physicians may request reinstatement of membership and privileges within 90 days of their resignation date by sending written notice to the Medical Staff Services Department, completing a reappointment application and providing a summary of relevant activities from the time of resignation, which will be verified. Physicians requesting reinstatement of membership and privileges more than 90 days from the resignation date must complete a new application for staff membership and privileges and must submit and initial application fee.

#### **7.3 PROCESS FOR REINSTATEMENT**

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

## ARTICLE EIGHT: CORRECTIVE ACTION

### **8.1 CRITERIA FOR INITIATING AN INVESTIGATION AND CORRECTIVE ACTION**

An investigation and 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 Banner Heart Hospital, that is detrimental to patient care or lower than the standards or aims of the Medical Staff.

### **8.2 PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION**

#### **8.2-1 PROFESSIONAL REVIEW INITIATED OUTSIDE THE DEPARTMENT**

- (a) A request for an investigation and/or corrective action may be submitted to the President of the Medical Staff by any member of the Medical Staff, the Chief Executive Officer, or the Board. The request shall be in writing and shall be supported by reference to the specific activities conduct forming the basis for the request.
- (b) The Executive Committee may consider the request or direct the request to the appropriate Medical Staff Department. If the Executive Committee or an Ad Hoc Committee thereof considers the request, it shall determine whether an investigation is warranted. If the Executive Committee determines that the request is warranted, it shall begin the investigation and delegate the responsibility for the investigation to the appropriate Medical Staff department or committee, who shall follow the procedures, set forth in Section 8.3. In certain instances, the Executive Committee may conduct its own investigation following the procedures set forth in Section 8.3

#### **8.2-2 PROFESSIONAL REVIEW INITIATED WITHIN THE DEPARTMENT**

Certain matters that may lead to corrective action are routinely considered by each Medical Staff department as a part of its ongoing quality assurance, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the department that may suggest an investigation or corrective action is warranted, the department or the appropriate section of the department shall determine whether an investigation is warranted. If an investigation is warranted, the Department shall begin the investigation and either conduct the investigation in accordance with Section 8.3 of these Bylaws or designate an Investigating Committee to conduct such investigation. The Executive Committee shall be kept informed of the status of such investigations. The department may require the use of "evaluation tools" to determine if an investigation is warranted. The use of these tools does not constitute an investigation. Evaluation tools include concurrent or retrospective chart review, in-person oversight, and/or consultation requirements. Refusal to cooperate in an evaluation shall result in suspension of privileges. The practitioner has the right to request a review of the imposition of evaluation tools at the Department's next meeting, but is not entitled to the additional procedural rights afforded by these Bylaws.

### **8.3 PROCEDURE FOR PROFESSIONAL REVIEW**

#### **8.3-1 TIME FRAMES**

- (a) The department (or the Investigating Committee designated by the department) shall conclude an investigation and document its findings within sixty days of the department's receipt of a request for investigation and/or corrective action, or,



(b) The determination by the department that an investigation is warranted. If the findings warrant the recommendation that corrective action be taken, the department Chair shall forward a recommendation for such action to the Executive Committee. Prior to making an adverse recommendation to the Executive Committee, the affected practitioner shall have an opportunity for an interview with the Investigating 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. A record of such interview shall be made by the Investigating Committee and included with its report. In certain instances, an investigation may not be concluded within sixty days. In such instances, the Investigating Committee shall report the status of the investigation and the date the investigation is expected to be concluded to the Executive Committee. The investigation shall be concluded as soon as reasonably practicable. The affected practitioner shall have no procedural rights arising out of such delay.

**8.3-2 DISCUSSIONS OF FINDINGS**

In the event that corrective action is recommended and the recommendation of the Investigating Committee differs from the recommendation of the department, the Chair of the Investigating Committee shall be invited to discuss the findings of the Investigating Committee with the Executive Committee.

**8.3-3 CONSIDERATION OF FINDINGS**

At its next scheduled meeting, the Executive Committee shall consider the recommendation for corrective action. After its deliberations, the Executive Committee may uphold, modify, or reject the recommendation and shall forward any adverse recommendation to the Board. If the type of corrective action is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws.

**8.4 SUMMARY SUPERVISION**

**8.4-1 INITIATION**

Whenever criteria may exist for initiating an investigation and/or 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. Supervision may include but is not limited to concurrent or retrospective chart review, in-person oversight, and/or consultation by a second physician. Any two of the following individuals in concert shall have the right to impose supervision:

- (a) President of the Medical Staff or designee, acting as a member of and on behalf of the Executive Committee;
- (b) Applicable department Chair or designee, acting as a member of and on behalf of the applicable department;
- (c) Chief Executive Officer or designee, acting on behalf of the Board of Directors, and;
- (d) Executive Committee member, acting as a member of and on behalf of the Executive Committee.

**8.4-2 REVIEW BY THE DEPARTMENTAL COMMITTEE**

A practitioner whose clinical privileges have been placed under summary

supervision by any two individuals identified in Section 8.4-1 shall be entitled to request a review of the summary supervision, by the Departmental Chair or a subcommittee designated by the Departmental Committee, having no less than five members. The review shall be requested within fifteen days of the practitioner's receipt of notice of the supervision. Such review shall take place within thirty days of the request for review. Upon deliberation, the department or committee acting for the Department may direct that the summary supervision be terminated or continued.

**8.4-3 TEMPORARY AUTOMATIC SUSPENSION FOR INCOMPLETE MEDICAL RECORDS**

A temporary suspension as defined in the General Rules and Regulations, shall be imposed for failure to complete medical records within the time periods established by the Executive Committee. Such suspension shall not apply to the suspended practitioner's patients admitted or already scheduled at the time of the suspension or to emergency patients. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension shall become automatic permanent suspension for failure to complete delinquent records as set forth in the General Rules and Regulations.

**8.5 SUMMARY SUSPENSION**

**8.5-1 INITIATION**

Whenever immediate action shall be taken in the best interest of patient care in Banner Heart Hospital 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) President of the Medical Staff, acting as a member of and on behalf of the Executive Committee;
- (b) Applicable department Chair, acting as a member of and on behalf of the applicable department committee;
- (c) Chief Executive Officer or designee, acting on behalf of the Board of Directors, and
- (d) Executive Committee member, acting as a member of and on behalf of the Executive Committee.

A summary suspension is effective immediately upon imposition and shall be followed promptly by special notice to the affected practitioner.

**8.5-2 REVIEW BY THE EXECUTIVE COMMITTEE**

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Executive Committee or a subcommittee of the Executive Committee having no less than five members who shall be appointed by the President of the Medical Staff. The review shall be requested within fifteen days of the practitioner's receipt of notice of the suspension. Such review shall take place within fifteen days of the request for review. Upon deliberation, the Executive Committee or subcommittee acting for the Executive Committee may direct that summary suspension be terminated or continued.

**8.5-3 EXPEDITED HEARING RIGHTS**

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

**8.5-4 ALTERNATIVE COVERAGE**

Immediately upon imposition of summary suspension, the President of the Medical Staff, department Chair, or section Chief shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in Banner Heart Hospital. Patient's wishes shall be considered in the selection of an alternative practitioner.

**8.6 AUTOMATIC SUSPENSION OR LIMITATION**

Automatic suspension shall be immediately imposed under the conditions contained in this section. Affected practitioners may request reinstatement during a period of ninety calendar days following suspension upon presentation of the required documentation. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and shall reapply for staff membership and privileges. In addition, further corrective action may be recommended in accordance with the provisions contained within these Bylaws whenever any of the following actions occur:

**8.6-1 LICENSE**

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

**8.6-2 CONTROLLED SUBSTANCES REGISTRATION**

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

**8.6-3 EXCLUSION FROM FEDERAL PROGRAMS**

Whenever a practitioner is excluded from Medicare, AHCCCS or other state or federally funded healthcare programs, the excluded practitioners shall not be permitted to provide services to patients enrolled in these programs, according to the Banner Health "Compliance OIG/GSA Exclusion Review" Policy.

**8.6-4 TEMPORARY AUTOMATIC SUSPENSION FOR INCOMPLETE MEDICAL RECORDS**

A temporary suspension as defined in the General Rules and Regulations, shall be imposed for failure to complete medical records within the time periods established by the Executive Committee. Such suspension shall not apply to patients admitted or already scheduled at the time of the suspension or to emergency patients. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension shall become automatic permanent suspension for failure to complete delinquent records as set forth in the General Rules and Regulations.

**8.6-5 PROFESSIONAL LIABILITY INSURANCE**

A practitioner's Medical Staff appointment and clinical privileges shall be voluntarily resigned for failure to maintain the minimum amount of professional liability insurance required under Section 3.1-11 of these Bylaws.

**8.6-6 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, in accordance with Section 13.3-2, shall automatically be suspended from exercising all clinical privileges. Failure to appear within 90 days of the request to appear shall result in revocation of staff membership and privileges.

**8.6-7 FAILURE TO PAY STAFF DUES**

A practitioner who fails to pay staff dues by April 1<sup>st</sup> annually shall automatically be suspended from the Medical Staff.

**8.6-8 FAILURE TO EXECUTE RELEASES OR PROVIDE REQUESTED INFORMATION**

A practitioner who fails to execute a release, as set forth in Section 14.4, or who fails to provide documentation or other information during a term of appointment when requested by the President of the Medical Staff, department Chair, or section Chief, shall automatically be suspended.

**8.6-9 FAILURE TO ESTABLISH FREEDOM FROM INFECTIOUS PULMONARY TUBERCULOSIS (TB)**

A practitioner's staff membership and clinical privileges shall be immediately suspended for failure to provide documentation of freedom from infectious pulmonary TB, whenever such evidence is requested.

**8.6-10 CURRENT OFFICE/CONTACT INFORMATION**

A practitioner who fails to provide the Medical Staff Services Department with a current office address and contact information shall automatically be suspended from exercising all clinical privileges.

**8.6-11 FAILURE TO ENROLL IN PECOS/OPT OUT OF MEDICARE**

A practitioner who has not obtained a National Provider Identification Number (NPI) shall be automatically suspended. A practitioner who is not enrolled in the Provider Enrollment, Chain and Ownership System (PECOS) or who has not submitted the required affidavit to the Medicare Carrier to opt out of the Medicare Program and who fails to enroll or opt out within 10 business days of being requested by Banner to enroll or opt out shall automatically be suspended. If evidence that the practitioner has obtained an NPI and/or has enrolled in PECOS or has opted out of Medicare is provided within 90 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.

## 8.7 **NON-REVIEWABLE ACTIONS**

Not every action entitles the practitioner to rights pursuant to Article 9, the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension as set forth in Section 8.6 are not reviewable under Article 9, the Fair Hearing Plan. In addition, the following occurrences are also non-reviewable under the Fair Hearing Plan:

- (a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights;
- (b) Issuance of a warning, a letter of admonition, or reprimand;
- (c) Imposition of evaluation tools or monitoring of professional practices, other than direct supervision, for a period of six months or less;
- (d) Termination or limitation of temporary privileges;
- (e) Any special requirements imposed during the practitioner's Provisional Staff membership;
- (f) Termination of any contract with or employment by Banner Heart Hospital;
- (g) Any recommendation voluntarily imposed or accepted by a practitioner;
- (h) Denial of membership and privileges for failure to complete an application for membership or privileges;
- (i) Removal of membership and privileges for failure to complete requirements for advancement to Active, Courtesy, or Consulting Staff;
- (j) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period;
- (k) Reduction or change in staff category;
- (l) Refusal of the Credentials Committee, department, or Executive Committee to consider a request for appointment, reappointment, staff category, department or section assignment, or privileges within one year of a final adverse decision regarding such request;
- (m) Removal or limitation of call obligations;
- (n) Any requirement to complete an educational assessment or training program; and any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional,
- (o) Denial or removal of membership and/or privileges as a result of the decision of the hospital to enter into, terminate, or modify an exclusive contract for certain clinical services or the termination or modification of the practitioner's relationship with the exclusive provider.
- (p) Grant of conditional appointment for a limited duration.

When an action that is not reviewable under the Fair Hearing Plan has been taken against a practitioner, the affected practitioner may request that the Executive Committee review the action,

and the practitioner may submit information demonstrating why the action is unwarranted. The Executive Committee shall review the practitioner's submission and make a recommendation. The affected practitioner shall have no appeal or other rights in connection with the Executive Committee's decision.

- 8.8** **LIMITATION OF REAPPLICATION:** Termination or summary suspension of a practitioner's membership and privileges pursuant to Article VI or as a result of resignation while under investigation may disqualify the practitioner from reapplying for membership and privileges for twelve months following the date of resignation or Board's final action.

## **ARTICLE NINE: FAIR HEARING PLAN**

### **9.1** **INITIATION OF HEARING**

#### **9.1-1** **TRIGGERING EVENTS**

Any practitioner whose membership and/or privileges are denied, revoked, suspended, reduced, or otherwise limited shall be entitled to a hearing upon timely and proper request, unless such limitation constitutes non-reviewable action as defined in Article 8.7 of the Medical Staff Bylaws.

### **9.2** **NOTICE OF ADVERSE RECOMMENDATION OR ACTION**

Upon the adverse recommendation of the Executive Committee, the Chief Executive Officer shall promptly notify the practitioner by special notice, of a reviewable adverse recommendation. Special notice required by this Fair Hearing Plan shall be either hand-delivered with confirmation of receipt or sent by certified mail, return receipt requested. The notice shall:

- (a)** Advise the practitioner that an adverse recommendation has been proposed; and contain a concise statement of the practitioner's alleged acts or omissions, a list of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action or recommendation that is the subject of the hearing;
- (b)** Advise the practitioner of his or her right to a hearing upon timely and proper request; and specify that the practitioner has thirty calendar days after receiving the notice within which to submit a written request for a hearing to the Chief Executive Officer;
- (c)** State that failure to request a hearing within the above stated time period and in the proper manner constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice;
- (d)** Specify the hearing rights to which the practitioner is entitled; and,
- (e)** State that after receipt of the request for a hearing, the practitioner will be notified of the date, time and place of the hearing.

### **9.3** **AMENDED ADVERSE RECOMMENDATION OR ACTION**

The Executive Committee may modify its proposed adverse recommendation or action, or the grounds for such recommendation or action at any time during the course of the proceeding, and shall notify the practitioner of all additions or deletions. However, the Executive Committee must provide timely notice of such modifications to the practitioner. In the event a practitioner received notice of any such modification, the practitioner may request a postponement of the hearing, if it has been scheduled, so as to give the practitioner a reasonable opportunity to respond to the modified proposed adverse recommendation or action and/or the additional rounds for such

recommendation or action. If the President of the Medical Staff determines that the request is reasonable, the hearing will be postponed.

**9.4 REQUEST FOR HEARING**

The practitioner shall have thirty calendar days after receiving a notice under Section 9.2 to deliver to the Chief Executive Officer a written request for a hearing.

**9.5 CONCURRENT HEARINGS**

Where the Executive Committee and other Banner Executive Committees make an adverse recommendation against the same practitioner, the President of the Medical Staff, at his/her sole discretion may elect to participate in a concurrent hearing. The Chief of Staff's/Presidents of the participating Medical Centers shall collectively determine the members of the hearing committee.

**9.6 WAIVER BY FAILURE TO REQUEST A HEARING**

A practitioner who fails to request a hearing within the time and in the manner specified in Section 9.4 shall be deemed to waive his or her right to any hearing or appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse recommendation triggering the Section 9.2 notice. A waiver shall constitute acceptance of the recommendation and action, which shall immediately be transmitted to the Board for a final decision. The Chief Executive Officer shall, as soon as reasonably practicable, send the practitioner notice of the Board's decision.

**9.7 WAIVER BY FAILURE TO PARTICIPATE CONSTRUCTIVELY IN THE HEARING PROCESS**

A practitioner who fails to participate constructively in the Hearing Process shall be deemed to have waived his or her right to any hearing or appellate review to which he or she might otherwise have been entitled. The Presiding Officer must inform the practitioner that a waiver is being considered and give the practitioner reasonable opportunity to participate constructively prior to a ruling that his or her hearing rights have been waived. Examples of failure to participate constructively include, but are not limited to, refusal of the practitioner to be sworn in or to answer questions posed by the Hearing Committee; failure to proceed with the hearing; and failure to abide by a ruling of the Presiding Officer. The waiver has the same force and effect as provided in Section 9.5. A practitioner who has been deemed to have waived his or her right to a hearing may request that the Executive Committee review the ruling and may submit information demonstrating why the ruling is unwarranted. Such request and information in support of the practitioner's position must be submitted, if at all, within ten days of the ruling. The Executive Committee shall decide whether to reinstate the practitioner's hearing rights, and the practitioner shall have no appeal or other rights in connection with the Executive Committee's decision.

**9.8 HEARING PREREQUISITES**

**9.8-1 NOTICE OF TIME AND PLACE FOR HEARING**

Upon receiving a timely and proper request for a hearing, the Chief Executive Officer shall deliver the request to the President of the Medical Staff, who shall schedule the hearing. At least thirty calendar days prior to the hearing, the Chief Executive Officer shall send the practitioner special notice of the date, time, and place of the hearing. The President of the Medical Staff shall use his or her best efforts to schedule the meeting to commence not less than thirty calendar days nor more than ninety calendar days after the CEO sends special notice to the practitioner; provided, however, that a practitioner who is under suspension then in effect may request an expedited hearing. 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, with a goal that the hearing commence within thirty

calendar days after the receipt of the request for the expedited review. The above stated time periods may be modified upon the mutual agreement of the practitioner and the President of the Medical Staff.

## **9.9 APPOINTMENT OF HEARING COMMITTEE**

### **9.9-1 BY BANNER HEART HOSPITAL**

A hearing shall be conducted by an ad hoc Hearing Committee appointed by the President of the Medical Staff, and composed of at least three members. The President of the Medical Staff shall designate one of the appointees as Chair of the committee. If the President of the Medical Staff is in direct economic competition with the practitioner, the Vice President of the Staff, Secretary/Treasurer, Immediate-Past-President or remaining member of the Executive Committee (in that order) shall appoint the committee members and Chair. No person in direct economic competition with the practitioner shall participate in the selection of the committee or its Chair.

### **9.9-2 SERVICE ON HEARING COMMITTEE**

The Hearing Committee shall be composed of individuals who are not in direct economic competition with the involved practitioner. Members of the hearing committee shall be physicians and may, but need not be, members of the medical staff. Any individual shall be disqualified from serving on the Hearing Committee if such member has directly participated in the consideration of the adverse recommendation.

### **9.9-3 PRACTITIONER'S RIGHT TO OBJECT**

The President of the Medical Staff or his/her designee shall notify the practitioner of the names of the committee members and the date by which the practitioner must object, if at all, to the appointment of any member(s). Such objection must be in writing and must include the basis for the objection. If the President of the Medical Staff or his/her designee who appointed the committee determines that the objection is reasonable, the President of the Medical Staff or his/her designee may designate alternative member(s) and shall notify the practitioner of such new member(s). The practitioner may object to any new member(s) by giving written notice of the objection and the reasons therefore.

### **9.9-4 HEARING OFFICER**

The President of the Medical Staff, at his/her discretion or upon request of the affected practitioner, may appoint a Hearing Officer. The Hearing Officer shall serve as the Presiding Officer; maintain decorum, and rule on matters of law, procedure, and the admissibility of evidence, including the admissibility of testimony and exhibits. The Hearing Officer may participate in the deliberations and assist in the preparation of a written decision, but may not act as an advocate or advisor for either party and may not vote. The Hearing Officer need not be a member of the Medical Staff or a physician and may not be in direct economic competition or affiliation with the practitioner. The practitioner has the right to object to the Hearing Officer in the same manner as specified in Section 9.9-3.

### **9.9-5 PRESIDING OFFICER**

In the absence of a Hearing Officer, the Hearing Committee Chair shall be the Presiding Officer. The Presiding Officer shall maintain decorum, and rule on matters of law, procedures, and the admissibility of evidence, including the admissibility of testimony and exhibits. The Chair shall be entitled to vote.

## **9.10 LIST OF WITNESSES**

At least ten days prior to the scheduled date for commencement of the hearing, each party shall give the other party a list of the names of the individuals who, as far as is then reasonably known,



will give testimony or evidence in support of the practitioner at the hearing. The list shall contain only the names of individuals who can provide testimony relevant to the grounds for the adverse recommendation or action. Such list and the list of the Executive Committee's witnesses shall be amended as soon as possible when additional witnesses are identified. The Presiding Officer may permit a witness who has not been listed in accordance with this Section to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, and that the testimony of such witness will materially assist the hearing committee in making its report and recommendation under Section 4.1 below. The practitioner and the representative of the Executive Committee will be permitted to testify regardless of whether identified as a witness.

**9.11 STATEMENTS IN SUPPORT**

If a statement in support of a party's position is to be submitted to the Hearing Committee, such party shall supply five copies of such statement to the Medical Staff Services Department at least five days prior to the scheduled date for commencement of the hearing. The party shall also supply two copies of the statement to the other party and his or her representative. The Medical Staff Services Department shall distribute the statements (if any) to members of the ad hoc committee at least three days prior to the scheduled date of the commencement of the hearing. Nothing in this paragraph shall preclude the Executive Committee or its representative from submitting procedural information to the hearing committee.

**9.12 EXHIBITS**

At least ten days prior to the scheduled date for commencement of the hearing, each party shall give the other party a copy of all exhibits, as far as then reasonably known which will be introduced during the hearing. Documents previously provided to a party need not be resupplied. The Presiding Officer may permit the introduction of an exhibit which has not been provided in accordance with this Section if he/she finds that the failure to provide such exhibit was justified, that such failure did not prejudice the party entitled to receive it, and that the exhibit will materially assist the Hearing Committee in making its report and recommendation under Section 9.15 below.

**9.13 DUTY TO NOTIFY OF NONCOMPLIANCE**

If the practitioner believes that there has been a deviation from the procedures required by this Fair Hearing Plan or applicable law, the practitioner must promptly notify the President of the Medical Staff of such deviation, including the Fair Hearing Plan/Bylaws or applicable law citation. If the President of the Medical Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation. The practitioner shall be deemed to have waived any violation of the Bylaws, this Fair Hearing Plan, or law not raised timely pursuant to this Section.

**9.14 HEARING PROCEDURE**

**9.14-1 PERSONAL PRESENCE**

The right to a hearing shall be waived if the physician fails, without good cause, to appear for the hearing. The personal presence of the practitioner is required throughout the hearing. The presence of the practitioner's counsel or other representative does not constitute the personal presence of the practitioner. A practitioner who fails, without good cause, to be present throughout the hearing shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Section 9.7. The hearing Presiding Officer shall determine what constitutes "good cause".

**9.14-2 REPRESENTATION**

The practitioner may be represented at the hearing by legal counsel or any other person of the practitioner's choice. The Executive Committee shall appoint a representative who may

be a member of the Executive Committee or another member of the Active staff to represent it and may also be represented by legal counsel.

**9.14-3 RIGHTS OF PARTIES**

During a hearing, each party shall have the following rights, subject to the rulings of the Chair on the admissibility of evidence and provided that such rights shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

- (a) Call, examine, and cross-examine witnesses;
- (b) Present relevant evidence;
- (c) Rebut any evidence;
- (d) Submit a written statement in support of such party's position if such statement is tendered pursuant to Section 9.11;
- (e) Submit proposed findings of fact and recommendations at the close of the hearing;
- (f) Have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof, and;
- (g) Have the right to receive the written recommendations of the Hearing Committee and the Executive Committee, both of which must include a statement of the basis for the decision.

**9.14-4 PROCEDURES AND EVIDENCE**

The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. At the discretion of the Chair, any relevant matter may be considered. During the hearing, each party shall be entitled to submit a statement in support concerning any issue of law or fact if such statement was tendered pursuant to Section 9.11, and those statements shall become part of the hearing record. The Hearing Committee may ask questions of witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate. The practitioner may be examined by the Executive Committee representative and the Hearing Committee members regardless of whether the practitioner testifies in his or her own behalf. The Chair may order that oral evidence be taken only on oath.

**9.14-5 BURDEN OF PROOF**

The Executive Committee has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the practitioner has the burden of demonstrating, by preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

**9.14-6 HEARING RECORD**

A record of the hearing shall be kept. A court reporter shall be used for making the record.

**9.14-7 POSTPONEMENT**

Requests for postponement or continuance of a hearing may be granted by the Presiding Officer only upon a timely showing of good cause.

**9.14-8 RECESSES AND ADJOURNMENT**

The Hearing Committee may without special notice recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

**9.14-9 DELIBERATIONS**

In reaching its conclusions of fact and making its recommendations, the Hearing Committee must act:

- (a) in the reasonable belief that the recommendation is in furtherance of quality health care;
- (b) after a reasonable effort to obtain the facts of the matter; and,
- (c) in the reasonable belief that the action is warranted by the facts known after reasonable effort to obtain such facts.

**9.15 HEARING COMMITTEE REPORT**

Within ten days after adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations. The report shall include a statement of the basis for its recommendations. The Hearing Committee shall forward the report along with the record and other documentation to the Executive Committee.

**9.16 ACTION ON HEARING COMMITTEE REPORT**

At its next regularly scheduled meeting after receipt of the Hearing Committee report and the hearing record, the Executive Committee shall consider the report of the Hearing Committee. The Executive Committee shall also have available to it the hearing record and all documentation submitted at the hearing. If the recommendation of the Hearing Committee differs from the initial recommendation of the Executive Committee, the Chair of the Hearing Committee shall be invited to the Executive Committee to discuss the findings and recommendation of the Hearing Committee. The Executive Committee shall affirm, modify, or reverse its previous recommendation or action and shall include with its recommendation, a statement of the basis therefore.

**9.17 NOTICE AND EFFECT OF RESULT**

**9.17-1 NOTICE**

As soon as is practicable after the Executive Committee meeting, the Chief Executive Officer shall send the practitioner a copy of the Hearing Committee's report and recommendations, the reconsidered recommendation of the Executive Committee along with the statements for the basis of the recommendations.

**9.17-2 EFFECT OF FAVORABLE RESULT**

When the recommendation of the Executive Committee is favorable to the practitioner, the Chief Executive Officer shall promptly forward it to the Board.

**9.17-3 EFFECT OF ADVERSE RESULT**

(a) If, after the Executive Committee's reconsidered recommendation continues to be adverse, the CEO shall promptly so notify the practitioner by special notice and shall also notify the practitioner of the appellate review rights to which the practitioner is entitled. The Chief Executive Officer shall also forward such

recommendation to the Board, but the Board shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived the right to an appellate review.

- (b) When the Executive Committee's recommendation continues to be adverse, the CEO shall notify the appropriate licensing authority and make such other notifications as are required by law regarding the recommendation and the grounds therefore and of the affected practitioner's pending appeal rights.

**9.18 APPELLATE REVIEW**

The appellate review process is set forth in the Banner Health Appellate Review Policy.

**9.19 ACTION TAKEN BY THE APPEALS SUBCOMMITTEE**

As soon as practicable after adjournment of the appellate review, the Appeals Subcommittee shall prepare its report and recommendation. The General Counsel shall send a copy of the report and the recommendation to the practitioner and the President of the Medical Staff for transmittal to the Executive Committee. The report and recommendation will be presented to the Medical Staff Subcommittee, which will make a recommendation to the Banner Health Quality and Care Management Committee. The President of the Medical Staff will be invited to attend the presentation of the report and recommendation to the Medical Staff Subcommittee, but may not remain for the deliberations or the vote.

**(a) APPEALS SUBCOMMITTEE IN ACCORD WITH THE EXECUTIVE COMMITTEE**

If the Appeals Subcommittee's recommendation is in accord with the Executive Committee's last recommendation in the matter, the Medical Staff Subcommittee shall promptly forward its recommendation to the Quality and Care Management Committee along with all relevant documentation.

**(b) APPEALS SUBCOMMITTEE NOT IN ACCORD WITH THE EXECUTIVE COMMITTEE**

If the Appeals Subcommittee's recommendation differs from the Executive Committee's last recommendation, the Medical Staff Subcommittee may make a recommendation to the Quality and Care Management Committee or refer the matter back to the Executive Committee for further consideration.

**9.20 SPECIAL JOINT CONFERENCE REVIEW**

Prior to a recommendation by the Medical Staff Subcommittee or the Quality and Care Management Committee or a decision by the Board that differs from the Executive Committee's last recommendation, the Executive Committee will be permitted to request review by a special Joint Conference Subcommittee; provided, however, that the Executive Committee is entitled to only one Joint Conference review with respect to the adverse recommendation against the practitioner. As soon as practicable after receiving a matter referred to it, a special Joint Conference Subcommittee shall convene to consider the matter and submit its recommendation to the Board.

**9.21 NUMBER OF APPELLATE REVIEWS**

No practitioner is entitled as a right to more than one appellate review with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right.

**ARTICLE TEN: GENERAL STAFF OFFICERS**

**10.1 GENERAL OFFICERS OF THE STAFF**

**10.1-1 IDENTIFICATION**

The general officers of the staff are:

- (a) President of the Medical Staff;
- (b) Vice-President of the Medical Staff;
- (c) Immediate-Past-President of the Medical Staff;
- (d) Secretary/Treasurer;
- (e) Nine Members-At-Large to include:
  - One Cardiologist
  - One Cardiothoracic Surgeon
  - One Emergency Medicine Physician
  - One Anesthesiologist
  - One Hospitalist
  - One Pulmonologist
  - One Vascular Surgeon
  - Two additional Members-At-Large of the Active Staff in any specialty.

#### **10.1-2 QUALIFICATIONS**

Each general officers of the staff shall:

- (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 with the exception of the Emergency Medicine physician who does not have to be a member of the Active staff;
- (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 Banner Heart Hospital; and
- (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 Chief Executive Officer, and the Board.

A practitioner may not simultaneously hold two or more General Staff offices.

#### **10.2 TERM OF OFFICE**

The term of office of General Staff Officers is two years. Except for initial Officers, all 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 resigns sooner or is removed from office. The Vice President of the Medical Staff shall automatically succeed to the office of President at the end of his/her term as Vice President.

#### **10.3 ELIGIBILITY FOR RE-ELECTION**

A General Staff Officer is eligible for nomination and re-election in succeeding terms except that the President of the Medical Staff may not serve two successive terms as President.

#### **10.4 SELECTION**

The initial Officers shall be appointed by the Board, with a term to expire December 31, 2001. Thereafter, the officers shall be nominated by the Nominating Committee and elected by the Active staff members of the Medical Staff. The position of Emergency Medicine Member-At-Large will be appointed by the President of the Medical Staff with ratification by the Executive Committee.

## **10.5 NOMINATIONS**

A Nominating Committee, consisting of the last three Immediate Past Presidents still in the active practice of medicine, the Vice President and two Members-At-Large selected by the Medical Staff to serve on the Nominating Committee, shall submit a slate of nominees which shall include at least one candidate for each office. There shall be no maximum number of nominees for Officers. Additionally, a designated line for a write-in candidate shall be included for each staff Officer position. In the event there are not three past Presidents of the staff who are in the active practice of medicine, the President of the Medical Staff shall make an appointment with the approval of the Executive Committee. At the October Executive Committee meeting, the Nominating Committee shall present for information the list of nominations to the Executive Committee and the Chief Executive Officer. The Secretary shall give written notice of the nominations to all Active Medical Staff members of the Medical Staff.

Two weeks prior to the meeting of the Nominating Committee, a memorandum shall be forwarded to all members of the Active Staff, requesting the names of physicians qualified for and interested in serving in a staff officer position.

## **10.6 ELECTIONS, VACANCIES, AND REMOVALS**

### **10.6-1 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 shall mail one official ballot and two official envelopes, with instructions to each Active Staff Member of the Medical Staff within fourteen days after nominations are completed. The name of the voting member shall appear on the official outer envelope. The sealed ballot shall be returned on or before the date specified in the instructions, which shall be no more than fourteen 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, and one other member of the Executive Committee appointed by the President, shall identify the outer envelope as containing the vote of a qualified voter and shall deposit the sealed inner envelope into the ballot box. On the date designated in the ballot instructions, the inner envelopes shall be opened and the ballots counted by the Secretary and the appointed Executive Committee member.
- (c) A majority of the votes cast for any office shall be necessary to elect any Officer.
- (d) In the case of a tie, when only two nominees appear on the ballot, a majority vote of the Executive Committee shall decide the election.
- (e) Electronic Balloting – The Secretary/Treasurer or designee shall electronically mail one official ballot with instructions to each qualified voter within 2 weeks after the Executive Committee meets. 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. The voter's name will be verified as a qualified voter by the Secretary/Treasurer of the Staff or designee. The ballot results will be tallied by the Medical Staff Services Department the same day. For elections, at least one member of the Executive Committee shall be present at the tallying/counting of the ballots.

### **10.6-2 VACANCIES IN ELECTED OFFICES**

In the event of a vacancy in the office of President of the Medical Staff, the Vice President of the Medical Staff shall assume the duties of the President of the Medical Staff for the remainder of the unexpired term. A vacancy in any other General Staff office shall be filled by appointment by the President of the Medical Staff with the approval of the Executive Committee.

**10.6-3 RESIGNATIONS AND REMOVAL FROM OFFICE**

- (a) Any officer may resign at any time by giving written notice to the Executive Committee. Such resignation takes effect on the date of receipt of the resignation or at any later time specified in the notice.
- (b) Removal from office may be initiated only by the Executive Committee or by petition signed by at least one third of the Active staff members. Such removal shall be considered at a special meeting of the Medical Staff as provided in Section 10.1-2, for the purpose of considering and acting upon the request for removal. Removal shall require a two thirds vote of the voting members present at the special meeting and shall be effective immediately upon tabulation of the vote by the Chief Executive Officer or designee.
- (c) Criteria for consideration for removal from office shall include failure to continue to meet the qualifications for the office, failure to perform the duties required of the position in a timely and appropriate manner, failure to meet meeting attendance requirements, misfeasance in office (i.e., illegal activities), or substantiated allegations as an impaired practitioner in accordance with the Medical Staff Services Policies and Procedures and these Bylaws. Removal of an Officer of the General Staff shall be effective immediately upon approval by the Board of Directors.

**10.7 DUTIES OF OFFICERS**

**10.7-1 PRESIDENT OF THE MEDICAL STAFF**

The President of the Medical 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 Chair of these committees;
- (e) as appropriate, participate in Sentinel Clinical Event assessments and delegate responsibility to appropriate Department Chairs and/or other Medical Staff members to lead the process review and/or Root Cause Analyses;
- (f) interact with the Chief Executive Officer and the Board in all matters of mutual concern within Banner Heart Hospital;

- (g) represent the views and policies of the Medical Staff to the Board and to the Chief Executive Officer;
- (h) be a spokesman for the Medical Staff in external professional affairs;
- (i) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Executive Committee, and;
- (j) represent Banner Heart Hospital at Banner Health meetings to which Banner Health Medical Staff leadership has been invited.

**10.7-2 VICE PRESIDENT OF THE MEDICAL STAFF**

The Vice President of the Medical Staff shall assume all duties and authority of the President of the Medical Staff in his/her absence. The Vice President of the Medical Staff shall be a member of the Executive Committee and shall serve as Chair of the Credentials Committee and shall perform such other duties as the President of the Medical Staff may assign or as may be delegated by these Bylaws or by the Executive Committee.

**10.7-3 IMMEDIATE PAST-PRESIDENT OF THE MEDICAL STAFF**

The Immediate Past-President of the Medical Staff shall be a member of the Executive Committee and shall serve as Chair of the Bylaws Committee. The Immediate Past-President shall perform such other duties as may be assigned by the President of the Medical Staff or delegated by these Bylaws or by the Executive Committee.

**10.7-4 SECRETARY/TREASURER**

The Secretary/Treasurer shall be a member of the Executive Committee. As Secretary, the Secretary/Treasurer shall determine that accurate and complete minutes of all Executive Committee and Medical Staff meetings are maintained. As Treasurer, the Secretary/Treasurer shall receive and safeguard all funds of the Medical Staff. Additionally, the Secretary/Treasurer shall be responsible for maintaining and investing all Medical Staff funds, including annual dues, special assessments, and application fees. The Secretary/Treasurer shall make a monthly report to the Executive Committee. 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 President of the Medical Staff or the Executive Committee.

**10.7-5 MEMBERS-AT-LARGE**

Members-At-Large shall serve as members of the Executive Committee.

**ARTICLE ELEVEN: CLINICAL DEPARTMENTS AND SECTIONS**

**11.1 CLINICAL DEPARTMENTS AND SECTIONS**

The Medical Staff shall be divided into two clinical departments: Medicine and Surgery. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities as specified in this Article. A department may be further divided into sections that shall be directly responsible to the department within which it functions, and that shall have a Section Chief selected and entrusted with the authority, duties, and responsibilities 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.



## **11.2 ASSIGNMENT TO DEPARTMENTS AND SECTIONS**

Each member shall be assigned membership in one department and to a section within a department, where applicable. A practitioner may be granted clinical privileges in more than one department or section. The exercise of clinical privileges within the jurisdiction of any department or section is always subject to the rules and regulations of that department and section.

## **11.3 FUNCTIONS OF DEPARTMENTS**

Each department shall:

- (a)** provide leadership for the process measurement, assessment and improvement activities provided by practitioners with privileges in the department and make recommendations based on the results of these reviews. These processes include, although are not limited to, medical assessment and treatment of patients, use of medications, use of blood and blood components, use of operative and other procedure(s), efficiency of clinical practice patterns, significant departures from established patterns of clinical practice, and Sentinel Clinical Event reviews;
- (b)** develop recommendations for the qualifications appropriate to obtain and maintain clinical privileges in the department and its sections;
- (c)** establish and implement clinical policies and procedures as well as patterns of practice, and monitor its members' adherence to them;
- (d)** 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. They shall be appended to the Medical Staff Rules and Regulations. Any rule, regulation or policy that may be temporarily adopted on an emergency basis shall be approved by the President of the Medical Staff prior to communication or enforcement;
- (e)** meet at least quarterly to consider the results of the review for quality and appropriateness of patient care and any other review and evaluation activities, and to provide a forum for discussion of matters of concern to its members;
- (f)** be responsible for the conducting of continuing education and research programs within the department;
- (g)** coordinate the professional services of its members with those of other departments and with Banner Heart Hospital nursing and support services;
- (h)** report and make recommendations regarding clinical, quality review, and administrative activities to the Executive Committee;
- (i)** participate in budgetary planning pertaining to department activities with Banner Heart Hospital Administration, and;
- (j)** establish any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the subcommittee members shall be defined within the department rules and regulations;
- (k)** develop for approval by the Executive Committee and the Board, specific policies and procedures that delineate the scope of permissible supervised patient care responsibilities of resident/fellows and the nature and degree of supervision, establish a framework for the department's residency/fellowship program responsibility, ensure appropriate

interdepartmental communication among all departments affected by any residency/fellowship program, establish an evaluation process and provide a grievance procedure for residents/fellows. The department must review their rules annually and forward them to the Executive Committee for approval.

#### **11.4 FUNCTIONS OF SECTIONS**

Subject to approval by the Executive Committee, each section shall perform the functions assigned to it by the department Chair. Such functions may include review and evaluation of patient care practices, development of criteria for privileges; credentials and privileges recommendations; and research programs. The section shall transmit regular reports to the department Chair on the conduct of its assigned functions.

#### **11.5 DEPARTMENT OFFICERS**

##### **11.5-1 QUALIFICATIONS**

Each department shall have a Chair who shall be and remain, during his/her term, a member in good standing of the Active Medical Staff and shall be certified by an appropriate specialty board or have comparable demonstrated competence by training and experience; demonstrated ability in and have privileges to practice cardiology or cardiothoracic surgery; and shall demonstrate a high degree of interest in and support of the Medical Staff and Banner Heart Hospital. Departments may also have a Vice Chair or other officers as defined in the department's rules and regulations.

##### **11.5-2 SELECTION**

The initial department Chair shall be appointed by the Board, with a term to expire December 31, 2002. Thereafter, the department Chair shall be elected every two years by the Active staff members of the department. Each department Chair shall appoint a Nominating Committee of three members at least sixty days prior to the mailing of the ballots. The Nominating Committee shall submit a slate of nominees which shall include at least one candidate for each office. There shall be no maximum number of nominees for each department chair position. Additionally, a designated line for a write-in candidate shall be included for each department Chair position. The recommendations of the Nominating Committee shall be presented and approved at the September department and Executive Committee meetings. Nominees will be notified and be allowed to prepare a statement or position letter to be included with the ballot. Ballots shall be mailed within fourteen days after the Executive Committee meeting. Nominations may also be made at the meeting, so long as the nominee is qualified and has consented to the nomination. 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. Selection of any additional officers defined by the department shall follow this same procedure.

Two weeks prior to the meeting of the department Nominating Committees, a memorandum shall be forwarded to all Active Staff members of the department, requesting the names of physicians qualified for and who have an interest in serving in a department Chair position.

##### **11.5-3 TERM OF OFFICE**

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

##### **11.5-4 RESIGNATIONS AND REMOVAL FROM OFFICE**

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- (a) Any department officer may resign at any time by giving written notice to the Executive Committee. Such resignation takes effect on the day of the receipt of the resignation or at any later time specified in the notice. The President of the Medical Staff, with the approval of the Executive Committee, shall appoint a replacement for the vacated position for the remainder of the term.
  - (b) Removal of an elected department officer may be initiated by petition signed by at least one third of the Active staff members of the department. Such vote shall occur by written ballot conducted in the same manner as that used in the election of department officers. Removal shall require a two thirds vote of the Active staff members of the department. Removal of a department officer shall be effective upon approval by the Executive Committee and Board of Directors.
  - (c) Criteria for consideration for removal from office shall include
    - 1) failure to be a member in good standing of the Medical Staff;
    - 2) failure to continue to meet the qualifications of the office;
    - 3) failure to perform the duties required of the position in a timely and appropriate manner;
    - 4) misfeasance in office (i.e., illegal activities);
    - 5) failure to meet meeting attendance requirements;
    - 6) substantiated allegations as an impaired practitioner in accordance with the Medical Staff Services Policies and Procedures and these Bylaws; or
    - 7) Involuntary loss or significant limitation of practice privileges.

#### **11.5-5 DUTIES**

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

- (a) Act as presiding officer at department meetings;
- (b) Account to the Executive Committee for all clinically related activities of the department;
- (c) Be accountable for all administratively related activities of the department, unless otherwise provided by the hospital;
- (d) Provide continual surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
- (e) Recommend to the Executive Committee, the criteria for clinical privileges that are relevant to the care provided in the department;
- (f) Recommend clinical privileges for each member of the department;
- (g) Assess and recommend to the relevant hospital authority, off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
- (h) Assure integration of the department into the primary functions of the organization;
- (i) Coordinate and integrate interdepartmental and intradepartmental services;

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- (j)** Develop and implement Rules and Regulations and Policies and Procedures that guide and support the provision of care, treatment, and services;
  - (k)** Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services;
  - (l)** Determine the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
  - (m)** Provide continuous assessment and improvement of quality of care, treatment, and services;
  - (n)** Maintain quality control programs, as appropriate;
  - (o)** Oversee the orientation and continuing education of all persons in the department;
  - (p)** Recommend space and other resources needed by the department;
  - (q)** Act as the presiding member of the Sentinel Clinical Event Assessment Committee when requested to do so by the President of the Medical Staff, appoint Medical Staff members to conduct the process review and/or root cause analysis, recommend process changes, monitor the effectiveness of improvements, refer issues related to practitioner involvement to the department or section; and refer other issues to other quality management committees as appropriate;
  - (r)** Monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the department;
  - (s)** Recommend to the Executive Committee and implement department rules and regulations, criteria for credentials review and privileges delineation, programs for continuing medical education, and improvement in quality of care and utilization management;
  - (t)** Be a member of the Executive Committee, give guidance on overall medical policies of Banner Heart Hospital, and make specific recommendations regarding the department;
  - (u)** Transmit to the Executive Committee the department's recommendations concerning the clinical privileges and staff category of practitioners who are members of or applying to the department, and corrective action specific to practitioners with privileges within the department;
  - (v)** Enforce the Medical Staff Bylaws, General Rules and Regulations, the Rules and Regulations of the department, the Medical Staff Services Policies and Procedures, and the Banner Health and Banner Heart Hospital Policies and Procedures;
  - (w)** Implement, within the department, actions directed by the Executive Committee or the Board;
  - (x)** Participate in every phase of administration of the department, including cooperation with nursing service and Banner Heart Hospital administration;

- (y) Appoint such committees as are necessary to conduct the functions of the department;
- (z) Appoint such Chairs or committee members as required by these Bylaws and department rules and regulations; and
- (aa) Perform such other duties as may, from time to time; be reasonably requested by the President of the Medical Staff, the Executive Committee, or the Board.

## **11.6 SECTION CHIEFS**

### **11.6-1 QUALIFICATIONS**

Each Section shall have a Chief who shall be a member of the Active Staff, a member of the Section and qualified by training, experience, and demonstrated current ability in the clinical area covered by the section.

### **11.6-2 SELECTION**

Each Section Chief shall be selected by the department Chair with the approval of the Executive Committee except those sections where the Section Chief serves as such under contract with Banner Heart Hospital. Vacancies due to any reason shall be similarly filled.

### **11.6-3 TERM OF OFFICE**

Each Section Chief shall serve a two year term which shall coincide with the term of the department Chair or until a successor is chosen, unless he or she sooner resigns, is removed from office, or fails to maintain the qualifications in Section 8.6-l. Section Chiefs shall be eligible to succeed themselves.

### **11.6-4 RESIGNATIONS AND REMOVAL FROM OFFICE**

- (a) Any Section Chief may resign at any time by giving written notice to the Executive Committee. Such resignation takes effect on the day of the receipt of the resignation or at any later time specified in the notice.
- (b) A Section Chief may be removed by the Department Chair with the approval of the Executive Committee. Removal may also be initiated by petition of one third of the Active members of the Section. Removal in this circumstance shall require a two-thirds vote of the Active members of the Section. Such vote shall occur by written ballot in the same manner as that used in the election of department officers.

### **11.6-5 DUTIES**

Each Section Chief shall:

- (a) act as presiding officer at Section meetings;
- (b) in cooperation with the Department Chair, assist in the development and implementation of programs to carry out any quality review, monitoring, and evaluation functions assigned to the Section;
- (c) monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the Section;

- (d) conduct investigations and submit reports and recommendations to the Department Chair regarding the criteria for granting clinical privileges and the clinical privileges to be exercised within the Section by members of or applicants to the Medical Staff; and
- (e) perform such other duties as may, from time to time; be reasonably requested by the Department Chair, the President of the Medical Staff, or the Executive Committee.

**11.7**      **DEPARTMENT, SECTION, AND COMMITTEE VICE CHAIRS**

**11.7-1** Vice Chairs of the Departments, Vice Chiefs of the Sections and Vice Chairs of Medical Staff Committees shall be elected at the first meeting of each term by the Department, Section, or Committee membership in attendance at the meeting, upon the approval of the Executive Committee. Vice Chairs, Vice Section Chiefs, and Vice Chairs of Committees shall assume all of the responsibilities of the Department Chairs, Section Chiefs, and Committee Chairs in his/her absence.

**11.8**      **CONFLICT OF INTEREST**

**11.8-1**   **CONFLICTS**

Conflicts of interest among the Medical Staff leaders are not completely avoidable since they often indicate broad experience, accomplishments, and diversity. The goals of the Medical Staff are, therefore, to identify and manage interests that could conflict with fulfilling the Medical Staff's responsibilities (e.g. Preamble) and to ensure the integrity of Medical Staff decision-making.

**11.8-2**   **DISCLOSURE**

Elected and appointed Medical Staff leaders, entrusted with fulfilling the Medical Staff's responsibilities and with decision-making authority on behalf of the Medical Staff, shall use good faith to disclose material, financial and personal interests that may potentially lead to a conflict to the Medical Staff as described below. Candidates for elected and appointed Medical Staff leadership positions shall disclose material financial and personal interests with potential for conflicts to the Executive Committee prior to election and appointment.

**11.8-3**   **MEANS**

When relevant to a deliberation or decision on behalf of the Medical Staff (e.g. during a committee meeting), Medical Staff leaders should disclose interests verbally to the relevant Medical Staff body.

**11.8-4**   **CONFIDENTIALITY**

Any documentation of disclosures shall be maintained by Medical Staff Services as privileged and confidential, pursuant to this Medical Staff approved policy and not be accessible or used for other purposes.

**11.8-5**   **ACTION AND DISCLOSURE**

Whether a disclosed interest constitutes a conflict (and, if so, its nature and scope) is determined by the deliberating Medical Staff committee. If a conflict is identified, the committee shall take the least disruptive action to manage the conflict and to preserve (to the extent feasible and appropriate) the leader's ability to carry out his/her leadership responsibilities, for example:

- (a) abstention from voting on the matter to which the conflict arises
- (b) recusal from the decision-making process
- (c) non-receipt of written and/or verbal information related to the matter to

which the conflict relates

**11.8-6 FAILURE TO DISCLOSE/EXECUTIVE COMMITTEE ACTION**

The Executive Committee may take appropriate action when a leader has failed to disclose, abstain or recuse as required by this Policy.

**ARTICLE TWELVE: COMMITTEES**

**12.1 DESIGNATION**

The committees described in this Article shall be the standing committees of the Medical Staff. The President of Staff may appoint other standing committees for specific purposes, the descriptions of which shall be contained in the Medical Staff Rules and Regulations. In addition, special or ad hoc committees may be appointed for specific purposes by the President 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.

**12.2 GENERAL PROVISIONS**

**12.2-1 EX-OFFICIO MEMBERS**

The President of the Medical Staff and the Chief Executive Officer or designees are ex-officio members of all standing and special committees of the Medical Staff.

**12.2-2 SUBCOMMITTEES**

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

**12.2-3 APPOINTMENT OF MEMBERS, CHAIRS, AND VICE CHAIRS**

The Chair of all standing committees shall be members of the Active staff. Chairs of special or ad hoc committees may also be appointed from the Courtesy, Consulting, or Honorary staff. Committee Vice Chairs shall be elected at the first meeting each term by committee members in attendance at the meeting. Committee Vice Chairs shall assume all of the responsibilities of the Chair in his/her absence.

**12.2-4 TERM, REMOVAL, RESIGNATIONS, AND VACANCIES**

- (a) Except as otherwise provided, committee members and Chairs shall be appointed by the President of the Medical Staff for a term of two years which shall coincide with the term of the President of the Medical Staff or until the member's successor is appointed, unless such member or Chair sooner resigns or is removed from the committee.
- (c) Any committee member or Chair may resign at any time by giving written notice to the President of the Medical Staff. Such resignation takes effect on the day of the receipt of the resignation or at any later time specified in the notice.
- (c) A Medical Staff member serving on a committee, except one serving ex-officio, may be removed by the President of the Medical Staff or by action of the Executive Committee. A committee member or Chair removed by the Executive Committee or the President of the Medical Staff shall have the right to an appearance before the Executive Committee to request reconsideration of the removal.

(d) Criteria for consideration for removal of a committee member or committee Chair shall include failure to continue to meet the qualifications for the office, failure to perform the duties required of the position, (i.e., illegal activities), failure to meet attendance requirements, or substantiated allegations as an impaired practitioner in accordance with the Medical Staff Services Policies and Procedures and these Bylaws. Removal of a committee Chair or member shall be effective upon approval by the Board of Directors.

(e) A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment was made.

#### **12.2-5 VOTING RIGHTS**

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

### **12.3 EXECUTIVE COMMITTEE**

#### **12.3-1 COMPOSITION**

The Executive Committee shall consist of:

- (a) President of the Medical Staff, as Chair;
- (b) Vice-President of the Medical Staff, as Vice Chair;
- (c) Immediate-Past-President of the Medical Staff;
- (d) Secretary/Treasurer;
- (e) Nine Members-At-Large of the Active staff, to include one cardiologist, one cardiothoracic surgeon, one emergency medicine physician, one anesthesiologist, one hospitalist, one pulmonologist and two additional Members-At-Large of the Active Staff in any specialty.
- (f) Department Chairs;
- (g) Chief Medical Officer (ex-officio without vote);
- (h) Chief Executive Officer or designee (ex-officio without vote)

The Executive Committee shall not be composed of more than 49% employed physicians.

#### **12.3-2 ELECTIONS, TERMS, VACANCIES, AND REMOVALS**

##### **(a) Elections**

The Medical Staff Officers, except for the initial Officers, shall be elected in the manner prescribed in Section 10.5. Department Chairs shall be selected in the manner prescribed in Section 11.5. At-Large members shall be nominated and elected in the same manner as prescribed for the election of General Staff Officers with the exception of the Emergency Medicine Member-At-Large who shall be appointed by the President of the Medical Staff with ratification by the Executive Committee. The Board shall appoint all Medical Staff Officers and At-Large members for the initial term, to expire December 31, 2001.



**(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 and At-Large members shall serve terms that terminate December 31 in odd-numbered years. Department Chairs shall serve terms that terminate December 31 in even numbered years.

**(c) Removals and Vacancies**

Removals and vacancies of General Staff Officers and Department Chairs shall be handled in the manners prescribed in Section 10.6 and Section 11.5, respectively. At-Large-members may be removed in the manner prescribed for removal of a General Staff Officer. Vacancies among At-Large members shall be filled in the manner prescribed for General Staff Officers.

**12.3-3 DUTIES**

The authority of the Executive Committee is delegated by the Medical Staff and may be limited by amending these Bylaws or removing any or all members of the Executive Committee pursuant to the removal provision set forth in these Bylaws:

The duties and authority of the Executive Committee are to:

- (a)** act on behalf of the organized Medical Staff between Medical Staff meetings, 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 and committees;
- (c)** coordinate and implement the professional and organizational activities and policies of the Medical Staff;
- (d)** make recommendations to the Chief Executive Officer and to the Board on Banner Heart Hospital medico-administrative matters;
- (e)** review the qualifications, credentials, performance, and professional competence and character of Medical and Allied Health Professional Staff applicants and members and make recommendations to the Board regarding such matters;
- (f)** establish processes to promptly address bioethical issues and professional health issues;
- (g)** account to the Board for the quality and efficiency of medical care provided to patients in Banner Heart Hospital, including a summary of specific findings, actions, and results and including an assessment of the quality of services rendered pursuant to contract;
- (h)** take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members;

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- (i) 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 President of the Medical Staff in the appointment of members to such committees;
  - (j) assist in obtaining and maintaining accreditation of Banner Heart Hospital;
  - (k) organize the Medical Staff organization's performance-improvement activities and establish a mechanism designed to conduct, evaluate and revise such activities;
  - (l) determine annual dues and assessments, as may be necessary to carry out the functions of the staff;
  - (m) approve all expenditures from Medical Staff funds on behalf of the General Staff;
  - (n) take reasonable steps to ensure department performance of responsibilities for patient care and safety, performance review and improvement (e.g., supervision of residents/fellows and allied health practitioners, evaluation of resident/fellow rotations, and monitoring of Provisional periods);

#### **12.3-4 MEETINGS**

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

#### **12.3.-5 ATTENDANCE REQUIREMENTS**

All members of the Executive Committee are required to attend or be excused from a minimum of 50% of the Executive Committee meetings. Excused absences shall be approved by the Executive Committee. Member attendance shall be assessed by the Executive Committee at the July and December meetings of the first year of the term, and at the July meeting of the second year of the term. If attendance does not meet the minimum requirement during the previous six months, the President of the Medical Staff shall appoint a replacement with the approval of the Executive Committee.

### **12.4 ALLIED HEALTH PROFESSIONAL COMMITTEE**

#### **12.4.-1 COMPOSITION**

The Allied Health Professional Committee shall consist of a physician Chair appointed by the President of the Medical Staff, at least one other medical staff representative that routinely utilizes AHP's and at least five allied health staff professionals appointed by the President of the Medical Staff. The Committee membership shall be approved by the Executive Committee. Ex-officio members of the committee shall include the Hospital CEO or designee, the Chief Nursing Officer, the Chief Medical Officer, and the Director of Medical Staff Services.

#### **12.4-2 DUTIES**

The duties of the Allied Health Professional Committee shall be to:

- (a) examine the qualifications of each allied health professional applicant to determine whether all qualifications for initial AHP staff membership and reappointment have been met. The committee shall then forward the application to the Medical Staff department Chair in which privileges have been requested. The Allied Health Professional Committee's and department Chair's recommendations shall be forwarded to the Credentials Committee, the Executive Committee, and the Board for final approval;

- (b) review, modify, and make recommendations to appropriate Medical Staff departments regarding revisions to scopes of practice;
- (c) participate in appropriate allied health professional peer review activities, referring recommendations for disciplinary action to the appropriate Medical Staff department;
- (d) develop additional scopes of practice, as necessary, and make recommendation for approval to the appropriate Medical Staff department.

#### **12.4-3 MEETINGS**

The Allied Health Professional Committee shall meet at least quarterly. The date, time, and location of the meetings shall be designated by the committee.

### **12.5 BYLAWS COMMITTEE**

#### **12.5-1 COMPOSITION**

The Bylaws Committee shall consist of the Immediate-Past-President as Chair, at least three members of the Active staff appointed by the President of the Medical Staff and approved by the Executive Committee. Ex-officio members shall include the Hospital CEO or designee and the Director of Medical Staff Services.

#### **12.5-2 DUTIES**

The duties of the Bylaws Committee shall include:

- (a) conducting an annual review of the Medical Staff Bylaws and General Rules and Regulations or a more frequent review when deemed necessary;
- (b) submitting to the Executive Committee, recommendations for changes to the Bylaws and General Rules and Regulations;
- (c) receiving and evaluating, for recommendation to the Executive Committee, suggestions for modifying the Bylaws and General Rules and Regulations.

#### **12.5-3 MEETINGS**

The Bylaws Committee shall meet at least bi-annually. The date, time, and location of the meetings shall be designated by the committee.

### **12.6 CREDENTIALS COMMITTEE**

#### **12.6-1 COMPOSITION**

The Credentials Committee shall consist of the Vice President of the Medical Staff as Chair, another member of the Executive Committee as Vice Chair; and at least two members of the Active staff appointed by the President of the Medical Staff and approved by the Executive Committee. Ex-officio members of the Credentials Committee shall include the Hospital CEO or designee, the Chief Medical Officer, and the Director of Medical Staff Services.

#### **12.6-2 DUTIES**

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

#### **12.6-3 MEETINGS**

The Credentials Committee shall meet at least ten times annually. The date, time, and location of the meetings shall be designated by the committee.

## **12.7 ENDOVASCULAR COMMITTEE**

### **12.7-1 COMPOSITION**

The Endovascular Committee shall consist of a Chair who shall be a member of the Active Staff and at least five members of the Active Medical Staff. The membership shall be appointed by the President of the Medical Staff for a two year term and shall be approved by the Executive Committee. Ex-officio members of the Committee shall include the Hospital CEO or designee, the Chief Medical Officer, and the Director of Medical Staff Services.

### **12.7-2 DUTIES**

The Endovascular Committee shall be responsible for developing appropriate endovascular privileging criteria and forwarding these criteria to the Departments of Medicine and Surgery, the Executive Committee and the Banner Health Board for approval. As new areas of endovascular procedures develop, the Endovascular Committee shall meet and recommend appropriate privileging criteria in a timely fashion. The Committee's duties shall include review and comment of the potential appropriate safety and efficacy of new endovascular devices as necessary to provide and promote the well-being and safety of patients undergoing these procedures. Recommended privileging criteria shall be forwarded to the appropriate Medical Staff Department, the Credentials and Executive Committees and the Banner Board, for approval.

### **12.7-3 MEETINGS**

The Endovascular Committee shall meet as necessary. The date, time, and location of the meetings shall be designated by the Committee.

## **12.8 ETHICS COMMITTEE**

### **12.8-1 COMPOSITION**

The Ethics Committee shall be composed of a Chair who shall be a member of the Active Medical Staff and at least three members of the Active Staff, a representative of Risk Management, a representative of Pastoral Care, a community member, a hospital volunteer, a representative of Social Services, the Hospital CEO or designee, the Chief Medical Officer, a representative of CVICU nursing, and two representatives from hospital ancillary services (i.e., Cardiopulmonary Services, Cardiac Rehabilitation Services). The Ethics Committee membership shall be approved by the Executive Committee. Resource individuals may be requested to participate in the Committee's deliberations without becoming members of the Committee. The Ethics Committee shall report directly to the Executive Committee.

### **12.8-2 DUTIES**

The Ethics Committee shall:

- (a) develop information and tools to clarify ethical issues to aid in the decision-making processes;
- (b) utilize any medico-legal and/or ethics authorities for the benefit of the Committee or for the dissemination of information to any involved group of professional and/or lay individuals;
- (c) make known the existence of the Committee and its availability for augmenting the education of the Medical Staff, nursing, and other hospital staff;

- (d) develop guidelines for the Committee or for any Subcommittees;
- (e) provide consultation for individual cases, when requested;
- (e) ensure that consultations are consistent with Federal and State requirements;
- (g) do not infringe on the physician's authority in dealing with the patient and the patient's responsible party.

### **12.8-3 MEETINGS**

The Ethics Committee shall meet annually and as necessary. The date, time, and location of the meetings shall be designated by the Committee.

## **12.9 NEW TECHNOLOGY COMMITTEE**

### **12.9-1 COMPOSITION**

The Chair of the New Technology Committee shall be appointed by the President of the Medical Staff and approved by the Executive Committee. The Committee shall consist of at least 3 members of the Medical Staff appointed by the President of the Medical Staff. Facility representatives should include the CEO or designee, CNO, CMO and appropriate nursing and/or other facility representation.

### **12.9-2 DUTIES**

The New Technology Committee shall:

- (a) review the completed request form and consider new technologies and procedures to determine whether privileges to use such technologies or perform such procedures require additional education, training and/or experience and demonstrated competence;
- (b) make recommendations to the Medical Staff and facility.

## **12.10 PRACTITIONER HEALTH COMMITTEE**

### **12.10-1 COMPOSITION**

The Practitioner Health Committee shall consist of a Chair who shall be a member of the Active Medical Staff, at least two members of the Active Medical Staff, and an Allied Health Professional. The membership shall be appointed by the President of the Medical Staff and approved by the Executive Committee. Whenever possible, at least one member of the Committee shall be a practitioner who is in recovery from alcohol or chemical dependency. Those who have recovered from emotional or physical impairment shall also be considered for membership. Ex-officio members of the committee shall include the Hospital CEO or designee, the Chief Medical Officer, and the Director of Medical Staff Services.

### **12.10-2 DUTIES**

(a) The duties of the Practitioner Health Committee shall include:

- 1) safeguarding patients;
- 2) providing ongoing education to the medical and AHP staffs and administrative leadership on physician and AHP health and impairment recognition issues; on the different kinds and levels of impairment, and on resources available for the diagnosis, prevention, treatment, and rehabilitation of impairment;

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- 3) recommending available resources for diagnosis and/or treatment of physicians and AHPs experiencing possible illness and impairment issues;
  - 4) serving as a resource for physicians and AHPs experiencing illness and impairment issues;
  - 5) assisting the medical and AHP staffs in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
  - 6) assisting the Medical Staff leadership with an intervention when so requested by a department Chair or President of the Medical Staff or designee.

(b) The Committee will not have any disciplinary authority, but shall have the responsibility for:

- 1) recommending to the affected practitioner that either a psychological, psychiatric, and/or physical examination be obtained;
- 2) ensuring the recommendations of the committee are being followed;
- 3) requiring the affected practitioner to obtain a report from his/her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine, and obtain subsequent periodic reports from his/her treating physician/psychologist for a period of time specified by the Practitioner Health Committee or appropriate department Chair;
- 4) advising the appropriate Department Chair/Executive Committee of the affected practitioner's failure to adhere with the recommendations.

If the Committee does not feel that the recommendations are being followed, the Committee Chair shall notify the practitioner's Department Chair and the Chief Executive Officer for consideration of appropriate corrective action in accordance with article 6. "Corrective Action", as set forth in the Medical Staff Bylaws.

### **12.10-3 MEETINGS**

Meetings of the Practitioner Health Committee shall be called and held as needed. The date, time, and location of the meetings shall be designated by the Chair.

## **12.11 PROFESSIONAL CONDUCT COMMITTEE**

### **12.11-1 COMPOSITION**

The Professional Conduct Committee shall consist of the President of the Medical Staff as Chair, the Vice-President of the Medical Staff as Vice Chair, the Chairs of the Departments of Medicine and Surgery. Ex-officio members shall include the Hospital CEO or designee and the Director of Medical Staff Services.

### **12.11-2 DUTIES**

The duties of the Professional Conduct Committee shall include:

- (a) development of appropriate policies and procedures describing the process for intervention by Medical Staff officers in critical situations unable to be resolved by hospital staff and for initiating and processing complaint forms;

- (b) prompt review of all Complaint Form Cs by the committee;
- (c) ensuring appropriate investigation of all complaints;
- (d) resolving the issues prompting the complaint by making appropriate recommendations for disciplinary actions, as needed, to the Executive Committee.

#### **12.11-3 MEETINGS**

The Professional Conduct Committee shall meet as necessary. The date, time, and location of the Meetings shall be designated by the committee.

### **12.12 UTILIZATION MANAGEMENT COMMITTEE**

#### **12.11-1 COMPOSITION**

Co-Chairs of the Utilization Management Committee shall be a Non-Interventional Cardiologist and the Director of Case Management. Physician membership shall include the Chair and at least one hospitalist, one vascular surgeon, one cardiothoracic surgeon and one interventional cardiologist. Required ex-officio participation shall include the Chief Nursing Officer, the Director of HIMs, the Director of Quality Management, the Chief Medical Officer and representatives of Finance, Cardiac Cath Lab and CVOR. All physician members shall be appointed by the President of the Medical Staff.

#### **12.12-2 DUTIES**

The Utilization Management Committee primarily reviews the appropriateness of initiative work. Other recommended data includes admissions, level of care, continued stays, procedures, testing and treatment, discharges and transfers. Data elements to review include avoidable days, reimbursement, denial of payments and readmissions. Trends will be reviewed. Physician and patient information will be identified by numbers unless there is a need to know for the purpose of performance improvement. This Committee reports to the Executive Committee.

#### **12.12-3 MEETINGS**

Meetings will be held at least quarterly. The meeting date, time and place will be determined by Committee members.

## **ARTICLE THIRTEEN: MEETINGS**

### **13.1 MEDICAL STAFF MEETINGS**

#### **13.1-1 REGULAR MEETINGS**

General Staff meetings will be held as needed.

#### **13.1-2 SPECIAL MEETINGS**

A special meeting of the Medical Staff may be called by the President of the Medical Staff, the Executive Committee, or the Banner Health Board. The President of the Medical Staff will call for such a meeting upon petition by any ten members of the Active staff.

### **13.2 CLINICAL DEPARTMENT, SECTION, AND COMMITTEE MEETINGS**

#### **13.2-1 REGULAR MEETINGS**

Clinical departments, sections, and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. A department or its sections, individually or in combination, shall meet at least six times per year.

**13.2-2 SPECIAL MEETINGS**

A special meeting of any department, section, or committee may be called by the Chair or Chief thereof, and shall be called by the Chair or Chief at the written request of the President of the Medical Staff, or the Executive Committee. A notice of such special meeting shall be sent to all members of the department, section, or committee.

**13.2-3 EXECUTIVE SESSION**

Any department, section, 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 shall be kept of any executive session.

**13.3 ATTENDANCE REQUIREMENTS**

**13.3-1 GENERALLY**

In addition to satisfying the special appearance requirements of Section 13.3, each member of the Active staff is encouraged to attend the Annual and General Staff meetings, meetings of his or her department or section, and meetings of committees on which he or she serves, unless excused. Other staff members who serve on committees have these same attendance requirements for the committees to which they have been appointed. To maintain Active status, staff members are encouraged to attend the annual General Staff meeting and are encouraged to attend their department meetings unless a more stringent department meeting attendance requirement has been established by the department.

**13.3-2 SPECIAL APPEARANCE OR CONFERENCES**

- (a) A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the department, section, or committee to present the case. If the practitioner has been so notified, his or her attendance shall be mandatory at the meeting at which the case is to be discussed.
- (b) Whenever a department or section perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified by the department Chair 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 summary suspension or other initiation of corrective action proceedings.
- (c) Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance, the President of the Medical Staff, the applicable department Chair, or section Chief may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner shall be notified of the date, time, and place of the conference, and the reasons therefore. Failure of a practitioner to appear at any such meeting may result in summary suspension or the initiation of corrective action proceedings.

**13.4 QUORUM**



**13.4-1 GENERAL STAFF MEETINGS**

The presence of three physicians, with voting privileges, shall constitute a quorum at all General Staff meetings.

**13.4-2 COMMITTEE MEETINGS**

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

**13.4-3 DEPARTMENT MEETINGS**

The presence of three voting members of the department shall constitute a quorum at Department of Medicine or Department of Surgery meetings.

**13.5 ALTERNATIVE MECHANISIMS TO CONDUCT MEDICAL STAFF BUSINESS**

General Staff, Department, Section and Committee meetings may be held in alternative forums, including telephonically. Medical Staff members may be advised of Medical Staff business, asked to vote or requested to provide input through mail, facsimile, email, or other electronic communication.

**ARTICLE FOURTEEN: CONFIDENTIALITY, IMMUNITY AND RELEASES**

**14.1 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 Banner Heart Hospital, a practitioner:

- (a) authorizes Banner Heart Hospital 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 Banner Heart Hospital;
- (d) agrees to release from legal liability and hold harmless Banner Heart Hospital, the Medical Staff, Medical Staff committees and all persons engaged in peer review activities, which include but are not limited to those activities identified in Article 14.3 of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws or any applicable federal or state statute or regulation; agrees that his/her sole remedy for any corrective action taken or recommended by the Medical Staff, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review action shall be the right to seek injunctive relief pursuant to 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 Banner Heart Hospital or its representatives,
- (f) authorizes the release of information about the practitioner to other Banner Health facilities where the practitioner has or requests membership or privileges.

#### **14.2 CONFIDENTIALITY OF INFORMATION**

Appropriate confidentiality shall be maintained pursuant to the Banner Health "Confidentiality" policy and procedure. Information obtained or prepared 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.

#### **14.3 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 hospitals or organizations 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) risk management activities;
- (j) other hospital, committee, department, section, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

#### **14.4 RELEASES**

Each practitioner shall, upon request of Banner Heart Hospital, execute general and specific releases in accordance with the tenor and import of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases 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 upon request during a term of appointment to the staff shall result in automatic suspension-as provided in Section 8.6-8.

#### **14.5 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 FIFTEEN: GENERAL PROVISIONS**

### **15.1 CONFLICT RESOLUTION**

#### **15.1-1 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 20% of the members of the Active Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

#### **15.1-2 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 the Board approval as required. The Executive Committee will communicate all changes to the Medical Staff.

#### **15.1-3 Conflict Resolution Resources and Board Responsibility**

A recommendation to use other 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.

### **15.2 HISTORIES AND PHYSICALS**

A history and physical examination (H&P) in all cases shall be completed by a physician or allied health professional that is approved by the medical staff to perform admission H&P examinations and placed in the patient's medical record within 24 hours after admission or registration for all inpatients and observation patients. The completed H&P must be on the medical record prior to surgery or invasive procedure or any procedure in which anesthesia or conscious sedation will be administered or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient. A new H&P is required to be completed for all patients admitted or transferred to a rehabilitation unit. A legible office H&P performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. The content of a completed H&P is delineated in the General Rules and Regulations.

### **15.3 STAFF DUES**

Each January, the Executive Committee shall establish the amount of annual Medical Staff and Allied Health Professional Staff dues and will give notice of dues to the staff. Dues are payable on or before March 31<sup>st</sup> of each year. If dues are not paid by April 1<sup>st</sup>, a special notice of delinquency shall be sent to the practitioner and an additional thirty days given in which to make payment. All new staff member shall be billed on a pro-rate basis and given thirty days in which to make payment for the current year upon their appointment to the staff. Failure to render payment of annual or pro-rated dues shall result in automatic suspension as provided in Section 8.6-7. 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 Executive Committee may exempt certain practitioners from paying dues and assessments. Executive Committee members and underserved specialties, as defined annually by the Executive Committee, are not required to pay medical staff dues.

**15.4 SPECIAL NOTICE**

When special notice is required, the Medical Staff Services Department shall send such notice by hand-delivery or certified mail to the address provided by the practitioner or by email or 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 or if the hand-delivery is refused, the Medical Staff Services Department 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.

**15.5 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.

**15.6 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 that they are not inconsistent with these Bylaws, and any special rules of order the Medical Staff may adopt.

**ARTICLE SIXTEEN: ALLIED HEALTH PROFESSIONALS**

**16.1 ALLIED HEALTH PROFESSIONALS**

Allied health professionals (AHPs) are individuals who, though not members of the Medical Staff:

- (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.

**16.2 CATEGORIES OF AHPs CURRENTLY CREDENTIALLED BY THE MEDICAL STAFF AND AUTHORIZED TO FUNCTION IN BANNER HEART HOSPITAL**

- (a) The following are the only categories of AHPs currently authorized to provide services at Banner Heart Hospital:

Clinical Perfusionists, Nurse Practitioners, Physician's Assistants, Registered Nurse First Assistants, Certified First Assistants, and Private Scrubs.

- (b) The Executive Committee may recommend for Board approval other categories of AHPs to be given authorization to provide services in Banner Heart Hospital. Such categories may be authorized by the Executive Committee and the Board without amendment of these Bylaws.

**16.3 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS**

A statement of qualifications, contained in the scope of practice, for each category of allied health professional shall be developed by the department to which the AHP would be assigned, subject to approval by the Executive Committee and the Board. Each statement shall:

- (a) be developed with input, as applicable, from the physician director of the clinical unit or service involved if any, the physician supervisor of the AHP, and other representatives of the Medical Staff, Banner Heart Hospital management, and other professional staff;

- (b) require the individual AHP to hold a current license, certificate, or such other credential, if any, as may be required by state law, and
- (c) satisfy the qualifications as are set forth for Medical Staff appointment, including appropriate professional liability insurance coverage.

#### **16.4 PREROGATIVES OF ALLIED HEALTH PROFESSIONALS**

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 Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the AHPs practice in Banner Heart Hospital, and other applicable Medical Staff or Banner Heart Hospital policies;
- (b) serve on committees when so appointed;
- (c) attend open meetings of the staff or the department;
- (d) exercise such other prerogatives as the Executive Committee with the approval of the Board may accord AHPs in general or to a specific category of AHPs.

#### **16.5 OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS**

Each AHP shall:

- (a) meet the basic responsibilities required by Section 3.2 (a-g) for Medical Staff members;
- (b) retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in Banner Heart Hospital for whom services are provided;
- (c) participate in quality review program activities and in discharging such other functions as may be required from time to time;
- (d) attend meetings of the staff, the department, and the section, as appropriate;
- (e) fulfill the applicable attendance requirements of these Bylaws and the Rules and Regulations of the department to which assigned;
- (f) refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of practice authorized by the Board.

#### **16.6 TERMS AND CONDITIONS OF AFFILIATION**

An AHP shall be individually assigned to the clinical department appropriate to his or her professional training and subject to an initial provisional period, formal periodic reviews, and disciplinary procedures as determined for the category. An AHP is not entitled to the procedural hearing rights provided in the Fair Hearing Plan.

#### **16.7 DEFINITION OF SCOPE OF SERVICE**

##### **16.7-1 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 shall include at least:

- (a) specifications of categories of patients to who services may be provided;
- (b) 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;
- (c) 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.

**16.8 PROCEDURE FOR CREDENTIALING, PERIODIC REVIEW AND DISCIPLINARY ACTIONS**

The procedures for processing individual applications from AHPs, for reviewing performance during the provisional period and for periodic reappraisal are outlined in Section 5 through 5.10.

**16.9 AHP PROCEDURE FOR ADVERSE ACTION REVIEW AND APPELLATE PROCESS**

- 16.9-1** Allied Health Professionals who are subject to adverse action, other than non-reviewable action as defined in the Medical Staff Bylaws, shall be afforded an adverse action review and appeal process in accordance with these Bylaws provisions. Adverse action includes: denial of a request to provide any patient care services within the appropriate scope of practice, or revocation, suspension, reduction, limitation, or termination of permission to provide any patient care services within the appropriate scope of practice.
- 16.9-2** AHPs are not entitled to due process rights as set forth in the Medical Staff Bylaws and none of the procedural rules set forth therein apply.
- 16.9-3** AHPs whose applications are not processed because of their failure to meet the qualifications to provide patient care services are not entitled to due process rights.
- 16.9-4** Within fifteen days after adverse action is taken against an AHP, the AHP shall be notified in writing of the specific reasons for the adverse action and the AHP's rights per these Bylaws provisions.
- 16.9-5** The AHP may request an adverse action review following the procedures set forth in these Bylaws. If the AHP does not deliver a written request for an adverse action review to the Chief Executive Officer within ten days following the AHP's notice of the adverse action, the adverse action shall be final and non-appealable.
- 16.9-6** At least three members of the department to which the AHP is assigned, a member of the AHP Committee (peer), and the Chief Nursing Officer shall consider the request and serve as the review committee.
- 16.9-7** The AHP shall be given ten days prior written notice of the time, place, and date of the adverse action review, names of the Medical Staff representatives, and a list of witnesses, if any that will be called to support the adverse action. The Medical Staff representative is the individual representing the Hospital or Medical Staff in the adverse action review and appellate process.

- 16.9-8** The Medical Staff representative and the AHP shall be entitled to submit a written statement in support of and/or to introduce all relevant documentation by supplying two copies of the statement and/or documentation to the Medical Staff Services Department at least five days prior to the review. The Medical Staff Services Department shall distribute a copy of the statement and/or documentation to the other party and to the members of the review committee at least three days prior to the hearing.
- 16.9-9** During the adverse action review, the parties shall be given an opportunity to present relevant evidence, call witnesses, and make arguments in support of their positions. Neither the AHP nor the Medical Staff representative shall be entitled to legal counsel at the adverse action review or appellate review.
- 16.9-10** 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.
- 16.9-11** Upon completion of the review, the review committee shall consider the information and evidence presented make a recommendation, which shall include the basis thereof, and forward it to the President of the Medical Staff. The AHP and the Medical Staff representative shall be provided with a copy of the committee's recommendation.
- 16.9-12** If the AHP believes that there has been a deviation from the procedures required by this adverse action plan or applicable law, the AHP shall promptly notify the President of the Medical Staff of such deviation, including the adverse action review plan or applicable law citation. If the President of the Medical Staff agrees that a deviation has occurred, is substantial, and has created demonstrable prejudice, he/she shall correct such deviation.
- 16.9-13** If either party is dissatisfied with the committee's recommendation, such party may submit a written request for an appellate review, provided that the Chief Executive Officer receives such request within ten days following the AHP's receipt of the committee's recommendation. The request shall identify the grounds for appeal and shall 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 Bylaws 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 in a timely fashion, the committee's recommendation shall become final and non-appealable.
- 16.9-14** Upon a proper and timely request for an appellate review, the AHP shall be given an interview with the Executive Committee or a subcommittee thereof, consisting of at least three members. The AHP shall be given at least five 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.
- 16.9-15** The Executive Committee shall make a final determination on the adverse action which shall be provided to both parties. The decision of the Executive committee shall not be subject to further appeal. The final decision shall be submitted to the Medical Staff Subcommittee of the Board.

## **16.10 AUTOMATIC SUSPENSION OR LIMITATION**

Automatic suspension shall be immediately imposed under the conditions contained in this Section. Affected practitioners may request reinstatement during a period of ninety days following suspension upon presentation of the required documentation. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and shall reapply for staff membership and privileges. In addition, further corrective action may be recommended in accordance with the provisions contain in these Bylaws, whenever any of the following actions occur:

**(a) LICENSE**

Whenever an AHP's license or certification is revoked, restricted, or suspended, the AHP's scope of practice is similarly revoked, restricted, or suspended.

**(b) CONTROLLED SUBSTANCES REGISTRATION**

Whenever an AHP's DEA or other controlled substances registration is revoked, restricted, or suspended, the AHP's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

**(c) PROFESSIONAL LIABILITY INSURANCE**

An AHP's staff appointment shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Board. Affected AHPs may request reinstatement during a period of ninety calendar days following suspension, upon presentation of documentation of adequate insurance. Thereafter, such AHPs shall be deemed to have voluntarily resigned from the staff and shall reapply for membership.

**(d) EXCLUSION FROM MEDICARE/STATE PROGRAMS**

The Chief Executive Officer, with notice to the President of the Medical Staff, shall immediately and automatically suspend an excluded AHP. An "excluded practitioner" is a practitioner whose name is listed on the current "listing of excluded individuals/entities" maintained by the Office of the Inspector General (OIG), Department of Health and Human Services (DHHS), 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 Services, or Champus program.

**(e) FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT**

An AHP who fails, without good cause, to appear at a meeting where his/her special appearance is required, shall automatically be suspended.

**(f) FAILURE TO PAY STAFF DUES AND/OR ASSESSMENTS**

An AHP who fails to pay staff dues and/or assessments shall automatically be suspended from the AHP staff. If the dues are paid within thirty calendar days of notification of suspension, the AHP shall be re-instated. Thereafter, such AHP shall be deemed to have resigned voluntarily from the AHP Staff and shall reapply for staff membership.

**(g) FAILURE TO EXECUTE RELEASES AND/OR PROVIDE DOCUMENTS**

An AHP who fails to execute a general or special release and/or provide documents during a term of appointment when requested by the President of the Medical Staff, department Chair, section Chief, or designee shall automatically be suspended. If the release is executed and/or documents provided within thirty calendar days of the notice of suspension, the AHP shall be reinstated. Thereafter, such AHP shall be deemed to have resigned voluntarily



from the staff and shall reapply for staff membership.

**16.11 NONREVIEWABLE ACTIONS**

Not every action entitles the AHP to rights pursuant to the AHP procedure for adverse action review and appellate process. Those types of corrective action giving rise to automatic suspension as set forth in this section are not reviewable under the Fair Hearing Plan. In addition, the following occurrences are also non-reviewable under the Fair Hearing Plan:

- (a) imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights;
- (b) issuance of a warning or letter of admonition or reprimand;
- (c) imposition of monitoring of professional practices, other than direct supervision, for a period of six months or less;
- (d) termination or limitation of temporary privileges;
- (e) any recommendation voluntarily imposed or accepted by a practitioner;
- (f) denial of membership for failure to complete an application for membership and privileges;
- (g) removal of membership and privileges for failure to submit an application for reappointment within the allowable time period;
- (h) any requirement to complete an educational assessment or training program;
- (i) imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights;
- (j) any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by a designated or approved healthcare professional;
- (k) retrospective chart review;
- (l) removal of privileges for lack of a sponsoring physician;
  
- (m) denial or removal of membership and/or privileges as a result of the decision of the hospital to enter into, terminate, or modify an exclusive contract for certain clinical services or the termination or modification of the practitioner's relationship with the exclusive provider.

**ARTICLE SEVENTEEN: ADOPTION AND AMENDMENT**

**17.1 ADOPTION AND AMENDMENT**

**17.1-1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

The Medical Staff shall be responsible for the development, adoption, and at least annual review of these Bylaws which shall be consistent with the Banner Health Bylaws, the Banner Heart Hospital policies and procedures, and applicable laws.

The Medical Staff shall also be responsible for the development, adoption, and at least annual review of the general rules and regulations which shall also be consistent with Banner Health Bylaws, the Medical Staff Bylaws, the Banner Heart Hospital policies and procedures, and applicable laws. The General Rules and Regulations of the Medical Staff are adopted by the Executive Committee and shall be amended as required under the Medical Staff action specified below.

**17.2 PERIODIC BYLAWS REVIEW**

The Bylaws shall be reviewed and revised as needed, but must be reviewed at least annually. When necessary, the Bylaws will be reviewed to reflect current practices with respect to medical staff organization and functions. Reviews shall also be conducted upon request of the Board.

**17.3 ADOPTION AND AMENDMENT**

The Bylaws of the Medical Staff are adopted by the Executive Committee, the Active Medical Staff and approved by the Board prior to becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws. The Bylaws Committee shall distribute by mail or email proposed changes to the Medical Staff Bylaws to the Active Staff along with a ballot and its recommendations regarding the changes. A favorable vote of a majority of those voting is required on each proposed amendment. The ballots shall be returned within 14 days at which time they shall be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

Further, neither body may take any action which would affect the rights and obligations of the Medical Staff nor the Board under the Bylaws, except the Board may do so in order to assure compliance with state and federal laws. The action described in the preceding sentence shall be taken only after consideration of the proposed amendment by an Ad Hoc Committee appointed by the Board with equal representation from both the Medical Staff and the Board and administration.

**17.4 MEDICAL STAFF PROCESS**

The Medical Staff may propose Bylaws or amendments thereto 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. The Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposed language, the members of the Medical Staff who proposed the challenge can decide to accept such language or whether to recommend its language directly to the Medical Staff for a vote. 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 on the Hospital website. The ballots must be returned within 14 days after their distribution 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

**17.5 BOARD ACTION**

**17.5-1 WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION**

When approved by the Board, the Medical Staff recommendations regarding proposed Bylaws and General Rules and Regulations, or amendments thereto shall be effective upon the affirmative vote of the Board.

**17.5-2 BOARD CONCERNS**

In the event the Board has concerns regarding any provision or provisions of the proposed Bylaws or General Rules and Regulations, or amendments thereto, the Board and Medical Staff shall establish a Joint Conference Committee comprised of three representatives of each body to resolve such concerns.

#### **17.6 TECHNICAL AND EDITORIAL AMENDMENTS**

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

#### **17.7 GENERAL RULES AND REGULATIONS**

##### **17.7-1 PERIODIC REVIEW**

Subject to approval by the Board, the Executive Committee shall adopt such Medical Staff General Rules and Regulations as may be necessary to define the responsibilities of members to provide medical services to their patients. Such rules and regulations shall be consistent with these Bylaws and Banner Heart Hospital policies. The Executive Committee may act for the staff in adopting or amending them. A copy shall be sent to all members of the Medical and Allied Health Professional Staffs' or shall be available on the Hospital website. The General Rules and Regulation shall be reviewed at least every two years and shall be revised as needed. Review of the General Rules and Regulations shall also be conducted upon request of the Banner Board.

##### **17.7-2 COMMUNICATION TO THE MEDICAL STAFF**

###### **a) Routine Matters**

Absent a documented need for urgent action, before acting, the Executive Committee will communicate to Staff by email proposed changes to the Medical Staff 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 to 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 20% of the Active Staff oppose the amendment, the Executive Committee will utilize the conflict resolution process set forth in Section 15. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

##### **17.7-3 General Rules and Regulations Amendments**

The Medical Staff may propose amendments to the Medical Staff 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. 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 accept the language as revised or recommend its language directly to the Board. The Executive Committee will submit the proposed amendment to the Board along with its recommendation.

**17.8 DEPARTMENT RULES AND REGULATIONS**

Each department and section shall formulate written rules and regulations for the conduct of its affairs and the discharge of its responsibilities, all or which shall be consistent with the Bylaws, General Rules and Regulations, and Banner Heart Hospital Policies and Procedures. Upon the recommendation of the department/section, the department/section Rules and Regulations and any revisions thereto shall be approved by the Executive Committee and the Board. The Executive Committee may act for the Staff in adopting or amending the department/section Rules and Regulations. A copy of the appropriate Department Rules and Regulations shall be sent to all members of the Medical and Allied Health Professional Staffs or shall be available on the Hospital website. Department Rules and Regulations shall be reviewed at least every two (years and shall be revised as needed. Review of Department Rules and Regulations shall also be conducted upon request of the Board.

**ADOPTION AND APPROVAL**

Approved by Banner Heart Hospital Active Medical Staff July 12, 2013

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Darryl Stein, MD, President, Medical Staff  
BANNER HEART HOSPITAL

Approved and adopted by the Banner Health Board of Directors: September 19, 2013

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David Bixby, Vice President and General Counsel  
BANNER HEALTH BOARD