Banner Health®

Ocotillo Medical Center

MEDICAL STAFF BYLAWS

BANNER OCOTILLO MEDICAL CENTER

Chandler, Arizona

BYLAWS OF THE MEDICAL STAFF

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PREAMBLE

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

ARTICLE ONE: NAME

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

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 PURPOSES

The purposes of this Medical Staff are:

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

2.1-2 To continually seek to provide quality and efficient care for all patients admitted to, or treated in, any facilities, departments, or service of the Hospital.

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

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

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

2.1-6 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Medical Center and through which they fulfill the obligations of staff appointment.

2.1-7 To provide an orderly and systematic means by which staff members can give input to the Banner Board and CEO on medical administrative issues and on Medical Center policy-making and planning processes. The CEO or their designee is defined as the individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital.

2.2 RESPONSIBILITIES

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

2.2-1 To participate in the performance improvement, patient safety, education of patients and families and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided in the Medical Center, including:

a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria and taking action to reduce morbidity and mortality;
b) Engaging in the ongoing monitoring of patient care practices;
c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and
d) Promoting the appropriate use of Medical Center resources; and
e) Complying with the Banner Care Management initiatives and clinical practices as well as Banner Health strategic and long-term initiatives.

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

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

2.2-4 To review and recommend Bylaws and policies that are consistent with sound professional practices, and to enforce compliance with them.

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

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

2.2-7 To take action, as necessary to enforce the Medical Staff Bylaws, rules and regulations, and policies.

ARTICLE THREE: MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

Every physician, advanced practice professional or other practitioner who seeks or holds staff membership must, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Banner Board, the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws or in department rules and regulations:

3.1-1 **ELIGIBLE HEALTH CARE PROVIDERS**

Medical Doctors (MD)
Osteopathic Medicine (DO)
Dentists
Oral Surgeons
Doctors of Podiatry
Psychologists
Advanced Practice Registered Nurses (APRNs)
- Certified Registered Nurse Anesthetists
- Certified Nurse Midwives
- Nurse Practitioners

Physician Assistants

3.1-2 **LICENSURE**

Evidence of a currently valid license issued by the State of Arizona to practice his/her profession.

3.1-3 **PROFESSIONAL EDUCATION AND TRAINING**

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

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

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

c) Advanced Practice Professionals. Advanced Practice Professionals must have successfully completed a training program required for licensure or certification, or an equivalent program approved by the Medical Executive Committee and the Governing Body.

3.1-4 **BOARD CERTIFICATION**

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

   For purposes of this section, "Board certification" or "Board certified" means is certified and/or shows active participation in the Maintenance of Certification (MOC) program, if applicable by a board approved by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists or by a board determined by the department to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the applicant has completed the training necessary to be accepted to become/applied for and been accepted to become an active candidate for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed qualified during this time period if the director of his/her training program certifies that he/she has met all training requirements for qualification by the appropriate board.

b) Exceptions to board eligibility/certification/recertification may be granted in the following circumstances:
   i. Where a particular field or specialty of the department does not have a Board certification;
   ii. Where the applicant's privileges are limited to surgical assisting or referring only:
   iii. To applicants/members where there is a shortage of qualified Medical Staff members in the practitioner's specialty necessary to meet the Medical Center's demand for services where the Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board certification.

(c) Members are required to remain board certified. Recertification must be obtained within three years from the expiration of Board certification or recertification. Failure to become recertified within the time allowed under these Bylaws shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

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

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

(e) Advanced Practice Professionals. Advanced Practice Professionals must have successfully obtained certification from the appropriate professional organization, as applicable.

3.1-5 **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.

3.1-6 **COOPERATIVENESS**

Demonstrated ability and willingness to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care and patient and employee satisfaction. It is the policy of Banner Ocotillo Medical Center and this Medical Staff, that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, all Medical Staff members, and other practitioners must conduct themselves in a professional and cooperative manner. Failure to do so may constitute disruptive behavior. Disruptive behavior by any practitioner against any individual (e.g., against another Medical Staff member, house staff, hospital employee or patient) shall not be tolerated. If a practitioner fails to conduct himself/herself appropriately, corrective action may be taken.

3.1-7 **TEAMWORK**

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

3.1-8 **SATISFACTION OF MEMBERSHIP OBLIGATIONS**

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

3.1-9 **SATISFACTION OF CRITERIA FOR PRIVILEGES**

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

3.1-10 **PROFESSIONAL ETHICS AND CONDUCT**

Demonstrated high moral character and adherence to generally recognized standards of medical and professional ethics which include refraining from: paying or accepting commissions or referral fees for professional services; delegating the responsibility for diagnosis or care to a practitioner or allied health professional not qualified to undertake that responsibility; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and failing to obtain appropriate informed patient consent for treatment.

3.1-11 **PARTICIPATION IN GOVERNMENT PROGRAMS**

Ability to participate in Medicare/AHCCCS and other federally funded health programs.

3.1-12 **HEALTH STATUS**

Freedom from or adequate control of any significant physical or mental health impairment and freedom from abuse of any type of substance or chemical that may affect cognitive, motor, or communication ability in a manner that interferes with the ability to provide quality patient care or the other qualifications for membership, and freedom from infectious tuberculosis.

3.1-13 **VERBAL AND WRITTEN COMMUNICATION SKILLS**

Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-14 **PROFESSIONAL LIABILITY INSURANCE**

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

3.1-15 **EFFECTS OF OTHER AFFILIATIONS**

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

a) Licensure to practice;
b) Completion of a postgraduate training program at any Banner facility;
c) Certification by any clinical board;
d) Membership on a medical school faculty;
e) Staff appointment or privileges at another health care facility or in another practice setting; or
f) Prior staff appointment or any particular privileges at Medical Center.

3.1-16 **NONDISCRIMINATION**

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

3.1-17 **FELONY CHARGES**

A practitioner must never have been convicted of, or entered a plea of guilty to or a plea of no contest to any felony related to the practice of medicine.

3.1-18 **EXEMPTIONS FROM QUALIFICATIONS**

Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the Emeritus as otherwise provided in these Bylaws.

3.2 RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP

Each staff member, regardless of assigned staff category, shall have the following rights:

a) The right to meet with the Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department chairman. The member must submit written notice to the Chief of Staff at least two weeks in advance of the regular meeting;
b) The right to request a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;

c) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken.
d) The right to request review by the Executive Committee in the event that non-reviewable corrective action is taken.
e) The right to request that the Executive Committee request a Joint Conference Committee meeting with the Banner Board to resolve concerns regarding medical staff bylaws, credentialing recommendations, policies or other issues which such medical staff has been unable to resolve through informal processes with the CEO, senior management, the Medical Staff Subcommittee, the Care Management and Quality Committee, or the Banner Board of Directors

3.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

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

a) Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate;
b) Abide by the Banner Health Bylaws and Code of Conduct, these Bylaws, department rules and regulations, and all other standards and policies of Banner, the Medical Staff and Medical Center;
c) Participate such staff, committee, department, and Medical Center functions for which he or she is responsible, including review and supervise the performance of other practitioners;
d) Prepare and complete in timely fashion, according to these Bylaws, the rules and regulations and other Medical Center policies, the medical and other required records for all patients in the Medical Center, or within its facilities, services, or departments to whom he or she provides care.
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 and complete all required continuing education programs;
g) Use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and Banner Health's business information designated as confidential by Banner Health or its representatives prior to disclosure;
h) Refrain from disclosing confidential information to anyone unless authorized to do so;
i) Protect access codes and computer passwords and to ensure confidential information is not disclosed;
j) Disclose to the Medical Staff and CEO any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or the Medical Center;
k) Refrain from making treatment recommendation/decisions for economic benefit of the practitioner and unrelated to needs of the patient;
l) Comply with all applicable state and federal law in disclosing to a patient any direct financial interest that the practitioner, his/her group or his/her employer has in a separate diagnostic or treatment facility prior to transferring the patient to such facility.

m) Participate in Banner training program for the electronic medical record (EMR) prior to exercising clinical privileges and to remain current with all relevant changes, upgrades and enhancements to the EMR.
n) Participate in the Banner Ocotillo Medical Staff Orientation Program as required by the Medical Executive Committee and Administration.
o) Demonstrate his/her continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patters at either the Medical Center or other hospitals or outpatient surgical centers.
p) Electronic communication is the Medical Center's primary method of communication with the Medical Staff. All applicants and members of the Medical Staff must provide a current email address for communication of regular Medical Center business. All applicants and members are responsible for reading email notifications and responding timely to Medical Center business. Electronic communication will follow Banner Health's policies and procedures regarding confidentiality/disclosure of protected health information.

3.4 TERM OF APPOINTMENT

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

3.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.5-1 QUALIFICATIONS

A practitioner, who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Medical Center, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as any other staff member. For purposes of this section, practitioners providing specified professional services does not include outside practitioners assisting the Medical Staff with its peer review functions.

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

3.6 EXCLUSIVE CONTRACTS

The Medical Center may enter into an Exclusive Agreement with, or transfer an Exclusive Agreement to, members of the Medical Staff which limit the rights of other practitioners to exercise clinical privileges and/or the rights and prerogatives of Medical Staff membership. Such Agreements may only be entered into after a determination by the CEO that expected improvements to the quality of care, coverage, care-management initiatives, cost-efficiency, appropriate utilization, stability of coverage, and/or service excellence will

outweigh any potential anticompetitive effect of the Agreement. Any such Exclusive Agreement must comply with the Banner Board's Exclusive Arrangements for Hospital Based Physician Services Policy.

Prior to entering into an Exclusive Agreement, the CEO shall notify the Medical Executive Committee of the need for, and benefits of, the exclusive contract as well as any other information it deems relevant, and give the Medical Executive Committee the opportunity to provide input.

If the Medical Center enters into an Exclusive Agreement, only Practitioners performing services for the contracted group ("Covered Practitioners") may exercise those clinical privileges covered by the Exclusive Agreement ("Covered Privileges") while the Exclusive Agreement is in effect. Covered Privileges of non-Covered Practitioners will expire. If a non-Covered Practitioner's privileges are limited to Covered Privileges, the Practitioner's Medical Staff membership and privileges will expire. If a Practitioner leaves the contracted group privileges will expire with respect to covered services and membership will expire if privileges are limited to covered privileges. Only Practitioners employed or contracted with the contracted group are eligible to apply for Covered Privileges. No other applications will be processed.

3.7 PARTICIPATION IN CALL COVERAGE PROGRAMS

In order to meet the needs of Hospital inpatients and outpatients and ensure compliance with applicable regulatory requirements, the CEO will determine, with input from the Medical Executive Committee, which programs and specialty services require on-call coverage. The Executive Committee will support the CEO in assuring adequate on-call coverage for patients consistent with resources available within the Medical Staff.

For those Departments and specialty services for which on-call coverage is required, Active and Associate Medical Staff Members are obligated (but not entitled) to participate in such coverage. Individual Staff Members may request a waiver from call coverage participation requirements pursuant to Medical Staff Rules and Regulations. Call schedules shall be prepared by the applicable Department Chair at the direction of the CEO or designee.

Removal or limitation of on-call obligations may be made by the CEO, CMO or Medical Executive Committee when evidence supports the failure of the practitioner to abide by terms outlined in the Medical Staff Bylaws, Rules and Regulations or Policy and Procedures. Removal from on-call obligations is a non-reviewable action.

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

3.8 MEDICAL DIRECTORS

A medical director is a practitioner engaged by the hospital either full or part-time in an administrative capacity. Where provided for by contract, a medical director's responsibilities shall include assisting the Medical Staff and/or Care Management

to carry out its peer review and quality improvement activities. Medical Directors must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1.

3.9 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall automatically be granted Active Staff membership. The Chief Medical Officer need not remain in the active practice of medicine, and need not comply with the applicable requirements in Section 3.1. The Chief Medical Officer shall have Medical Staff leadership and peer review responsibilities including, but not limited to, responsibility for reviewing care, conducting investigations, identifying trends and resolving issues in collaboration with the MEC.

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.1 CATEGORIES

There will be five categories of appointment to the staff: Active, Associate, Telemedicine, Emeritus, Advanced Practice Professionals (APPs) and one category of non-membership affiliation with the facility (community-based affiliation).

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS FOR ACTIVE STAFF

The active staff shall consist of physicians, dentists, podiatrists and psychologists who demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center and/or are regularly involved in the care of patients in the Medical Center facilities. The volume of annual patient contacts and involvement in the affairs of the Medical Staff or Medical Center necessary to achieve and maintain active staff shall be established by the Executive Committee.

4.2-2 PREROGATIVES

An active staff member may:

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

4.2-3 OBLIGATIONS

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

a) Contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff, and faithfully perform the duties of any office or position to which elected or appointed; provide continuous care and supervision of his/her patients in the Medical Center or arrange a suitable alternative and
b) Pay all staff dues and assessments.

4.2-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure of an active staff member to satisfy the qualifications or obligations of the active staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate.

4.3 ASSOCIATE STAFF

4.3-1 **QUALIFICATIONS**

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

4.3-2 **PREROGATIVES**

An Associate Staff member may:

a) Admit patients, except as set forth in department rules and regulations, privilege criteria and Medical Center admission policies;
b) Exercise such clinical privileges as have been granted by the Banner Board;
c) Be appointed to committees unless otherwise provided by these Bylaws;
d) Vote on matters presented at committees to which he or she has been appointed and at department meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.3-3 **OBLIGATIONS**

An Associate Staff member must meet the basic obligations set forth in these Bylaws, including in Section 3.3:

a) provide continuous care and supervision of his/her patients in the Medical Center or arrange a suitable alternative and
b) Pay all staff dues and assessments.

4.3-4 **CHANGE IN STAFF CATEGORY**

Associate members will automatically be advanced to the active staff category at the time of reappointment if they have met the volume of annual patient contacts requirement defined in the Medical Staff Rules and Regulations. Failure to utilize the Medical Center during an entire reappointment period may result in a practitioner being dropped from the Medical Staff or moved to the Community Based Physician Staff. Members may request a change in staff category at any time.

4.4 TELEMEDICINE STAFF

4.4-1 **QUALIFICATIONS FOR TELEMEDICINE STAFF**

The Telemedicine Staff shall consist of practitioners who provide care, treatment and services of patients only via an electronic communication link. These practitioners are subject to the credentialing and privileges process of the Medical Center.

4.4-2 **PEROGATIVIES**

A telemedicine staff member may:

a) Treat patients via electronic communication link, except set forth in department rules and regulations, privilege criteria and Medical Center policies.

b) Exercise such clinical privileges as granted by the Banner Board.
c) Be appointed to committees unless otherwise provided by these Bylaws.

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

4.4-3 **OBLIGATIONS**

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

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

Members of the Telemedicine Staff will be placed in other staff categories if they provide patient care services while physically located at the Medical Center.

4.4-4 **AUTOMATIC EXPIRATION OF MEMBERSHIP AND PRIVILEGES**

The membership and privileges of members of the Telemedicine Staff will automatically expire if their relationship terminates with the group with which Medical Center contracts or if their privileges terminate at their distant primary site.

4.5 COMMUNITY BASED PHYSICIAN STAFF

Community-based practitioners are those who request Medical Center services for their patients and wish to be affiliated with the Medical Center. Community-based physician/practitioner are not members of the Medical or Allied Health Staff and do not have clinical privileges at the Medical Center. Community-based practitioners need not meet all requirements for membership or privileges.

4.5-1 **QUALIFICATIONS**

Community Based Providers seeking to be affiliated with the Medical Center must apply for community-based status and provide evidence of the following qualifications:

a) Arizona licensure in good standing;
b) Ability to participate in Medicare/AHCCCS and other federally funded health programs;
c) Ability to relate in a professional manner with medical Center staff and physicians/practitioners; and
d) Demonstrate professional ethics and conduct.

4.5-2 **PREROGATIVES**

The Community Based Physician/Practitioner Staff Members may:

a) Order outpatient diagnostic services for patients;
b) Access Medical Center information via Clinical Connectivity for their own patients;
c) Receive Medical Staff newsletters and other BOMC publications;
d) Attend Medical Center Continuing Medical Education programs.

4.5-3 **OBLIGATIONS**

The Community Based Physician/Practitioner Staff must maintain the confidentiality of patient information and access and use only as necessary for treatment, payment or healthcare operations regarding their own patients in accordance with HIPPA laws and regulations. Inappropriate use of patient information will result in loss of affiliation and Clinical Connectivity access.

4.5-4 **DENIAL OR TERMINATION OF MEMBERSHIP**

Community Based Physician/Practitioner or those seeking affiliated status are not entitled to due process rights.

4.6 EMERITUS STAFF

4.6-1 **QUALIFICATIONS**

Emeritus status shall be granted to practitioners retired from professional practice who are recognized for their noteworthy contributions and outstanding service to the Medical Center and/or long-standing service to the Medical Center. The recommendation for Emeritus Staff will be initiated by the Department Committee with approval by the MEC and CEO. Emeritus Staff practitioners are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any other credentialing processes.

4.6-2 **PREROGATIVES**

Emeritus 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. Emeritus staff members may serve on committees. Emeritus Staff shall be invited and welcome to attend educational and social functions of the Medical Center and Medical Staff.

4.7 ADVANCED PRACTICE PROVIDERS

a. The term, "Advanced Practice Provider" (APP) refers to APRNs and PAs, who provide direct patient care services in the Medical Center under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Banner Board and shall be credentialed through the same processes as a Medical Staff member and shall be granted clinical privileges as defined in State laws and in these Bylaws. They may provide patient care services only to the extent of the clinical privileges that have been granted.
b. Other categories of dependent healthcare professionals, known as Allied Health Professionals, who provide patient care services in support of, or under the direction of a Medical Staff member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Medical Staff as defined in the Allied Health Rules and Regulations.

4.7-1 **REQUIREMENTS FOR ADVANCED PRACTICE PROVIDERS**

APP providers shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision of a member of the Medical Staff. In addition to a complete application, as defined in these Bylaws, the supervising Physician will sign the agreement of supervision included on the APP provider's privilege form and/or reference form.

4.7-2 **PEROGATIVES OF ADVANCED PRACTICE PROVIDERS**

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

(b) Perform such teaching activities as are authorized.
(c) Serve on committees to which they have been appointed.
(d) Vote on all matters presented at department and committees of which he or she is a member.

4.7-3 **OBLIGATIONS OF ADVANCED PRACTICE PROVIDERS**

Each APP provider shall discharge the basic obligations as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Medical Center, as applicable to his/her activities in association with the Medical Center.

4.7-4 **ADVERSE ACTION AND APPELLATE PROCESS**

a. **INITIATION OF ADVERSE ACTION REVIEW AND APPEAL PROCESS**

APPs subject to Adverse Action (other than Non-reviewable Actions defined in Section 6.8 of the Medical Staff Bylaws) shall be afforded an Adverse Action Review and appeal process in accordance with this policy. Adverse Action includes: denial of a request to provide any patient care services within the applicable scope of practice or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable scope of practice. APPs are not entitled to due process rights set forth in the Medical Staff Bylaws and Fair Hearing Plan, and none of the procedural rules set forth therein shall apply.

b. **NOTICE OF ADVERSE RECOMMENDATION OR ACTION**

Within fifteen (15) days after Adverse Action is taken against an APP, the APP shall be notified in writing of the specific reasons for the Adverse Action and the APPs rights per this policy.

c. **REQUEST FOR REVIEW OF ADVERSE RECOMMENDATION OR ACTION**

The APP may request an Adverse Action Review following the procedure set forth in this policy. If the APP does not deliver a written request for an Adverse Action Review to the Chief of Staff within ten (10) days following the date of the written notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

d. **COMPOSITION OF THE REVIEW COMMITTEE**

The Chief of Staff will appoint up to three (3) members of the Medical Staff and if applicable, the Chief Nursing Officer to serve as the Review Committee.

e. **NOTICE OF TIME AND PLACE FOR REVIEW**

The APP shall be notified ten (10) days prior via written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any that will be called to support the Adverse Action.

f. **STATEMENTS IN SUPPORT**

A Representative acting on behalf of the Medical Staff (Medical Staff Representative) as appointed by the Chief of Staff, and the APP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Chief of Staff at least five (5) days prior to the review.

g. **RIGHTS OF PARTIES**

During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. None of the APP, the Hospital or the Medical Staff

Representative shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

h. **BURDEN OF PROOF**

The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the APP 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.

i. **ACTION ON COMMITTEE REVIEW**

Upon completion of the review, the Review Committee shall consider the information and evidence presented and make a recommendation, which shall include the basis therefore, and forward it to the Chief of Staff. The APP and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

j. **DUTY TO NOTIFY OF NONCOMPLIANCE**

If the APP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the APP must promptly notify the Chief of Staff of such deviation, including this policy or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

k. **REQUEST FOR APPELLATE REVIEW**

If the APP is dissatisfied with the Committee's recommendation, such party may submit a written request for an Appellate Review, provided that the Chief of Staff receives such request within ten (10) days following the APP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with the identified process or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable.

l. **INTERVIEW WITH MEDICAL EXECUTIVE COMMITTEE**

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

m. **FINAL DETERMINATION BY THE MEDICAL EXECUTIVE COMMITTEE**

The MEC shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the MEC shall not be subject to further appeal. The final decision will be submitted to the Banner Health Board of Directors.

n. **CONFIDENTIALITY**

The Medical Staff will strive to maintain the confidentiality of all matters reviewed to the extent appropriate under the circumstances and as permitted by law.

4.7-5 **AUTOMATIC SUSPENSION OR LIMITATION**

Automatic suspension shall be immediately imposed under the conditions contained in section 6.7 of the Medical Staff Bylaws.

4.7-6 **NON-REVIEWABLE ACTIONS**

Not every action entitles the APP to rights pursuant to Article 4. Non-Reviewable actions are defined in Section 6.8 of the Medical Staff Bylaws.

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

ARTICLE FIVE: PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRACTICE PRIVILEGES

5.1 PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES

Completed applications for membership and privileges are submitted at the time of initial appointment to the Credentials Committee, Department and Medical Executive Committee, subject to final approval by the Banner Board. Expedited applications may be submitted directly to the Chairmen of the Credentials Committee, Department and/or Section, to the Executive Committee, and to the Banner Board. Completed applications for reappointment are submitted to the Department, Section as appropriate, and Executive Committee, subject to final approval by the Banner Board. The process for appointment and reappointment to the Medical Staff is set forth in further detail in the Credentialing Procedures Manual.

5.2 PROCESS FOR "DISTANT SITE" CREDENTIALING OF TELEMEDICINE PROVIDERS

Where the Medical Center ("Originating Site") has a contract with a Joint Commission accredited facility ("Distant Site") approved by the Medical Executive Committee, the Medical Center will accept the credentialing and privileging decision of the distant site for applicants who provide telemedicine services and are credentialed at the distant site. Privileges at the Originating Site shall be identical to those granted at the Distant Site, except for services which the Medical Center does not perform. Privileges shall be granted and renewed for the same period as have been granted by the Distant Site except where corrective action is taken by the Medical Staff. Banner Board approval of privileges at the Distant Site qualifies as Banner Board approval at the Medical Center.

5.3 PROCESS FOR CREDENTIALING AND PRIVILEGING ALLIED HEALTH PROFESSIONALS

Completed applications for allied health membership for initial appointment and scopes of practice will be submitted to the Credentials Committee, Department, Section (if applicable) and Executive Committee for review and action prior to submission to the Banner Board. Completed applications for reappointment are submitted to the Department, Section as appropriate, and Executive Committee, subject to final approval by the Banner Board. The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Credentials Manual and AHP Rules and Regulations.

5.4 EXERCISE OF PRIVILEGES

5.4-1 IN GENERAL

Privileges may not be exercised at the Medical Center until the practitioner has successfully completed Banner's practitioner orientation, which includes electronic medical record/computer assisted order entry training (CPOE training). Except in an emergency, a practitioner providing clinical services at the Medical Center may exercise only those clinical privileges specifically granted.

5.4-2 PRIVILEGES IN EMERGENCY SITUATIONS

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to the degree permitted by the practitioner's license, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of department affiliation, staff category, or privileges. A practitioner providing such emergency services outside the scope of granted privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

5.4-3 EXPERIMENTAL PROCEDURES

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

5.4-4 TELEMEDICINE PRIVILEGES

5.4-4.1 The Medical Executive Committee shall continually evaluate the performance of the telemedicine services by practitioners at reappointment, renewal, or revision of clinical privileges. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine services may also be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand.

5.4-4.2 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of BOMC.

5.5 PROCEDURE FOR DELINEATING PRIVILEGES

5.5-1 REQUESTS

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. In some instances, staff membership may be granted to a practitioner who desires not to request clinical privileges. Specific requests must also be submitted for modifications of privileges in the interim between reappointment periods. All requests for clinical privileges will be processed in accordance with the procedures set forth in the Credentialing Manual, except that requests submitted after the initial granting of membership shall not require review by the Credentials Committee.

5.5-2 SUPERVISION

Whenever a practitioner requests clinical privileges not previously granted to the practitioner by the Banner Board, the practitioner must arrange for the number and types of cases to be reviewed or observed as required in the department rules and regulations and privilege criteria, unless a waiver of supervision has specifically been recommended by the department and the Medical Executive Committee and approved by the Banner Board. After the completion of such supervision, the practitioner may be granted unsupervised privileges.

5.6 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 and compliance with quality, safety and performance improvement initiatives and utilization review, peer review, supervised cases (if applicable), and where appropriate, practice at other hospitals will also be considered. In review of requests for changes in privileges, evidence of appropriate training and experience and current clinical competence must be documented.

5.7 PRIVILEGE DECISION NOTIFICATION

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

5.8 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, CMO and CEO or designee has considered and approved the department's recommendation to create/not create new criteria for privileges and, where new criteria are established, has determined that the physician has demonstrated that he/she has the necessary qualifications. The Medical Executive Committee's determination is subject to ratification by the Banner Banner Board.

5.9 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES

5.9-1 REQUEST FOR PRIVILEGES

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

5.9-2 **DETERMINATION OF APPROPRIATENESS**

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

5.10 TEMPORARY PRIVILEGES

5.10-1 **CONDITIONS**

Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has satisfied the professional liability insurance requirement of these Bylaws. Special requirements of supervision and reporting may be imposed by the Chief of Staff or department chairman. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws and the policies of the Medical Staff and Medical Center. Temporary privileges may be granted to an applicant for an initial period not to exceed 60 days upon completion of CPOE/EMR training. One extension may be granted for an additional period not to exceed 60 days. Any such renewal shall be made by the department chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges.

5.10-2 **CIRCUMSTANCES**

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

Pendency of Application: Temporary privileges may be granted to an applicant who has submitted a complete application that has been verified and raises no concerns, has been approved by the Credentials Committee and Department Chairman, and is awaiting review and approval of the Medical Executive Committee and the Banner Board Under no circumstances may such privileges be granted or extended if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

Care of Specific Patient: Temporary privileges may be granted to a practitioner for the care of a specific patient but only after receipt of a request for the specific privileges desired and confirmation of both appropriate licensure and adequate professional liability insurance coverage and favorable results of the National Practitioner Data Bank query. Such temporary privileges may not be granted in more than (3) three instances in any 12 month period after which the practitioner must apply for staff appointment, and are restricted to the care of specific patients for which they are granted.

Coverage of Services: Where a service is not adequately covered to meet patient care needs, temporary privileges may be granted to an applicant for staff membership upon receipt of application and verification of the following information: appropriate licensure; adequate professional liability insurance; DEA registration, (if applicable); current clinical competency; education and training; evidence of freedom from infectious tuberculosis and recent flu vaccination, when applicable; no involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial or loss of privileges at the practitioner's primary facility; freedom from government sanctions; and NPDB query responses as required to meet privilege criteria. Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 60 days upon completion of CPOE training. One extension may be granted for an additional period not to exceed 60 days.

5.10-3 **TERMINATION**

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

5.10-4 **RIGHTS OF THE PRACTITIONER**

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

5.11 DISASTER PRIVILEGES

5.11-1 In the event of an officially declared emergency or disaster, any physician, dentist, nurse practitioner, or physician assistant may be granted temporary disaster privileges upon recommendation of the CEO, Chief Medical Officer, Chief of Staff or designee provided that the care, treatment, and services provided are within the scope of the individual's license. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation.
- A current license to practice.
- Primary source verification of licensure.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group.

- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
- Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

5.11-2 Primary source verification of licensure will begin as soon as the immediate situation is under control, and must be completed within 72 hours (or as soon as possible) from the time the volunteer begins working at the hospital. If not verified within 72 hours, the reason must be documented.

5.11-3 Oversight of the professional performance of volunteer practitioners who receive disaster privileges (e.g. direct observation, mentoring, clinical record review) will be the responsibility of the Chief of Staff, appropriate Department Chairman, or other designee.

5.11-4 The CEO or designee, CMO or Chief of Staff may terminate any or all of a practitioner's disaster privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner.

5.11-5 Such privileges expire within thirty (30) days or upon the termination of the disaster or completion of inpatient care. A practitioner is not entitled the procedural rights afforded by these Bylaws either due to request for disaster privileges is refused, or such privileges are terminated or otherwise limited.

5.11-6 Volunteer practitioners functioning under disaster privileges will be identified as such by wearing an identification badge provided upon the granting of privileges.

ARTICLE 6: PROFESSIONAL PRACTICE EVALUATION AND CORRECTIVE ACTION

6.1 PROFESSIONAL PRACTICE EVALUATION

The Medical Staff conducts Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with Joint Commission requirements and Banner policy.

6.2 CRITERIA FOR INITIATING CORRECTIVE ACTION

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

6.3 PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

a) A request for an investigation and/or corrective action may be submitted to the Chief of Staff by any member of the Medical Staff, the CMO, CEO or designee, or the Banner Board. The request must be in writing and

must be supported by reference to the specific activities or conduct forming the basis for the request.

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

c) Certain matters that may lead to corrective action are routinely considered by each Medical Staff department and/or the Professional Review Committee as a part of their ongoing quality and performance improvement, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the department or the Professional Review Committee, the Professional Review Committee shall conduct a review as set forth herein, and no request for an investigation and/or corrective action is required.

6.4 PROCEDURE FOR PROFESSIONAL REVIEW

a) Within 45 days of the determination by the Professional Review Committee that corrective action may be warranted, the Professional Review Committee shall conclude an investigation and document its findings. If the findings warrant that corrective action be taken, the affected practitioner shall have an opportunity for an interview with the Professional Review Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. A record of such interview shall be made and included with its report. In certain instances, the Professional Review Committee may not be concluded within 45 days. In such instances, the investigation shall be concluded as soon as reasonably practical. The affected practitioner shall have no procedural rights arising out of such delay. After its deliberations, the Professional Review Committee will make its recommendation, and if adverse, shall forward it to the Executive Committee.

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

corrective action that is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws.

6.5 SUMMARY SUPERVISION

6.5-1 INITIATION

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

a) Chief of Staff or designee, acting as a member of and on behalf of the Executive Committee;
b) Chief Medical Officer;
c) Department chairman or designee, acting as a member of and on behalf of the applicable department committee;
d) Chief Executive Officer or designee.

6.5-2 REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE

A practitioner whose clinical privileges have been placed under summary supervision by any two individuals identified in Section 6.4-1 (and not by the Professional Review Committee pursuant to Section 6.2) shall be entitled to request a review of the summary supervision by the Professional Review Committee or subcommittee thereof, having no less than three (3) members. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary supervision be terminated or continued.

6.6 SUMMARY SUSPENSION

6.6-1 INITIATION

Whenever immediate action must be taken in the best interest of patient care in the Medical Center or to prevent imminent danger to the health of any individual, any two of the following individuals shall have the right to summarily suspend membership and all or any portion of the clinical privileges of a practitioner:

a) Chief of Staff or designee, acting as a member of and on behalf of the Executive Committee;
b) Chief Medical Officer;
c) Department chairman or designee, acting as a member of and on behalf of the applicable department committee;
d) Chief Executive Officer or designee;

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

6.6-2 REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Professional Review Committee or a subcommittee thereof having no less than three (3) Members.

6.6-3 ALTERNATIVE COVERAGE

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

6.7 AUTOMATIC SUSPENSION OR LIMITATION

When grounds exist for automatic suspension, the privileges of the practitioner will be automatically suspended without prior action by the Executive Committee or the Banner Board**.** Alternative medical coverage will be provided for patients as set forth in Section 6.5-4. The types of automatic suspensions or limitations as noted below are non reviewable corrective action under the fair hearing plan. In addition, further corrective action may be recommended in accordance with the provisions contained within these Bylaws whenever any of the following actions occur:

6.7-1 **LICENSE**

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

6.7-2 **CONTROLLED SUBSTANCES REGISTRATION**

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

6.7-3 **MEDICAL RECORDS**

A temporary suspension of privileges to admit new patients or to schedule new procedures shall be imposed for failure to complete medical records within the time periods established by the Medical Executive Committee and designated in the Medical Staff Rules and Regulations. Such suspension shall not apply to patients admitted or already scheduled at the time of the suspension, to emergency patients, or to imminent deliveries. Hospitalists and Emergency Medicine Physicians will not be scheduled for shifts if suspended. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension shall become automatic permanent suspension for failure to complete delinquent records within 60 cumulative days per calendar year. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if the delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-4 **PROFESSIONAL LIABILITY INSURANCE**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under Section 3.1-11 of these Bylaws. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-5 **FREEDOM FROM INFECTIOUS TUBERCULOSIS**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious tuberculosis as required by law and Hospital policy. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension upon presentation of evidence of freedom from TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-6 **FAILURE TO BE VACCINATED OR TO OBTAIN EXEMPTION**

A practitioner's Medical Staff clinical privileges shall be immediately suspended for failure to provide evidence of flu vaccination or an approved exemption granted by Banner or, where granted an exemption, for failure to wear a mask as required by Banner policy. Privileges will be reinstated at the end of flu season.

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

6.7-7 **EXCLUSION FROM MEDICARE/STATE PROGRAMS OR FRAUD CONVICTION**

The CEO or designee with notice to the Chief of Staff will immediately and automatically suspend the Medical Staff privileges of an Excluded Practitioner or a practitioner who has been found or has pled guilty or has pled no contest to a felony related to the practice of medicine. An "Excluded Practitioner" is a practitioner whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or CHAMPUS program.

6.7-8 **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 10.3-3, shall automatically be suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Failure to appear within 90 days of the request to appear shall result in revocation of staff membership and

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

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

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

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

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

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

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges as required by Section 11.2 shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-12 **FAILURE TO COMPLETE ASSESSMENTS AND PROVIDE RESULTS**

A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-13 **FAILURE TO BECOME BOARD CERTIFIED**

Whenever a practitioner's time period in which to become/remain board certified expires, the practitioner is deemed to have immediately and voluntarily relinquished his/her Medical Staff appointment and clinical privileges.

6.7-14 **FAILURE TO COMPLETE CPOE TRAINING OR ORIENTATION**

Failure to complete CPOE training and/or orientation will result in automatic suspension within 6 months of appointment to the Medical Staff will result in automatic relinquishment of membership and privileges.

6.7-15 **MISREPRESENTATION**

If it is discovered that an individual willfully misrepresented or omitted answers to questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, and the misrepresentation or omission is an intentional material or substantive misrepresentation, as determined by the

Medical Executive Committee, the individual's membership and clinical privileges shall be automatically terminated.

6.7-16 **AUTOMATIC LIMITATIONS**

When a practitioner's privileges are restricted or terminated at any Banner facility, such practitioner's privileges will be automatically restricted or terminated, as the case may be, at the Medical Center. When a practitioner has been asked to refrain from exercising all or a portion of privileges at any Banner facility, the practitioner shall be required to refrain from exercising such restricted privileges at the Medical Center. The practitioner has no due process rights arising out of restrictions taken at the Medical Center because of restrictions taken at another Banner facility, including a request to refrain. If the practitioner is reinstated at the Banner facility that restricted or terminated such practitioner's privileges or from which such practitioner refrained, such practitioner's privileges remain restricted or terminated at the Medical Center until Medical Center lifts the restriction. If the Medical Center decides not to reinstate the practitioner's privileges, the practitioner is entitled to due process rights as outlined in these Bylaws.

6.8 NONREVIEWABLE ACTION

Not every action entitles the practitioner to rights pursuant to the Fair Hearing Plan. In addition to those types of actions listed in 6.7, the following occurrences are also nonreviewable under the Fair Hearing Plan:

a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
b) Issuance of a warning or a letter of admonition or reprimand.
c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
d) Termination or limitation of temporary privileges.
e) Supervision and other requirement imposed as a condition of granting privileges.
f) Termination of any contract with or employment by the Medical Center(s).
g) Any recommendation voluntarily imposed or accepted by a practitioner.
h) Denial of membership and privileges for failure to complete and application for membership or privileges
i) Denial or termination of telemedicine membership or privileges or of community-based affiliation.
j) Removal of membership and privileges for failure to complete supervision with the time period granted by these Bylaws.
k) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
l) Reduction or change in staff category.
m) Refusal of the credentials committee, department, or Executive Committee to consider a request for appointment, reappointment, staff category, department assignment, or privileges within two years of a final adverse decision regarding such request.
n) Any requirement to complete an educational assessment or training program.
o) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.

p) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
q) Retrospective chart review.
r) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the CEO to enter into, terminate or modify an exclusive contract for certain clinical services; or (2) the termination or modification of the practitioner's relationship with the exclusive provider.
s) Grant of conditional appointment or appointment for a limited duration.
t) Termination or limitation of Remote membership or privileges based upon the failure to maintain Active Staff membership in good standing at another Banner Hospital.
u) Termination or limitation of Remote membership or privileges based upon a limitation in the type or extent of clinical services which may be provided to Medical Center Inpatients from a remote location.

6.9 REPORTING REQUIREMENT

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

6.10 HEARING AND APPEAL RIGHTS

6.10-1 HEARINGS AND APPEALS

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

6.10-2 FAIR HEARING PLAN

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

6.10-3 HEARING PANEL

When a hearing is requested, the hearing will be conducted by a committee composed of at least three members. No person in direct economic competition with the practitioner or who has participated in the adverse recommendation shall participate. Members of the hearing committee shall be physicians and may, but need not, be members of the medical staff.

6.10-4 SCHEDULING THE HEARING

The CEO shall send the practitioner notice of the date, time, and place of the hearing at least 30 calendar days prior to the hearing.

6.10-5 HEARING PROCESS

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

6.10-6 **APPEAL PROCESS**

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

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

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 GENERAL OFFICERS OF THE STAFF

7.1-1 **IDENTIFICATION**

The general officers of the staff are:

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

7.1-2 **QUALIFICATIONS**

a) Each general officer must:
   i. Be a member in good standing 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. Good standing is defined as having no pending adverse recommendations, current stipulated agreements, quality or conduct concerns regarding staff appointment or clinical privileges.
   ii. Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
   iii. Have demonstrated a high degree of interest in and support of the Medical Staff and the Medical Center.
   iv. Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general and department officers of the Medical Staff, the CEO, and the Banner Board.
   v. Not have a disabling conflict of interest with the Medical Staff or Medical Center as determined by the Executive Committee, CMO and CEO.
b) Candidates for the Chief of Staff must meet the qualifications for general officers and must also have served on the Executive Committee.
c) A practitioner may not hold simultaneously two or more general staff offices.
d) The provisions of the Article relating to qualifications, nomination and election do not apply to the initial general staff officers.

7.2 TERM OF OFFICE

The term of office of general staff officers is two years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office. The CEO shall appoint initial officers; initial granting of officers shall serve through December 31, 2022.

7.3 ELIGIBILITY FOR RE-ELECTION

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

7.4 NOMINATIONS

7.4-1 NOMINATING COMMITTEE

a) The General Officers of the Staff, CEO or designee, CMO and department chairs shall serve as the nominating committee. The Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each office. Nominees must disclose interests that potentially compete with the interests of the Medical Staff and/or the Medical Center, including ownership and financial interests in competing facilities or employment or contractual relationships with the Medical Center or with competing facilities. The CEO may remove a nominee whom he or she believes would not serve the interests of the Medical Center and/or the Medical Staff.

   At a designated meeting of the Executive Committee, the Nominating Committee shall present for information the list of nominations to the Executive Committee. The Vice Chief of Staff shall give electronic notice of the nominations to all active staff members of the Medical Staff 30 days prior to the designated meeting.

b) Nominations may also be made before the designated meeting date to the Executive Committee by any voting member of the Medical Staff if evidence is presented that the potential nominee meets the qualifications for office and consents to the nomination. Such nominees must also disclose potential conflicts of interest. The MEC and CEO will determine if the additional nominees serve the interests of the Medical Center and/or the Medical Staff prior to approving the final slate of nominees.

7.5 ELECTIONS, VACANCIES, AND REMOVALS

7.5-1 ELECTION PROCESS

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

a) If there is a solo candidate on the slate of nominations, that candidate will be deemed approved; a formal ballot will not be sent.

b) If there is more than one candidate on the slate of nominations the ballots must be sent out for electronic vote within 14 days after the MEC meeting. The Secretary shall email one official ballot to each active staff member of the Medical Staff. Potential conflicts of interest shall be noted on the ballot or in a notice enclosed with the ballot. The deadline for voting shall be no more than 14 days after ballots are sent out. Any

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

c) The candidate receiving the highest number of votes is elected. In the case of a tie, a majority vote of the Executive Committee shall decide the election.

7.5-2 **VACANCIES IN ELECTED OFFICES**

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

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

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

b) Removals: any officer may be removed from office for cause upon the recommendation of the Executive Committee or CEO.

Removal by the Executive Committee shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal for cause. Grounds for removal shall include failure to maintain qualifications of the office as outlined in Bylaws and/or uphold the duties of the office as outlined in Bylaws. The individual shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on removal.

Removal by the CEO shall occur when there is sufficient evidence for grounds for removal for cause. Grounds for removal shall include failure to maintain qualifications of office as outlined in Bylaws and/or uphold the duties of the office as outlined in Bylaws. The CEO will inform the Executive Committee of the sufficient evidence and obtain input prior to removing the candidate from office. The individual shall be afforded an opportunity to speak to the CEO prior to being removed from office. The MEC has a right to request a Joint Conference Committee as outlined in Article 13.7 should they disagree with the removal.

7.6 DUTIES OF OFFICERS

7.6-1 **CHIEF OF STAFF**

The chief of staff shall serve as the highest elected officer of the Medical Staff to:

a) Enforce the Bylaws and implement sanctions where indicated;

b) Call, preside at, and be responsible for the agenda of all general staff meetings, meetings of the Executive Committee;

c) Serve as an ex officio member of all other staff committees without vote. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;

d) Appoint, with the consultation of the Executive Committee, members for all standing and special Medical Staff or multi-disciplinary committees, and designate the chairman of these committee;

e) Interact with the CEO and Chief Medical Officer in all matters of mutual concern with the Medical Center;

f) Represent the views and policies of the Medical Staff to the CEO;

g) Be a spokesman for the medical staff in external professional affairs;

h) Perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Executive Committee;
i) Receive and act upon requests of the Banner Board to the Staff; and
j) Report to the Banner Board on the performance and maintenance of quality with respect to the Staff's delegated functions to promote quality patient care;
k) Serve on the Banner Peer Review Council;
l) Serve on the facility Peer Review Committee;
m) Meet and discuss with the Banner Board Subcommittee any matters of concern to the Medical Staff.

7.6-2 **VICE CHIEF OF STAFF**

The vice chief of staff shall assume all duties and authority of the Chief of Staff in his or her absence. The vice chief of staff shall be a member of the Executive Committee and shall Chair the Credential Committee and perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

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

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

ARTICLE EIGHT: CLINICAL DEPARTMENTS

8.1 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chairman selected and entrusted with the authority, duties, and responsibilities as specified in this Article. A department may be further divided into Sections that shall be directly responsible to the department within which they function, 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 recommendations require Banner Board approval and formal amendment of these Bylaws. The current clinical departments are:

Medicine
Surgery
Women and Infant Services

8.2 ASSIGNMENT TO DEPARTMENTS

Each member with privileges shall be assigned membership in one department. A practitioner may be granted clinical privileges in more than one department; the exercise of clinical privileges within the jurisdiction of any department is always subject to the rules and regulations of that department.

8.3 FUNCTIONS OF DEPARTMENTS

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

a) Develop, approve and review annually clinically relevant quality and appropriateness parameters and criteria/indicators and recommend appropriate action to the Medical Executive Committee.
b) Develop recommendations for the qualifications and credentialing criteria appropriate to obtain and maintain clinical privileges in the department and its sections.
c) Establish and implement clinical policies and procedures, and monitor its members' adherence to them.
d) Identify and engage in opportunities for education and process improvement.
e) Participate in Banner clinical initiatives and assist with the adoption of appropriate clinical standards to facilitate improved aggregated clinical outcomes and patient safety as determined by the Medical Staff and Banner;
f) Adopt rules and regulations to clarify or expand these Bylaws to meet the needs of it particular area of practice. Department rules and regulations shall not conflict with the Bylaws and shall be subject to approval by the Executive Committee and the Banner Board. Any rule, regulation or policy that may be temporarily adopted on an emergency basis shall be approved by the Chief of Staff prior to communication or enforcement.
g) Meet at as often as necessary to consider the results of the aggregated quality/appropriateness review and any other review and evaluation activities, make recommendations relating thereto and to provide a forum for discussion of matters of concern to its members.
h) Be responsible for the conducting of continuing education within the department.
i) Coordinate the professional services of its members with those of other departments and with Medical Center nursing and support services.
j) Participate with Medical Center Administration in planning related to department activities including but not limited to: space, resources and supply chain utilization including the review of new technologies.
k) Support the utilization management program by conducting reviews for appropriateness of:
    i. Admissions
    ii. Level of care
    iii. Continued stays
    iv. Procedures
    v. Testing and Treatment
    vi. Length of Stay
    vii. Status Determination
    viii. Discharges
    ix. Transfers
l) Establish a department committee and any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the department committee and subcommittee members shall be defined within the department rules and regulations.

8.4 DEPARTMENT OFFICERS

8.4-1 QUALIFICATIONS

Each department shall have a chairman who shall be and remain, during his or her term:

1. A member in good standing of the active Medical Staff;

2. Be Board Certified by an appropriate specialty board
3. Have no pending adverse recommendations, current stipulated agreements or FPPE concerning staff appointment or clinical privileges.
4. The provisions of this Article relating to qualifications, selection and term of office do not apply to the initial department officers.

8.4-2 **SELECTION**

A department chairman shall be elected every two years by the active staff members of the department except those departments where the department chairman serves as such under contract with the Medical Center. For this election, each department chairman shall appoint a nominating committee of at least two members. The recommendations of the nominating committee shall be presented at a designated department meeting. Advanced notice of the slate of nominees and designated meeting will be emailed to all members of the department at least 14 days in advance of the meeting. Nominations may also be made at the meeting, so long as the nominee is qualified and has consented to the nomination. If there is a solo candidate on the slate of nominations, the election will be conducted by the majority vote of active staff members present at the department meeting in which the slate of candidates is presented. This election shall constitute the election of the solo candidate; a formal ballot will not be sent. If there is more than one candidate on the slate of nominations the ballots must be sent out for electronic vote within 14 days after the department meeting. 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.

8.4-3 **TERM OF OFFICE**

Elected department chairmen and other department officers, if any, shall serve a two-year term terminating on December, unless a vacancy occurs for any reason. Department officers may be re-elected in succeeding terms not to exceed a total of two successive two-year terms. The term of office of a contract department chairman is as specified in the contract or employment arrangement with the Medical Center. The CEO shall appoint initial department chairs who shall serve through December 31, 2022.

8.4-4 **REMOVAL**

An elected department officer may be removed for failure to maintain the qualifications of the office as required by these Bylaws. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal for cause. Grounds for removal shall include failure to maintain qualifications of the office as outlined in Bylaws Section 8.4-1 and/or uphold the duties of the office as outlined in Bylaws Section 8.4-5. The individual shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on removal.

8.4-5 **DUTIES**

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

a) Act as presiding officer at department meetings;
b) Be a member of the Medical Executive Committee and account to the Medical Executive Committee for all administrative and clinically related activities within the department;

c) Monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the department;
d) 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, treatment, services and utilization management;
e) Provide guidance on overall medical policies of the Medical Center, and make specific recommendations regarding the department;
f) Recommend the clinical privileges and staff category of practitioners who are members of or applying to the department;
g) Refer to the Professional Review Committee issues relating to professional conduct and the quality and appropriateness of patient care and professional performance.
h) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
i) Implement, within the department, actions directed by the Executive Committee or the Banner Board;
j) Participate in administration of the department, including cooperation with the nursing service and Medical Center administration;
k) Appoint such committees as are necessary to conduct the functions of the department;
l) Appoint such chairmen or committee members as required by these Bylaws and department rules and regulations; an
m) Perform such other duties as may, from time to time, be reasonably requested by the Chief of Staff or the Medical Executive Committee.
n) Assess and recommend to the Executive Committee and the CEO off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center.
o) Assess and recommend to the Executive Committee and the CEO a sufficient number of qualified and competent persons to provide care, treatment, and service.
p) Ascertain the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment, and services.

ARTICLE NINE: COMMITTEES

9.1 DESIGNATION

The committees described in this Article or in the Medical Staff Rules and Regulations shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, the descriptions of which will be contained in the Medical Staff Rules and Regulations. When appropriate, the Medical Executive Committee may recommend the creation, elimination, modification, or combination of committees. Such recommendation shall become effective upon Banner Board approval and shall not require formal amendment of these Bylaws. In addition, special or ad hoc committees may be appointed for specific purposes by the Chief of Staff; such appointment will cease upon the accomplishment of the purpose of the committee. Such special or ad hoc committees shall report to the Medical Executive Committee.

9.2 GENERAL PROVISIONS

9.2-1 **EX OFFICIO MEMBERS**

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

9.2-2 **SUBCOMMITTEES**

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

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

When a procedure or group of procedures is performed on a regular basis by members of more than one clinical department, the Medical Executive Committee may create a committee to recommend privileges and develop regulations in regards to the performance of those procedures. The formed committee may also carry out peer review and make recommendations back to the members department or directly to the Medical Executive Committee with notification made to the department.

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

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

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

a) Except as otherwise provided, committee members and chairmen shall be appointed by the Chief of Staff for a term of two years or until the member's successor is appointed, unless such member or chairman sooner resigns or is removed from the committee.
b) A Medical Staff member serving on a committee, except one serving ex officio, may be removed by the Chief of Staff from the committee for failure to remain as a member of the staff in good standing, for failure to satisfy the attendance requirements specified in Section 10.3, or by action of the Executive Committee. A committee member removed by the Chief of Staff or the Executive Committee action shall have the right to an appearance before the Executive Committee to request reconsideration of the removal.
c) A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment was made.

9.2-6 **VOTING RIGHTS**

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

9.3 EXECUTIVE COMMITTEE

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

9.3-1 **COMPOSITION**

The Executive Committee shall consist of:

a) Chief of Staff, as chairman
b) Vice-Chief of Staff
c) Immediate past Chief of Staff
d) Chairmen of Departments
e) Chair of the Credentials Committee
f) (2) Advanced Practice Member-at-Large (with vote) representative from two of the three departments.
g) Chief Medical Officer (ex officio with vote)
h) Medical Director Care Coordination (MDCC) (ex officio without a vote)
i) Chief Executive Officer (ex officio without vote)
j) Chief Nursing Officer (ex officio without vote)
k) Chief Operating Officer (ex officio without vote)
l) Other representation as necessary, may be appointed by the Chief of Staff and approved by the Executive Committee (without vote)
m) Chairmen of standing committees may be invited to meetings of the Executive Committee (without vote).

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

a) **ELECTIONS**

The Medical Staff officers shall be elected in the manner prescribed in Section 7.5. Department chairmen shall be selected in the manner prescribed in Section 8.4.

b) **TERMS OF OFFICE**

With the exception of ex officio members, all members of the Executive Committee shall serve a two-year term. Committee chairmen serving on the Executive Committee by virtue of appointment by the Chief of Staff shall serve two-year terms. The Chief of Staff may appoint these members to subsequent two-year terms with approval of the Medical Executive Committee, or appoint new members, with approval of the Medical Executive Committee.

c) **REMOVALS AND VACANCIES**

Removals and vacancies of general staff officers and department chairmen will be handled in the manners prescribed in Section 7.5 and Section 8.4, respectively.

9.3-3 **DUTIES**

The duties and authority of the Executive Committee are to:

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

department and committee reports, the determination of dues and assessments of members; responsibility for the investment and expenditure of Staff funds which shall be exclusively for purposes permitted by the IRS and consistent with the responsibilities of the Medical Staff.

e) Review aggregate quality performance data and make recommendations for quality improvement;
f) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;
g) Account to the Banner Board for the quality and efficiency of medical care provided to patients in the Medical Center and for the other responsibilities delegated by the Banner Board to the Staff;
h) Represent the views of the Medical Staff to the Banner Board, and make recommendations to the CEO and to the Banner Board on Medical Center medico-administrative matters;
i) Review the qualifications, credentials, performance, and professional competence and character of Medical Staff applicants and members and make recommendations to the Banner Board regarding such matters;
j) Review quality issues raised by contracted services and make recommendations to the CEO as necessary.
k) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
l) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees; and
m) Assist in obtaining and maintaining accreditation of the Medical Center.
n) Review and act on information derived from Risk Management, incident reports, and trend analysis, concurrent and retrospective, to effectively maintain a safe patient environment and reduces liability;
o) Declare a medical record complete for purposes of filing after attempts to contact the responsible physician have failed.
p) Provide oversight for the Utilization Review process. Including review and approval of the annual Utilization Review Plan.
q) Review and Analyzing findings from the Infection Control Plan indicators;
r) Implement and assess measures to prevent infections and optimize care;
s) review and review policies and procedures related to the Medical Center's Infection Control Program.
t) Implement plans to protect patients, visitors and staff; recommend the adoption or assisting in the formulation of policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to medications in both the hospital and any associated ambulatory department;
u) recommend or assisting in the formulation of programs designed to meet the needs of the professional staff (physicians, licensed independent practitioners, nurses, pharmacists) for complete current information on matters related to medications and pharmaceutical care (i.e. Medication Use Evaluation and Improving Organizational Performance);
v) evaluate objectively the clinical data regarding new medications or agents proposed for use in the hospital;
w) participate in the formulation and analysis of Medication Use Evaluations;
x) review and approving pharmacy policies and procedures;

y) review adverse drug reactions reports and making appropriate recommendations;
z) review medication occurrence reports and pharmacy intervention activities and making appropriate recommendations;

9.3-4 **MEETINGS**

The Medical Executive Committee shall meet as often as necessary and shall maintain a record of its proceedings and actions.

9.3-5 **ATTENDANCE REQUIREMENTS**

All members of the Medical Executive Committee are required to attend. If any Department Chair is unable to attend, he/she shall arrange in advance for the attendance of the Vice-Chairman of the Department or designee. When a member fails to attend or send a designee to three meetings consecutively or a minimum of 50% of the meetings, he/she will be contacted by the Chief of Staff who may appoint a representative to replace that member.

9.4 PROFESSIONAL REVIEW COMMITTEE

9.4-1 **COMPOSITION**

The Professional Review Committee (PRC) shall consist of at least five multidisciplinary physician and APP members, including the Chief Medical Officer who shall serve as Chairman. The Chairman shall designate a member of the Committee as Vice-Chairman. Members shall be members of the medical staff engaged to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities utilizing a Just Culture methodology. The Chief of Staff, CEO and CNO shall serve as ex-officio members of the PRC (without vote). Members shall be appointed for staggered terms of three years and may be appointed for successive terms. For the initial term, members may be appointed for a term less than three years.

9.4-2 **QUALIFICATIONS**

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

9.4-3 **SELECTION AND REVIEW PROCESS**

The Chief of Staff and the Chief Medical Officer shall assemble a slate of nominees to serve on the PRC and present it to the Medical Executive Committee and CEO, which shall select the members. The Medical Executive Committee will periodically review the performance of PRC members and may remove any member for failure to maintain qualifications as outlined in Bylaws Section 9.4-2 and/or uphold the duties of the position as outlined in Bylaws Section 9.4-4.

9.4-4 **DUTIES**

The duties of the Professional Review Committee shall include to:

a) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members utilizing Just Culture methodology;
b) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
c) Review sentinel events, near misses, and complex clinical issues;

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

9.5 CREDENTIALS COMMITTEE

9.5-1 COMPOSITION

The Credentials Committee shall consist of at least three active staff members, appointed by the Chief of Staff, and the CNO or other representative as defined by the CEO.

9.5-2 DUTIES

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

9.6 BYLAWS COMMITTEE

9.6-1 COMPOSITION

The Bylaws Committee shall consist of members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chairman. Committee will meet as necessary. The CEO or designee, CMO and Banner Health legal counsel shall be an ex-officio member of the Bylaws Committee, without a vote.

9.6-2 DUTIES

The duties of the Bylaws Committee shall include:

a) Conducting a review of the Bylaws when deemed necessary;

b) Submitting to the Executive Committee recommendations for changes in the Bylaws; and
c) Receiving and evaluating, for recommendation to the Executive Committee, suggestions for modifying the Bylaws.

9.7 PROFESSIONAL HEALTH AND WELLNESS COMMITTEE

9.7-1 COMPOSITION

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

9.7-2 DUTIES

The duties of the Professional Health Committee shall include:

a) Providing ongoing education to the Medical Staff and Administrative leadership on physician and AHP health and impairment recognition issues, on the different kinds and levels of impairment and the problems of impairment, and on resources available for the diagnosis, prevention, treatment and rehabilitation of impairment.
b) Evaluating the credibility of a complaint, allegation, or concern;
c) Maintaining confidentiality of the practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened;
d) Recommending available resources for diagnosis and/or treatment of physicians and AHP experiencing possible illness and impairment issues;
e) Serving as a resource for physicians and AHP experiencing illness and impairment issues;
f) Assisting the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
g) Assisting Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee;
h) Recommending to the affected practitioner that either a psychological, psychiatric and/or physical examination is obtained;
i) Ensuring the recommendations of the committee/subcommittee are being followed;
j) Monitoring the practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required;
k) Requiring the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the PHC or appropriate department chairman; and
l) Advising the appropriate Department Chairman/Executive Committee of the affected practitioner's failure to adhere with the recommendations.
m) Initiating appropriate actions when a practitioner fails to complete the required rehabilitation program.

ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 REGULAR MEETINGS

General staff meetings will be held as often as necessary as determined by the Chief of Staff.

10.1-2 **SPECIAL MEETINGS**

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

10.2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

10.2-1 **REGULAR MEETINGS**

Clinical departments and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. A department must meet as often as necessary to conduct department business.

10.2-2 **SPECIAL MEETINGS**

A special meeting of any department or committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Chief of Staff, or the Executive Committee. A notice of such special meeting will be sent to all members of the department or committee. Two days advance notice of such special meeting will be given to all members of the department or committee except the Professional Health Committee, the Professional Review Committee and the Executive Committee.

10.2-3 **EXECUTIVE SESSION**

Any department or committee may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group, CMO and CEO or designee and other individuals who have a legitimate reason to be present may remain during such session. Separate minutes must be kept of any executive session

10.3 ATTENDANCE REQUIREMENTS

10.3-1 **CHART REVIEW**

A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the PRC committee to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to appear may result in automatic suspension under Section 6.6-7.

10.3-2 **CLINICAL CONFERENCE**

Whenever a department and/or the PRC committee perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified by the department chairman and/or PRC committee chairman of the time, date, place of the program, the subject matter to be covered, and its special applicability to their practice. Attendance is mandatory. Failure to attend may result in initiation of corrective action proceedings. Absent good cause, failure to attend may result in automatic suspension under Section 10.6-7.

10.3-3 **SPECIAL APPEARANCE**

Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the Chief of Staff, or the

applicable department chairman and/or PRC committee chairman may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefore. Failure of a practitioner to appear at any such meeting may result in automatic suspension under Section 10.6-7.

10.4 QUORUM

10.4-1 GENERAL STAFF MEETINGS

A majority of those present at any regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws.

10.4-2 COMMITTEE MEETINGS

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

10.4-3 DEPARTMENT MEETINGS

Two members of the department shall constitute a quorum for the transaction of business before the department as a whole unless the department establishes a higher quorum requirement in its rules and regulations.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY, RELEASES AND INDEMNIFICATION

11.1 AUTHORIZATIONS AND RELEASES

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

a) Authorizes Medical Center representatives to solicit, provide, and act upon information bearing on or reasonably believed to bear upon the practitioner's professional ability, utilization practices, and qualifications;
b) Agrees to be bound by these Bylaws regardless of whether membership or clinical privileges are granted or are subsequently limited;
c) Acknowledges that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and the exercise of clinical privileges or provision of specified patient care services at the Medical Center;
d) Agrees to release from legal liability and hold harmless the Medical Center, Medical Staff, members of the Medical Staff, Medical Staff committees and all persons engaged in peer review activities, which include but are not limited to those activities identified in Article 11.3 of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws or any applicable federal or state statute or regulation; agrees that his/her sole remedy for any corrective action taken or recommended by the Medical Staff, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review action shall be the right to seek injunctive relief pursuant to ARS 36-445 et seq.
e) Agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to the Medical Center or its representatives; and

f) Authorizes the release of information about the practitioner in accordance with the Banner Board's sharing of information policy.

11.2 CONFIDENTIALITY OF INFORMATION

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

11.3 ACTIVITIES COVERED

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

a) Applications for appointments, clinical privileges, or specified services;
b) Periodic reappraisals for reappointment, clinical privileges, or specified services;
c) Corrective or disciplinary actions;
d) Hearings and appellate reviews;
e) Quality review program activities;
f) Utilization review and management activities;
g) Claims reviews;
h) Profiles and profile analysis;
i) Significant clinical event review;
j) Risk management activities; and
k) Other hospital, committee, department, section, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.4 RELEASES AND DOCUMENTS

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

11.5 CUMULATIVE EFFECT

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

11.6 EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every applicant to and member of the Medical Staff agrees that when corrective action is initiated or taken or when a recommendation is made by any committee or any person acting on its behalf, the effect of which is to deny, revoke, or otherwise limit the

privileges or membership of the applicant or staff member, such applicant or member shall exhaust the administrative remedies afforded in these Bylaws (and Fair Hearing Plan) prior to initiating litigation.

11.7 LIMITATION OF DAMAGES

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

11.8 INDEMNIFICATION

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

ARTICLE TWELVE: GENERAL PROVISIONS

12.1 MEDICAL STAFF RULES AND REGULATIONS

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

12.2 DEPARTMENT RULES AND REGULATIONS

Each department and section will formulate written rules and regulations for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with the Bylaws and Medical Center policies. These department rules and regulations must be reviewed and approved by the Executive Committee and the Banner Board as needed.

12.3 STAFF DUES

The Executive Committee shall establish the amount of annual Medical Staff and allied health professional dues. Notice of dues shall be given to the staff by written notice in January. Dues are payable on or before March 31 of each year. If dues are not paid a special notice of delinquency shall be sent to the practitioner and an additional 30 days given in which to make payment. All new staff members shall be billed given 30 days in which to make payment for the current year upon their appointment to the staff. Failure to render payment shall result in automatic suspension as provided in Section 6.7-6. 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.

12.4 LEADERSHIP STIPENDS

On an annual basis, the Medical Executive Committee may recommend that stipends and/or other payments be made to Medical Staff Officers, Department Chairs and other leaders for their service to the Medical Staff. The amount of such stipends and/or other payments is subject to approval by Banner Health, and must be documented in a written agreement signed by both parties. Use of Medical Staff funds must comply with the sponsored organizations policies and procedures.

12.5 SPECIAL NOTICE

When special notice is required, the Medical Staff Office shall send an electronic notice to the email address provided by the practitioner with confirmation of receipt. If such attempt is unsuccessful, notice shall be deemed to be delivered on the date delivery was first attempted.

12.6 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

12.7 PARLIAMENTARY PROCEDURE

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

12.8 CONFLICT RESOLUTION

12.8-1 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 one third members of the Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

12.8-2 MEDICAL EXECUTIVE COMMITTEE REVIEW

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

12.8-3 CONFLICT RESOLUTION RESOURCES AND BANNER BOARD RESPONSIBILITY

A recommendation to use either internal or external resources to resolve the conflict may be made by the Banner 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 Banner Board through the Medical Staff Subcommittee. The Banner Board has final authority to resolve differences between the Medical Staff and the Executive Committee.

12.9 HISTORIES AND PHYSICALS

A history and physical examination ("H&P") in all cases shall be completed by a physician, oral surgeon, or Allied Health Professional who is approved by the medical staff to perform admission H&Ps within 24 hours after admission. 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 practitioner documents in writing that such delay would constitute

a hazard to the patient. A legible H&P performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The content of complete H&P is delineated in the Rules and Regulations.

ARTICLE THIRTEEN: ADOPTION AND AMENDMENT

13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff shall be responsible for the development, adoption, and periodic review of these Bylaws which must be consistent and may not conflict with Medical Center policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Banner Board and the community.

13.2 PERIODIC BYLAWS REVIEW

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

13.3 MEDICAL EXECUTIVE COMMITTEE PROCESS

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

13.4 MEDICAL STAFF PROCESS

The Medical Staff may propose Bylaws or amendments thereto directly to the Banner Board. A petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Executive Committee. The Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Executive Committee. The Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Banner Board. Ballots shall be sent to each Active Staff member, by mail *or email,* along with the comments of the Medical Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing/emailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

13.5 URGENT PROCESS.

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Executive Committee may provisionally adopt, and the Board may provisionally approve the urgent amendment without the prior notification of the voting members of the Medical Staff. In such cases, the

voting members of the Medical Staff shall be immediately notified by the Executive Committee of the urgent amendment within ten (10) days after the Board has approved the amendment. The voting members of the Medical Staff shall have ten (10) days in which to retrospectively review the amendment and provide written comment to the Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict resolution as referenced in Section 12.8-2 shall be implemented, and a revised amendment shall be submitted to the Board.

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

13.5 -1 PERIODIC REVIEW

The Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations shall be reviewed and revised as needed. Reviews shall also be conducted upon request of the Banner Board.

13.5-2 COMMUNICATION TO THE MEDICAL STAFF

a) Routine matters - Absent a documented need for urgent action, before acting, the Executive Committee will communicate to the Staff by email proposed changes to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations before approving such changes. Members may submit comments and concerns to the Chief of Staff c/o Medical Staff Services within 10 days. If concerns are not received within 10 days, the Executive Committee's recommendation relating to the proposed changes will be submitted to the Banner 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 Medical Executive Committee and Banner Board may provisionally adopt an urgent amendment without prior notification of the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If concerns are not received within 10 days, the amendment stands. If there is a conflict and 40% Of the Active Staff oppose the amendment, the Executive Committee will utilize the conflict resolution process set forth in 12.8. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Banner Board for action.

13.5-3 MEDICAL STAFF AMENDMENTS

The Medical Staff may propose amendments to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations to the Bylaws Committee or directly to the Banner Board. To submit the amendments directly to the Banner Board, a petition seeking approval of proposed amendments signed by at least one third of the Active Staff members shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Medical Executive Committee. The Medical Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposes language, the members of the Medical Staff who proposed the

challenge can decide to recommend its language directly to the Banner Board. Ballots shall be sent to each Active Staff member by mail *or email,* along with the comments of the Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing/emailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the amendments.

13.6 BANNER BOARD OF DIRECTORS ACTION

13.6-1 WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION

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

13.6-2 BANNER BOARD CONCERNS

In the event the Banner Board has concerns regarding any provision or provisions of the proposed Bylaws or amendments thereto, the Banner Board shall advise the Medical Staff of its concerns. The Medical Staff may request, and if so requested, the Banner Board will establish, a joint conference committee comprised of three representatives of each body to resolve such concerns.

Neither body may unilaterally amend the Medical Staff Bylaws, except the Banner Board may take action if the Medical Staff fails to act within sixty (60) days following receipt of notice from the Banner Board to assure compliance with state and federal laws, Medicare Conditions of Participation or Joint Commission standards; in the event of substantial circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients; or in the event the Medical Staff fails to perform its functions delegated hereunder. Such action may be taken only after consideration of the matter by a Joint Conference Committee.

13.7 JOINT CONFERENCE COMMITTEE

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

13.8 TECHNICAL AND EDITORIAL AMENDMENTS

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

ADOPTION AND APPROVAL

Approved by the BHS Banner Board of Directors on April 9, 2020.

Amended by the Board:
September 10, 2020
May 13, 2021
October 14, 2021
February 13, 2025