Banner Thunderbird®
Medical Center

MEDICAL STAFF BYLAWS

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PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Thunderbird 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.

ARTICLE ONE: NAME & PURPOSES

1.1 NAME

The name of this organization is "The Medical Staff of Banner Thunderbird Medical Center."

1.2 PURPOSES

The purposes of the Medical Staff are:

1.2-1 To provide oversight for the quality of care, treatment, and services provided by practitioners with privileges, and to approve and amend Medical Staff bylaws.

1.2-2 To continually seek to provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Thunderbird Medical Center (the "Medical Center").

1.2-3 To provide a mechanism for accountability to the Banner Health ("BH") Board of Directors ("Board"), through defined organizational structures, for the review of the appropriateness of patient care services, professional and ethical conduct and teaching and research activities of each practitioner appointed to the Medical Staff, so that patient care provided at the Medical Center's facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

1.2-4 To provide an appropriate educational setting and to maintain high scientific and educational standards for continuing medical education programs for residents, fellows and Members of the Medical Staff ("Members" or "Staff Members").

1.2-5 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Medical Center and through which they fulfill the obligations of Staff appointment.

1.2-6 To provide an orderly and systematic means by which Staff Members can give input to the Board and the Medical Center's Chief Executive Officer ("CEO") on medico-administrative issues and on Medical Center policy-making and planning processes.

1.2-7 To evaluate clinical processes and outcomes and identify and implement opportunities for professional performance improvement.

1.2-8 To maintain the highest scientific and educational standards for continuing medical education programs for members of the Medical Staff.

1.3 RESPONSIBILITIES

Members of the organized Medical Staff are designated to perform the oversight activities of the organized Medical Staff. The responsibilities of the Medical Staff, through its departments, committees, and officers, include:

1.3-1 To participate in performance improvement, patient safety, and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided in the Medical Center, including:

- Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria and review of conduct;
- Engaging in the ongoing assessment and monitoring of patient care and safety practices; including but not limited to assessing processes, conducting Significant Clinical Event root cause analyses to improve patient care and safety practices, and monitoring the effectiveness of such improvements.
- Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and
- Promoting the appropriate use of Medical Center resources.

1.3-2 To make recommendations to the Board concerning appointments and reappointments to the Staff, including but not limited to category and department assignments, clinical privileges, corrective action, and termination of membership.

1.3-3 To participate in the development, conduct, and monitoring of medical education programs and clinical research activities.

1.3-4 To develop and maintain Bylaws, Rules and Regulations and Policies that are consistent with sound professional practices, and to take action, as necessary, to enforce them.

1.3-5 To participate in the Medical Center's long-range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

1.3-6 To exercise through its officers, committees, departments and other defined components, the authority granted by these Bylaws, to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.

ARTICLE TWO: MEMBERSHIP

2.1 QUALIFICATIONS

Staff membership is a privilege extended to practitioners who continuously meet standards and requirements set forth in these Bylaws. Every practitioner who seeks or enjoys Staff membership must, at the time of application and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as set forth in these Bylaws, department rules and regulations, Credentialing Manual or privilege delineation forms.

2.1-1 **Licensure**

Applicants for Medical Staff membership ("Applicants") and Members must have a current, unrestricted license to practice in Arizona that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked or restricted by any professional licensing agency in any state or other jurisdiction.

2.1-2 **Professional Education and Training**

- Applicants must have graduated from an approved medical, dental, podiatric school or school of osteopathy or attainment of a Ph.D. degree in psychology. Foreign Medical Graduates must be certified by the Educational Council for Foreign Medical Graduates or must have successfully completed the Foreign Medical Graduate Examination in the Medical Sciences. For purposes of this section, an "approved" or "accredited" school is one fully accredited for the entire time of the practitioner's attendance by the Accreditation Council for Graduate Medical Education ("ACGME"), by the American Osteopathic Association ("AOA"), by the Royal College of Physicians and Surgeons of Canada, by the Commission on Dental Accreditation, by the American Podiatric Medical Association's accrediting body, the Council on Podiatric Medical Education, or by a successor agency to any of the foregoing; and

- Applicants (other than podiatrists, dentists, optometrists and psychologists) must demonstrate satisfactory completion of postgraduate training in an internship or residency accredited by the ACGME, the AOA, or the Royal College of Physicians and Surgeons of Canada, with such postgraduate training to be in a field or specialty appropriate and acceptable to the department to which the applicant would be assigned if appointed to the Staff. Applicants must provide evidence that he/she is within the board examination system or board certified in the specialty in which privileges have been requested; and
- Applicants for the Affiliate Staff who are optometrists must complete a four-year post-graduate degree program in Optometry from an accredited school or college of Optometry recognized by the Accreditation Council on Optometric Education (ACOE) AND completion of a one-year residency program associated with an accredited school or college of Optometry or equivalent experience.
- Applicants for the Affiliate Staff who are podiatrists and dentists must demonstrate satisfactory completion of a postgraduate training program accredited by the American Podiatric Association's accrediting body, the Council on Podiatric Medical Education or the Commission on Dental Accreditation; and
- Applicants for the Affiliate Staff who are psychologists must possess a Ph.D. degree in psychology from a program approved by the American Psychological Association, possess certification by the American Board of Professional Psychologists, be currently listed in the National Register of Health Services Providers in Psychology, or meet the educational requirements for licensure in the State of Arizona. Applicants must also demonstrate at least one-year full-time experience or its equivalent in an inpatient setting (either pre- or post-doctoral) or in a mental health care setting.

2.1-3 **Clinical Performance**

Applicants and Members must have current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency. Each Clinical Department is responsible for developing and describing in its Rules and Regulations the process for the delineation of clinical privileges to individual practitioners.

2.1-4 **Professionalism**

Demonstrated ability and willingness to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care, and patient and employee satisfaction.

2.1-5 **Health Status**

Applicants and Members must be free from, or exhibit adequate control of, any significant physical, mental or behavioral impairment, with or without accommodation and free from abuse of any type of substance or chemical that may adversely affect cognitive, motor, or communication skills. Documentation of freedom from tuberculosis must be provided. Documentation of an influenza vaccination or an approved exemption (per BH policy) must also be provided by the designated deadline each year as determined by Occupational Health and Infection Prevention. Telemedicine and eICU practitioners will be exempt from influenza vaccination documentation if they do not otherwise physically practice at the hospital.

2.1-6 **Professional Ethics and Conduct**

- Applicants and Members must demonstrate high moral character and adherence to generally recognized standards of medical and professional ethics including, but not limited to, refraining from paying or accepting commissions or referral fees for professional services, or delegating the responsibility for diagnosis or care of patients to a practitioner not qualified to undertake that responsibility; seeking appropriate consultation when medically indicated; providing or arranging for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and obtaining informed patient consent to perform procedures and treatments.

- Members must maintain the confidentiality of peer review activities of the Medical Staff. Members may make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs.
- Members caring for a patient covered through contracted insurance plans will not, without disclosure and consent of the patient, use surgical assistants or others not contracted through such plans who will independently bill the patient.

2.1-7 **Board Certification**

(a) Membership on the Medical Staff does not require board certification. However, except as specially provided below, having Medical Staff privileges to practice at the Medical Center requires the applicant and Members to either be board certified or board qualified followed by board certification in the area of practice for which the applicant or Member is requesting Medical Staff privileges, as provided in Section 2.1-7(c) by one of the following:

- Physician: The American Board of Medical Specialties, the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada;
- Podiatrist: The American Board of Podiatric Medicine; or The American Board of Foot and Ankle Surgery;
- Dentist: A specialty recognized by the American Board of Dental Specialties or the American Board of Pediatric Dentistry; or
- Psychologist: The American Board of Professional Psychologists.

(b) For purposes of this section, "board qualification" or "board qualified" means the applicant or Member has completed the training necessary to be accepted to become, and has applied for and been accepted to become, an active candidate for board certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for board 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.

(c) Where Medical Staff privileges are granted on the basis of being board qualified certification must be obtained within five years of completion of training. Failure to become certified within the time allowed under these Bylaws or failure to pass the Board certification exam on the third attempt shall result in the voluntary, automatic relinquishment of the Member's Medical Staff privileges.

For purposes of this section, "Board certification" or "Board certified" means certified by a board approved by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the Royal College of Physicians and Surgeons of Canada, the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery, the American Dental Association or the American Board of Professional Psychologists or by a board determined by the department and Medical Executive Committee to be equivalent.

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

(e) Exceptions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:

- Those Members of the Medical Staff as of January 10, 1995, as long as they continuously qualify for and maintain membership as otherwise specified in these Bylaws or the Rules and Regulations of the applicable department; Where a

practitioner had membership and privileges as of the date of approval of these bylaws and based upon bylaws then in effect, the practitioner was not required to be certified;

- Where a particular field or specialty does not have a board certification;
- Where privileges are limited to surgical assisting; or
- To applicants or 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 and where the Medical Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those required to obtain board certification.

(f) Extensions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:

- A practitioner has taken the exam, and is awaiting results or has applied to take the next available exam and provides evidence of this; or
- A practitioner has submitted evidence of extraordinary circumstances, including a particular medical, physical, family, or financial hardship in which they were unable to become certified or recertified within the required time frame. In this instance, the practitioner must sit for the next available board exam to become certified or recertified. In the event the practitioner fails to certify or does not take the exam, the practitioner will be deemed to have resigned.
- Members of the Medical Staff who are within the initial board qualification stage after training and whose board allows for a longer period of time within which to become board certified.

(g) Any Member who is granted a waiver must obtain a minimum of fifty (50) hours of continuing medical education each year in order to remain a Member of the Medical Staff. Evidence of such continuing medical education shall be submitted to the Medical Staff Services Office of the Medical Center each year on or before the anniversary date of such Member's date of appointment to the Medical Staff. The failure by a Member who has been granted a waiver pursuant to this Paragraph to obtain required CME will result in the voluntary relinquishment of Medical Staff privileges.

(h) Members of the Medical Staff who have never been board certified, who are no longer board qualified and who were Members of the Medical Staff as of June 11, 2009 may request and be granted a waiver in the manner specified above.

2.1-8 **Verbal and Written Communication Skills**

Applicants and Members must be able to read and understand the English language and 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 and thorough manner.

2.1-9 **Effect of Other Affiliations**

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

- Licensure to practice in this or in any other State; or
- Certification by a clinical board; or
- Staff appointment or privileges at another healthcare facility or in another practice setting; or
- Prior Staff appointment or any particular privilege at Banner Thunderbird Medical Center (the "Medical Center").

2.1-10 **Nondiscrimination**

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill

patient care and required Staff obligations or any other criterion unrelated to the delivery of quality and efficient patient care at the Medical Center.

2.1-11 **Professional Liability Insurance**

Members must maintain professional liability insurance with liability limits in an amount as determined from time to time by the Board and with an insurance company that is acceptable to the Board. Members without clinical privileges are not required to maintain professional liability insurance.

2.1-12 **DEA**

A practitioner shall have in full force and effect a current Arizona Drug Enforcement Agency (DEA) number in good standing. Exceptions will be made for any practitioner that does not prescribe medications under a DEA. Failure of a practitioner to file the required documentation shall be adequate grounds for automatic suspension of the practitioner's rights to prescribe medications covered by the DEA in accordance with Bylaws Section 9.5-2.

2.1-12 **Ability To Participate in Federal Programs**

Practitioners seeking membership must demonstrate that they are not currently suspended, excluded, barred or sanctioned under the Medicare program, any Medicaid programs, including AHCCCS, or any other federal program for the payment or provision of medical services or any other government licensing agency, and are not listed by any federal agency as barred, excluded or otherwise ineligible for federal program participation. Exceptions and limited privileges may be granted to an Excluded Practitioner upon his/her signing an agreement whereby he/she agrees (a) not to provide items or services to patients enrolled in Medicare/State Programs and (b) to indemnify the hospital and the Medical Staff for any liability they might have solely as a result of a breach of this agreement. A finding of guilt for Medicare fraud is equivalent to be excluded from federal programs.

2.1-13 **Satisfaction of Membership Obligations**

Satisfactory compliance with the basic obligations accompanying appointment to the staff as set for in Section 2.3.

2.1-14 **Satisfaction of Criteria for Privileges**

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

2.1-15 **Exemptions From Qualifications**

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

2.2 RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP

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

(a) The right to meet with the Medical Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department chairman. The member must submit a written request to the Chief of Staff at least two weeks in advance of the meeting;
(b) The right to initiate the scheduling of a general staff meeting by following the procedures set forth in Section 10.1-3;
(c) The right to challenge any rule or policy established by the Executive Committee by following procedures set forth in Section 11.7;
(d) The right to request conflict resolution of any issue by presentation to the Medical Executive Committee of a petition signed by 20% of the Active Staff. Upon receipt of such a petition, the Executive Committee will schedule a meeting to discuss the issue;
(e) The right to request a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;
(f) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken;
(g) The right to request a review by the Medical Executive Committee or CEO (or designee of the CEO) in the event that non-reviewable corrective action is taken.

(h) The right to request that the Medical Executive Committee request a Joint Conference Subcommittee meeting with the Board to resolve concerns regarding Medical Staff bylaws, credentialing recommendations, policies or other issues which such Medical Staff has been unable to resolve through informal processes with the CEO, senior management, the Medical Staff Subcommittee, or the Board of Directors.
(i) The right to initiate a recall election of a Medical Staff Officer and/or a department chairman by following the procedures set forth in Section 6.7 and/or Section 7.4

2.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

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

(a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate;
(b) Abide by the Banner Health Bylaws, these Bylaws, Department Rules and Regulations, the Banner Code of Conduct and all other standards and policies of the Medical Staff and/or Medical Center;
(c) Discharge such Staff, committee, section, department and Medical Center function for which he or she is responsible, including review and supervision of the performance of other practitioners and serving on the on-call roster for charity, unassigned, and emergency patients;
(d) Provide consultations for patients when requested directly or through coverage arrangements
(e) Cooperate in any review of a practitioner's (including one's own) credentials, qualifications or compliance with these Bylaws, and refrain from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise;
(f) Exhibit professional conduct at all times and refrain from unprofessional conduct.
(g) Prepare and complete in a timely fashion, according to these Bylaws and the Medical Center's policies, the medical and other required records for all patients to whom the practitioner provides care in the Medical Center, or within its facilities, services or departments;
(h) Abide by the ethical principles of the profession including arranging for appropriate and timely medical coverage and caring for patients for whom he or she is responsible and obtaining consultation when necessary for the safety of those patients;
(i) Treat as confidential any information discussed in executive session;
(j) Participate in mandatory call coverage (or pay appropriate assessments, if so permitted by the Executive Committee) and participate in supervisory or consultation panels if, as and when it may be determined necessary by the applicable department(s), the Executive Committee or the Board. Participation in mandatory call coverage is an obligation, and not a right, of membership on the Medical Staff. No one denied the right of such participation shall have a right to claim damages from the Medical Center or any of its employees or from the Medical Staff or any Staff Member.
(k) Immediately notify the Chief Executive Officer and the Chief of Staff of the revocation or suspension of his/her professional license, the imposition of terms of probation or limitation of his/her practice by any state licensing agency, including any stipulation; the cancellation or restriction of his/her professional liability coverage; or the revocation, suspension or voluntary relinquishment of his/her DEA number;
(l) Immediately notify the Chief Executive Officer and the Chief of Staff of his/her denial or loss of staff membership or denial, loss, curtailment or restriction of privileges at any hospital or other healthcare institution or an agreement to refrain from practice at any hospital or other healthcare institution or any adverse determination by a peer review organization concerning his/her quality of care;
(m) Communicate with patients and make entries in hospital medical records solely in accordance with, and to the extent authorized by, Medical Staff Rules and Regulations;
(n) 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;
(o) 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;

(p) Refrain from disclosing confidential information, including peer review information, to anyone unless authorized to do so;

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

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

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

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

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

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

(w) Participate in the BTMC orientation program as required by the MEC.

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

2.4 TERMS OF APPOINTMENT

Each appointment to the Staff shall be for two years. The appointment of each Member shall expire every two years.

2.4-1 Expiration

- The appointment of each staff member shall expire every two years on the last day of the birth month of the practitioner, except as provided below. An interim reappointment may be necessary to align the practitioner with the two-year birth month reappointment cycle.
- The Board, after considering the recommendations of the MEC, may set a more frequent reappraisal period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability, has been the subject of disciplinary action, or is under investigation or where further evaluation is pending.

2.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

2.5-1 Qualifications

All Practitioners rendering professional services at the Medical Center pursuant to contracts or employment with the Medical Center, including all practitioners rendering professional services on behalf of third-party payers with which the Medical Center contracts, shall be required to maintain Medical Staff membership and privileges in good standing under the provisions of these Bylaws. Unless otherwise specifically provided in the contracts for professional services, termination of such contract shall not result in automatic termination of Medical Staff membership and privileges. The Department of Surgery shall have the primary departmental responsibility for the Pathologists with respect to appointment, reappointment and the delineation of privileges.

2.6 EXCLUSIVE CONTRACTS

The Medical Center may enter into an Exclusive Agreement with members of the Medical Staff which limit the rights of other practitioners to exercise some or all of the clinical privileges and/or the rights and prerogatives of Medical Staff membership previously granted to them. Such Agreements may only be entered into after a determination that expected improvements to and or continuation of the quality of care, coverage, cost-efficiency and service excellence will outweigh the anticompetitive effect of the Agreement, as required by the Board's Physician Exclusive Agreements policy. No reporting is required under federal or state law when a practitioner's privileges or membership are limited because an Exclusive Agreement is entered into, and no such reports shall be made.

2.7 REVIEW OF POSITIONS

- Prior to entering into an Exclusive Agreement for a program or service not previously covered by an Exclusive Agreement, and prior to renewing or transferring an Exclusive Agreement, the CEO shall explain to the MEC the need for, and expected benefits of, the Exclusive Agreement.
- The MEC shall give Medical Staff members whose privileges may be adversely affected by the establishment or modification of the Agreement an opportunity to submit written information to the Medical Executive Committee regarding the impact the establishment of the Agreement would have on the quality of patient care to be provided and/or why the Agreement is not necessary to achieve the expected benefits.
- The MEC shall be given an opportunity to report its findings to the CEO before the Exclusive Agreement is entered into, renewed or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care, including information relating to the qualifications of the practitioners who would be providing services under the Agreement, and whether the Agreement is necessary to achieve the expected benefits. The report must be submitted, if at all, within 60 days of when the CEO provided the MEC with an explanation of the need for, and expected benefits of, the Agreement. The CEO is ultimately responsible for determining, in his/her discretion, whether to enter into, renew or transfer the Agreement.
- In the event the MEC disagrees with the decision of the CEO to enter into, renew or transfer an Exclusive Agreement, the MEC may request that the decision be reviewed by a Joint Conference Committee as set forth in Section 13.10. The request must be made, if at all, within 10 days of when the MEC's receives notification of the CEO's decision.

2.8 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 peer review committee, including the Medical Executive Committee, the effect of which is to deny, revoke, suspend or otherwise limit the privileges or membership of the applicant or Staff Member, he or she shall exhaust the administrative remedies afforded in these Bylaws and the Fair Hearing Plan prior to initiating any legal action.

2.9 LIMITATION OF DAMAGES

Neither the Medical Center, the Medical Staff nor any person involved in carrying out peer review duties or functions for the Medical Center or the Medical Staff may be liable for damages to any applicant to or Member of the Medical Staff who is denied membership on the Medical Staff or privileges to practice in the Medical Center or whose membership or privileges are denied, suspended, limited or revoked. The only legal action which may be maintained by an applicant to or Member of the Medical Staff based on the performance or nonperformance of such duties or functions, or any other violation of these Bylaws, is an action for injunctive relief seeking to correct an erroneous decision or procedure. The review shall be limited to a review of the record. If the record shows that the denial, revocation, limitation or suspension of membership and/or privileges is supported by substantial evidence, no injunction shall issue. In such actions, the prevailing party shall be awarded taxable costs, but no other monetary relief and no attorney's fee shall be awarded.

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

2.10 MEDICAL DIRECTORS, MDCC AND CMO

2.10-2 **Medical Director, Care Coordination**

The Medical Director of Care Coordination shall automatically be granted Active Staff membership and serve as an ex-officio member on Medical Staff Committees consistent with the scope of his or her responsibilities as related to care coordination and/or utilization management. For the MDCC to exercise privileges at the Facility s/he must apply for membership and privileges in the manner described in these Bylaws, must pay annual dues and must continuously satisfy the qualifications and complete the requirements set forth in Sections 2.1.

2.10-3 **Chief Medical Officer**

The Chief Medical Officer shall automatically be granted Active Staff membership and serve as an ex-officio member on all Medical Staff Committees. The Chief Medical Officer need not remain in the active practice of medicine and need not comply with the applicable requirements in Section 2.1. For the Chief Medical Officer to exercise privileges at the Facility, s/he must apply for membership and privileges in the manner described in these Bylaws and must pay annual dues. The Chief Medical Officer shall have Medical Staff leadership and peer review responsibilities as delegated by the Medical Executive Committee including, but not limited to, responsibility for reviewing care, conducting investigations, identifying trends and resolving issues.

2.11 GRADUATE MEDICAL EDUCATION

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

2.12 CREDENTIALING PROCESS

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

ARTICLE THREE: MEDICAL STAFF CATEGORIES

3.1 CATEGORIES

There will be five categories of appoints to the Medical Staff: active, courtesy, telemedicine, affiliate and honorary.

3.2 ACTIVE MEDICAL STAFF

3.2-1 **Qualifications**

The active staff shall consist of physicians and podiatrists who demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center or are regularly involved in the care of patients in the Medical Center facilities. Active staff must admit or otherwise be involved in a minimum of twenty-five (25) patient admissions, consultations or inpatient/outpatient procedures at the Medical Center during the previous 12 months or must be able to document he/she has made a significant contribution to support the Medical Center's patient care mission to the satisfaction of the MEC. For purposes of satisfying the patient contact requirements described in the preceding sentence, being involved in the care of patients treated at outpatient surgical centers affiliated with the Medical Center shall be counted. Active Staff status may be requested, when qualifications are met, any time after the first provisional year.

3.2-2 **Prerogatives**

An Active Medical Staff Member may:

- Admit patients, except as set forth in department Rules and Regulations and Medical Center admission policies;
- Exercise such clinical privileges as are granted by the Board;
- 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;
- 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 MEC.

3.2-3 **Obligations**

An Active Medical Staff Member, must meet the basic obligations set forth in these Bylaws, including Section 2.3, and pay staff dues and assessments as required and, in addition:

- Contribute to the organizational, administrative, quality and peer review and utilization management activities of the Medical Staff; be willing to serve in Medical Staff, department offices and on Medical Staff committees; and faithfully perform the duties of any office or position to which elected or appointed;
- Provide oversight in the process of analyzing and improving the patient experience.

3.2-4 **Failure to Satisfy Qualifications**

Failure of an Active Medical Staff Member to satisfy the qualifications or obligations of the Active Medical Staff category for any reappointment period or portion thereof may result in reassignment to another Staff category. A Medical Staff Member who feels he or she has unjustly been moved from the Active Medical Staff category may request reconsideration of the change by the MEC but shall not receive the benefit of the Fair Hearing Plan.

3.3 COURTESY MEDICAL STAFF

3.3-1 **Qualifications**

The Courtesy Medical Staff shall consist of physicians and podiatrists 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 the Medical Center.

3.3-2 **Prerogatives**

A Courtesy Medical Staff Member may:

- Admit patients, except as set forth in department rules and regulations and Medical Center admission policies;
- Exercise such clinical privileges as are granted by the Board;
- Be appointed to the committees unless otherwise specified by these Bylaws;
- Vote on all matters presented at committees to which he or she has been appointed; and
- Attend General Staff and assigned department meetings, without vote.

3.3-3 **Obligations**

A Courtesy Medical Staff Member must meet the basic obligations set forth in these Bylaws, including Section 2.3, and pay staff dues and assessments as required.

3.3-4 **Change in Staff Category**

Courtesy Medical Staff Members shall be advanced to the Active Medical Staff category at the time the qualifications set forth in Section 3.2-1 are satisfied.

3.4 AFFILIATE STAFF

3.4-1 **Qualifications**

The Affiliate Staff shall consist of dentists (not including oral surgeons), psychologists, PhDs and physicians whose privileges are limited to surgical assisting who treat patients at the Medical Center or who are involved in the affairs of the Medical Staff or Medical Center.

3.4-2 **Prerogatives**

An Affiliate Staff member may:

- Exercise such clinical privileges as have been granted by the Board;
- Demonstrate his/her continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results

and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers;

- Be appointed to committees unless otherwise provided by these Bylaws; and
- 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.

3.4-3 **Obligations**

An Affiliate Staff member must meet the basic obligations set forth in these Bylaws, including the applicable provisions of Section 2.3, and pay all staff dues and assessments.

3.4-4 **Change in Staff Category**

Failure to demonstrate treatment of patients in a Hospital setting during two reappointment periods may result in a practitioner reverting to community-based.

3.5 HONORARY MEDICAL STAFF

3.5-1 **Qualifications**

Membership on the Honorary Medical Staff is by invitation. It is restricted to practitioners for whom, upon retirement from practice, the MEC recommends and the Board approves this status in recognition of significant, prolonged service or other noteworthy contributions to the Medical Center. Honorary Medical Staff Members shall receive a lifelong appointment to the Medical Staff. Specific qualifications under Article 2.1 are waived for the Honorary Medical Staff.

3.5-2 **Prerogatives**

Honorary Staff Members are not eligible to vote or to hold an elected office and are not required to pay dues or assessments. Honorary Staff Members are not allowed to participate in patient care.

3.6 TELEMEDICINE STAFF

3.6-1 **Qualifications**

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

3.6-2 **Prerogatives**

A telemedicine staff member may treat patients via electronic communication link, except as set forth in department rules and regulations, privilege criteria and Medical Center policies; exercise such clinical privileges as are granted by the Board; be appointed to committees unless otherwise provided by these Bylaws; and vote on matters presented at committees to which he or she has been appointed unless otherwise limited by these Bylaws or by departmental rules and regulations. A telemedicine member may not vote on matters presented at general and special meetings of the Medical Staff or of the department of which he she is a member; nor hold office at any level of the staff organization.

3.6-3 **Obligations**

Telemedicine Staff Members must meet the applicable basic obligations set forth in these Bylaws, including the applicable provisions in Section 2.2, and pay all staff dues and assessments as determined by the Medical Executive Committee.

ARTICLE FOUR: ADVANCED PRACTICE PROVIDERS & ALLIED HEALTH PROFESSIONALS

4.1 ADVANCE PRACTICE PROVIDERS & ALLIED HEALTH PROFESSIONALS DEFINED

Advance Practice Providers (APPs) and Allied Health Professionals (AHPs) are individuals who provide services in the Medical Center, who are not members of the Medical Staff, but whose practice fits in one of the categories listed in Section 4.2 of these Bylaws and who:

4.1-1 Are qualified by training, experience and current competence in a discipline permitted to practice in the Hospital;
4.1-2 Function in a medical support role to physicians who have agreed to work with such APPs and/or AHPs;
4.1-3 Qualify for a category of APP or AHP approved by the MEC and the Board;
4.1-4 Meet the applicable qualifications set forth in Section 2.1; and
4.1-5 Follow established hospital policies and procedures.

4.2 CATEGORIES OF APP'S & AHPs CURRENTLY AUTHORIZED TO FUNCTION IN THE MEDICAL CENTER

4.2-1 The following are the only categories of APP's authorized to provide services in the Medical Center: Physician Assistants and Advanced Practice Nurses, including Nurse Anesthetists and Certified Nurse Midwives.
4.2-2 The following are the only categories of AHPs authorized to provide services in the Medical Center: Clinical Perfusionists, Intraoperative Monitoring Techs, Non-Physician first assistants (RNFAs/Certified Surgical Technician), Optometrists, Licensed Social Workers, Crisis Counselors, Scrub Techs and Radiology Practitioner Assistants.
4.2-3 If and when appropriate, the MEC may recommend the addition or elimination of categories of APPs and AHPs authorized to provide services in the Medical Center. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws.

ARTICLE FIVE: PRACTICE PRIVILEGES

5.1 BASIS FOR PRIVILEGES DETERMINATIONS

Clinical practice privileges shall be granted in accordance with the practitioner's qualifications and demonstrated current competence. In reappointment determinations, results of quality assurance and utilization review and, where appropriate, supervised cases and practice will also be considered. In review of requests for additional privileges, evidence of appropriate qualifications must be documented.

5.1-1 **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. Practitioners desiring to utilize new technologies or perform new procedures may apply for privileges to do so following the process set forth in Article Seven of these Bylaws after the Department has either created new criteria for such privileges or determined that no new criteria is necessary. The department's determination is subject to ratification by the Executive Committee and the Board.

5.2 TELEMEDICINE PRIVILEGES

The MEC shall determine which patient care, treatment, and services may be provided by Practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine and Teleradiology services may be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand.

5.3 EXERCISE OF PRIVILEGES

5.3-1 **In General**

(a) The following must be successfully completed, as applicable, prior to exercising privileges at the Medical Center:

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

(b) Provider's privileges will be pended until CPOE training, New Provider Orientation and/or the ID Verification is completed.

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

5.4 PRIVILEGE DECISION NOTIFICATION

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

5.5 EMERGENCY PRIVILEGES IN A DISASTER SITUATION

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 Medical Staff Member is authorized, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license. A Medical Staff Member 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.

5.5-1 In the event that the Hospital Emergency Management Plan is activated, and the organization is unable to meet immediate patient needs, the Hospital's CEO or Chief of Staff, or their respective designees, may grant emergency privileges during the disaster to volunteer licensed independent practitioners or allied health professionals who are not then members of the Medical Staff. Oversight of the professional performance of volunteer practitioners who receive disaster privileges will be the responsibility of the Chief of Staff, Chief Medical Officer, or the appropriate Department Chair or other designee. Such volunteer practitioner's credentials shall be verified by Medical Staff Services Department as soon as the immediate situation is under control and completed within 72 hours from the time the volunteer presents to the Hospital or, under extraordinary circumstances, as soon as possible. Volunteers must provide a valid photo identification issued by a state or federal agency and at least one of the following: (1) current hospital photo ID card, (2) current medical license verified through primary source, (3) valid photo ID issued by a state, federal, or regulatory agency, (4) an ID that certifies the physician is a member of a state or federal disaster medical assistance team, (5) an ID that certifies the physician has been granted authority by a federal, state or municipal entity to administer patient care in emergencies; and/or (6) verification by a current hospital or medical staff member who can attest to physician's identity. The procedure for granting emergency privileges during a disaster shall be in accordance with the Disaster Credentialing for Patient Care Provider Policy. Termination of these emergency privileges, regardless of reasons, shall not give rise to a hearing or review.

5.6 SPECIAL CONDITIONS FOR ORAL SURGEONS AND DENTISTS

Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Department of Surgery. An oral surgeon with qualifications approved by the Department of Surgery may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient, but only in those instances where the patient has no known current medical problems. In all other circumstances, a physician member of the Medical Staff must perform a basic medical appraisal on an oral surgery or dental patient, must determine the risk and effect of any proposed surgical or special procedure on the total health status of

the patient, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When a significant medical condition is present, the final decision on whether to proceed with the surgery must be agreed upon by the oral surgeon or dentist and the physician consultant. The chairman of the Surgery Section will decide the issue in case of a dispute.

5.7 SPECIAL CONDITIONS FOR PODIATRISTS

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

5.8 SPECIAL CONDITIONS FOR OPTOMETRISTS

Optometrists with clinical privileges must meet all requirements and have an arrangement with an admitting physician on the Medical Staff who agrees to perform the history and physical and provide physician services outside the scope of the practice of the Optometrist.

5.9 TEMPORARY PRIVILEGES

5.9-1 Conditions

Temporary privileges may be granted only under the conditions described below, to an appropriately licensed practitioner. Special requirements of consultation and reporting may be imposed by the Chief of Staff or chairman of the applicable department(s). Under all circumstances, the practitioner requesting temporary privileges must agree and shall be deemed to have agreed to abide by the Medical Staff Bylaws, Rules and Regulations, the Medical Center's policies and the BH Bylaws.

5.9-2 Circumstances

Temporary privileges may be granted in the following circumstances:

(a) Pendency of Application

Requests for temporary privileges during the pendency of the application may be granted by the Chief Executive Officer or designee upon review and approval of a complete application by the Credentials Committee chairman or designee, the department chairman or designee and the Chief of Staff or designee. A completed application includes; verification of current licensure and DEA, relevant training or experience, current competence, ability to perform the privileges requested and other such criteria as set forth in these Bylaws, rules and regulations; the results of the National Practitioner Data Bank query; and one that has no current or previously successful challenges to licensure or registration, has not been subject to involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization. When requested, temporary privileges may be granted in this circumstance until final action is taken but not greater than 120 days, on the application or until such privileges are terminated as set forth in Section 5.9-3. Temporary privileges may be granted only when the information available supports a favorable determination regarding the practitioner's application for membership and privileges. Under no circumstances may temporary privileges be granted if the application is pending because the Applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Care of Specific Patient

Temporary privileges may be granted to a practitioner when there is an important patient care need for of a specific patient, but only after receipt of a request for the specific privileges desired and telephone confirmation or receipt of a copy of appropriate licensure and DEA/controlled substances registration. Requests for temporary privileges of this nature may be granted by the Chief Executive Officer and one of the following: applicable department chairman, Chief of Staff, or their respective designees. Temporary privileges of this nature may not be granted in more than two (2) instances in any 12-month period

(except in the event of a disaster). Such temporary privileges are restricted to the specific patients for whom they are granted.

(c) Temporary Privileges Coverage of Service

In special circumstances where a service is not adequately covered to meet patient care needs, temporary privileges may be granted to an applicant staff membership, but only after receipt of a completed and verified application for Staff appointment, including a request for specific privileges; confirmation of appropriate licensure, DEA/controlled substances registration; education and training; current clinical competency; evidence of freedom from infectious tuberculosis and recent flu vaccination, when applicable; denial or loss of privileges at practitioner's primary facility; freedom from government sanctions; completion of CPOE training, NPO and photo ID verification; and NPDB query response. Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of the physician convenience. Requests for temporary privileges of this nature may be granted by the Chief Executive Officer upon review and approval of the completed application by the Credentials Committee chairman or designee and one of the following department chairman, Chief of Staff, or their respective designees. The temporary privileges granted to a practitioner may be considered on an individual basis for a period not exceed 60 days in length and may be extended for a period not to exceed 60 days. Any such extension shall be made by the department chair when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. If a practitioner is serving as locum tenens for one week or less, temporary privileges during this period may be granted by the CEO after consultation with the Chief of Staff and the department chairman, and verification of licensure and Staff membership and privileges in good standing at one other acute care hospital.

(d) Privileges for Additional Procedures

Temporary privileges to perform specific procedures which have been approved to be performed at the Medical Center for which the Member has not previously been granted privileges may be granted, but only after receipt of a request for the specific additional privileges desired and/or documentation of appropriate training and current clinical competence. Requests for temporary privileges of this nature may be granted by the Chief Executive Officer or designee and either the applicable department chair or the Chief of Staff, or their respective designee. Temporary privileges for specific additional procedures may not be granted more than once and may not be granted for a period of more than sixty (60) days. If the Member wishes to perform such procedure after the expiration of his or her temporary privileges, the Member must apply for full privileges to perform such procedures.

(e) Temporary privileges may be granted to a medical staff member with a routine application where the Banner Board Medical Staff Subcommittee has recommended reappointment to the Board.

5.9-3 Termination of Temporary Privileges

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

5.9-4 Rights of Practitioner

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

ARTICLE SIX: GENERAL STAFF OFFICERS

6.1 GENERAL OFFICERS

6.1-1 Designation

The Medical Staff will have the following general officers:

(a) Chief of Staff;
(b) Vice Chief of Staff;
(c) Secretary/Treasurer;
(d) Immediate Past Chief of Staff; and
(e) Two Members-at-Large

6.1-2 Eligibility Criteria

Only a Member of the Medical Staff who satisfies the following criteria initially and continuously will be eligible to serve as a General Officer of the Medical Staff (unless an exception is recommended by the Medical Executive Committee and approved by the Board). They must:

(a) have served on the Active Staff for at least five years (at least two years for members-at-large);
(b) be a member of the Active Staff and in good standing at the time of nomination and election and remain as such during his or her term of office;
(c) have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competency;
(d) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;
(e) not be under investigation by any state or federal agency regarding clinical competence or professional conduct;
(f) not presently be serving as a Medical Staff officer, Board member, or Department Chair at any other hospital and will not so serve during their terms of office;
(g) not have interests that materially conflict with the interests of Banner, the Medical Staff, or the Medical Center.
(h) have demonstrated an ability to work well with others;
(i) have actively and constructively participated in Medical Staff affairs;
(j) be willing to attend continuing education relating to Medical Staff leadership, peer review and/or credentialing functions; and
(k) be able and willing to faithfully discharge the duties and responsibilities of the position and work with other members of the Medical Staff, hospital Administration and the Board.

In addition, the Chief of Staff shall be board certified in his/her specialty by an approved board and have served as a general officer, department officer, or Chair of a standing committee of the Medical Staff for at least two years.

6.1-3 Compensation

The Medical Staff acknowledges that the MEC may compensate General Officers.

6.2 TERM OF OFFICE

6.2-1 The term of office for each general Staff officer shall be two years.

6.2-2 Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy shall assume office immediately upon appointment and serve for the remainder of the unexpired term.

6.2-3 Each officer shall serve until the end of his or her term or until a successor is elected and takes office, unless such officer resigns or is removed from office.

6.2-4 No officer shall hold the same office for more than two consecutive terms, however nonconsecutive terms are permissible.

6.2-5 No Medical Staff Member shall hold more than one general staff office at a single time and no Medical Staff Member may serve simultaneously as a General Officer and as a Department or Section Chair.

6.3 NOMINATIONS

6.3-1 The Medical Staff Leadership Development & Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each position. 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 any other hospitals or surgical centers. By the August meeting of the MEC, the Medical Staff Leadership Development and Nominating Committee will prepare and submit a slate of nominees for each General Officer position that is or will be vacant by the end of the year. Once approved by the MEC, notice of the nominees will be provided to the Medical Staff at least 30 days prior to the election.

6.3-2 Additional nominations may be submitted, in writing, by a petition signed by at least 10% of the voting Members of the Medical Staff. The petition must be presented to the Chairperson of the Medical Staff Leadership Development and Nominating Committee at least 20 Days prior to the election.

6.3-4 In order for a nominee to be placed on the ballot, the candidate must:

(a) Submit, in writing, a statement affirming willingness to serve;

(b) Disclose information known to the nominee that may conflict with the qualifications delineated in Section 6.1-2 of these Bylaws; and

(c) In the judgment of the Medical Staff Leadership Development and Nominating Committee satisfy the qualifications in Section 6.1-2 of these Bylaws.

6.4 ELECTION

(a) The election process shall occur via electronic voting using a secure system. The ballot shall be sent out electronically to all Active Staff Members (as of the first day of October) at their e-mail address of record no less than 30 days following approval of the slate by the MEC. Active Staff Members shall have five days to submit their votes, however this time period may be extended if a quorum has not been achieved.

(b) At least 10% of the Active Staff Members must participate in the voting.

(c) The candidates for each position receiving a majority of the votes cast will be elected.

(d) If no candidate for a position receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes. If a tie results, a quorum of Medical Executive Committee members shall vote by secret ballot at its next meeting or a special meeting called for that purpose and at which a quorum of the Medical Executive Committee members are present.

(e) If there is only one candidate on the slate of nominees for an open position, that candidate shall be deemed elected to the position upon approval of the slate by the Medical Executive Committee.

6.5 VACANCIES

6.5-1 If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve until the end of the unexpired term of the Chief of Staff.

6.5-2 If there is a vacancy in the office of Vice Chief of Staff or Secretary/Treasurer, the Medical Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 6.1-2 of these Bylaws, to the office until a special election can be held.

6.5-3 If there is a vacancy in the position of an at-large member of the Medical Executive Committee, the Medical Executive Committee will appoint an individual, who satisfies the qualifications set forth in Section 6.1-2 of these Bylaws, to the position until a special election can be held.

6.5-4 In the temporary or permanent absence of both the Chief of Staff and the Vice Chief of Staff, the Secretary/Treasurer shall assume all the duties and responsibilities and have the authority of the Chief of Staff until such time as a new Chief of Staff and Vice Chief of Staff are elected.

6.5-5 In the temporary or permanent absence of all General Officers, the Chief Executive Officer shall appoint interim officers to fill these positions and an election shall be conducted within 90 days. The Medical Staff Leadership Development and Nominating Committee shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following the nomination of candidates, the Medical Staff shall hold elections for these offices, using the election procedures described in these Bylaws.

6.6 RESIGNATIONS

Any General Officer of the Medical Executive Committee may resign at any time by giving written Notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

6.7 REMOVAL FROM OFFICE

6.7-1 Removal of a General Officer of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Staff or a two-thirds vote of the Medical Executive Committee for:

(a) failure to comply with or enforce applicable Hospital policies, these Bylaws, other Medical Staff policies, or the Rules and Regulations;
(b) failure to perform the duties of the position held;
(c) conduct detrimental to the interests of the Medical Staff or the Hospital;
(d) an infirmity that renders the individual incapable of fulfilling the duties of that office; or
(e) failure to continue to satisfy any of the criteria in Section 6.1-2 of these Bylaws.

6.7-2 A petition signed by at least one-third of the Active Staff or a simple majority vote of the Medical Executive Committee initiates the removal process and triggers a Special Meeting to consider the matter. Prior to scheduling a meeting to consider removal, a representative from the Medical Staff or the Medical Executive Committee, as applicable, will meet with and inform the individual of the reasons for the proposed removal proceedings.

6.7-3 The individual will be given at least ten Days' Special Notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the Medical Executive Committee or the Active Staff, as applicable, prior to a vote on removal.

(a) If initiated by petition, removal shall be considered by the Medical Staff at a special meeting as provided in Section 10.1-3 of these Bylaws for the purpose of considering and acting upon the request for removal. Removal shall require two-thirds vote of the Active Medical Staff and shall be effective immediately upon tabulation of the vote.

If initiated by the Medical Executive Committee, removal shall be considered at a Special Meeting or regularly scheduled meeting of the MEC. Removal shall require two-thirds vote of the MEC and shall be effective immediately upon tabulation of the vote.

6.8 DUTIES OF OFFICERS

6.8-1 Chief of Staff

The Chief of Staff shall serve as the highest elected officer of the Medical Staff and will:

(a) Promote adherence to and enforce the Bylaws, policies, manuals, Rules and Regulations of the Medical Staff, and the policies and procedures of the Hospital, and implement sanctions where indicated;
(b) Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and MEC;
(c) Serve as an ex-officio member of all other Medical Staff committees without vote, unless his or her membership in a particular department or committee is required by these Bylaws;
(d) Appoint, with the consultation of the MEC, members for all standing and special Medical Staff and multi-disciplinary committees, and designate the Chair of these committees;
(e) Act in coordination and cooperation with the CEO, CMO, and the Board in matters of mutual concern within the Medical Center;
(f) Represent the views and policies of the Medical Staff to the Board and to the CEO;
(g) Be a spokesperson for the Medical Staff in external professional affairs;
(h) Perform such other functions as may be assigned by these Bylaws, by the Medical Staff, or by MEC;
(i) Serve on the Banner Peer Review Committee;
(j) Attend meetings of the Banner Chiefs of Staff;
(k) Receive and act upon requests of the Medical Staff from the Board;
(l) At the Board's request, report on the performance and maintenance of quality and patient safety as delegated by the Board to the Medical Staff;
(m) Meet and discuss with the Board any matters of concern to the Medical Staff; and
(n) Perform the duties of appointees and other members of the MEC in the event of their absence or unavailability, after attempting to solicit input from relevant stakeholders

6.8-2 Vice Chief of Staff

The Vice Chief of Staff will:

(a) Assume all duties and authority of the Chief of Staff in his or her absence; and
(b) Perform other duties as are assigned by the Chief of Staff or the MEC.

6.8-3 Immediate Past Chief of Staff

The immediate Past Chief of Staff will:

(a) Serve as an advisor to other Medical Staff Leaders,
(b) Serve on the Nominating Committee; and
(c) Perform other duties as are assigned by the Chief of Staff or the MEC.

6.8-4 Secretary/Treasurer

The Secretary/Treasurer will:

(a) Cause to be kept accurate and complete minutes of meetings of the Medical Executive Committee and Medical Staff;
(b) Give proper Notice of Medical Staff meetings;

(c) Oversee the collection of and accounting for any Medical Staff funds and make disbursements authorized by the Medical Executive Committee;
(d) Perform other duties as are assigned by the Chief of Staff or the Medical Executive Committee; and
(e) in the temporary or permanent absence of the Chief Staff and the Vice Chief of Staff, assume all duties and responsibilities and have the authority of the Chief of Staff until such time as a new Chief of Staff is selected.

6.8-5 **Members-at-Large**
The members-at-large will:

(a) Perform duties as are assigned by the Chief of Staff or the Medical Executive Committee.

ARTICLE SEVEN: CLINICAL DEPARTMENTS

7.1 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 entrusted with the authority, duties and responsibilities as specified in this Article. When appropriate, MEC may recommend the creation, elimination, modification, or combination of departments. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws. The current clinical departments are:

- Department of Anesthesia
- Department of Cardiology
- Department of Emergency Medicine
- Department of Medicine
- Department of OB/Gyn
- Department of Pediatrics
- Department of Radiology
- Department of Surgery

7.2 ASSIGNMENT TO DEPARTMENTS

Each member of the Medical Staff 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.

7.3 FUNCTIONS OF DEPARTMENTS

Each department shall:

7.3-1 Continually seek to improve quality of care for all patients through an effective peer review process as defined by Medical Staff policy
7.3-2 Develop and approve clinically relevant quality indicators that identify variances which trigger evaluation of the care and review and approve criteria/indicators annually.
7.3-3 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;
7.3-4 Consider the aggregated results of the review for quality and appropriateness of patient care and make recommendations relating thereto to the MEC.
7.3-5 Provide oversight in the process of analyzing and improving the patient experience.
7.3-6 Provide a forum for discussion of Medical Staff matters of concern to its members.

7.3-7 Assure on-call coverage for emergency patients adequate to serve the needs of the community and consistent with the physician resources available within the department. Departments have the responsibility to determine whether a mandatory or voluntary Emergency Department (ED). If the Department recommends a mandatory ED call, it must forward the recommendation to the MEC for approval.

7.3-8 Develop recommendations for the qualifications appropriate to obtain and maintain clinical privileges in the department;

7.3-9 Establish and implement clinical policies and procedures, and monitor its members' adherence to them;

7.3-10 Adopt its own Rules and Regulations to clarify or expand these Bylaws to meet the needs of its particular area of practice. Department Rules and Regulations shall not conflict with these Bylaws and shall be subject to approval by MEC and the Board. Any rules, 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;

7.3-11 Conduct, participate in and make recommendations regarding continuing education programs pertinent to department clinical practice;

7.3-12 Coordinate the professional services of its members with those of other departments and with Hospital nursing and support services;

7.3-13 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.

7.3-14 Support utilization management review in regard to appropriateness of admissions and consultations, level of care, continued stays, diagnostic testing, transfers, and discharges.

7.4 DEPARTMENT OFFICERS

7.4-1 Qualifications

Each department shall have a Chair who shall be and remain during his or her term a member in good standing of the Active Medical Staff; shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department; and shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center. All department officers must also be board certified or satisfy the criteria established by the applicable department necessary to demonstrate comparable competence. Departments shall also have a Vice Chair.

7.4-2 Selection

The Department Chair shall be elected by electronic ballot in the manner prescribed in Section 6.4. A Department Chair shall be elected every two years by the Active Staff members of the department. For this election, a request for nominations will be requested from Department members electronically prior to October of odd-numbered years. Nominations may also be made at the Department meeting, so long as the nominee is qualified and has consented to the nomination. At the adjournment of the Department meeting where nominations are reviewed, the slate will be deemed finalized and ballots emailed out. Vacancies in elected Department offices due to any reason shall be filled for the unexpired term through a special election held for that purpose at a meeting of the Department.

7.4-3 Term of Office

Department Chairs shall be elected every other year and shall serve a two-year term or until their successors are chosen, unless a vacancy occurs for any reason. Department officers shall be eligible to succeed themselves.

7.4-4 Resignation

A Chair and Vice Chair may resign at any time by giving written notice to the MEC. Such resignation shall take effect on receipt or at any later time agreed to by the Chair, Vice Chair and the Chief of Staff.

7.4-5 **Vacancies**

The Vice Chair will automatically assume the duties of the Chair for a period of up to 45 days during which the respective Department will hold an election for purposes of filling the vacancy for the remaining time period.

7.4-4 **Removal**

A Department Chair and Vice Chair may be removed by MEC for failure to maintain the qualifications or perform the functions of the office as required by these Bylaws. Removal may also be initiated by petition of one-third (1/3) of the Active Staff Members of the department. Removal by the Active Staff Members of the Department shall require a two-thirds (2/3) vote of the Active Staff Members of the Department, such vote to occur by ballot in the same manner as that used in the election of Department officers. A physician who has been removed as a Department Chair is not eligible to be reelected or reappointed a Department Chair for a period of twelve (12) months from such removal. Any physician who wishes to be reelected as a Department Chair after having been removed must submit such information as MEC or the Active Staff Members of the Department may require to demonstrate that the basis for the earlier removal no longer exists.

7.4-5 **Duties**

Each Department Chair shall have the following authority, duties and responsibilities:

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

ARTICLE EIGHT: COMMITTEES

8.1 DESIGNATION

The committees described in this Article or in the Medical Staff Rules and Regulations shall be the current standing committees of the Medical Staff. 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 purposes of the committee. Such special or ad hoc committees shall report to MEC.

8.2 GENERAL PROVISIONS

8.2-1 Ex-Officio Members

The Chief of Staff, Chief Medical Officer (CMO) and the Chief Executive Officer (CEO) or their respective designees are ex-officio members of all standing and special committees and Departments of the Medical Staff.

8.2-2 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 other than members of the standing committee as appointed by the committee chair.

8.2-3 Appointment of Members and Chair

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

8.2-4 Term, Prior Removal and Vacancies

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

(b) A Medical Staff Member serving on a committee, except one serving ex-officio, may be removed from the committee by the Chief of Staff or the Chair of the Committee for any reason. Such removal is not an adverse action and does not entitle the member to a fair hearing, however the member may appeal the removal to the MEC whose decision is final.

(c) Except as otherwise provided, 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.

8.2-5 Voting Rights

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

8.3 MEDICAL EXECUTIVE COMMITTEE

The organized Medical Staff has authorized MEC to carry out Medical Staff responsibilities in accordance with law, regulations, these Bylaws and the Medical Staff Rules and Regulations. All Active Staff members of any discipline or specialty are eligible for membership on the MEC.

8.3-1 Composition

The MEC shall include physicians and may include other licensed practitioners or individuals as determined by the organized Medical Staff. Membership shall consist of the following:

(a) Chief of Staff, who shall serve as Chair;
(b) Vice Chief of Staff;
(c) Immediate Past Chief of Staff;
(d) Secretary/Treasurer;
(e) Chairs of all Departments;

(f) Two Members at Large;
(g) Chair of the Credentials Committee;
(h) Chair of the Bylaws Committee;
(i) Chair of the Pharmacy and Therapeutics Committee;
(j) Chair of the Bioethics Committee;
(k) Chair of the Hospitalist Committee;
(l) Chair of the Quality Improvement Committee;
(m) Chair of the Professional Health and Wellness Committee;
(n) Chief Executive Officer (ex officio member, without vote);
(o) Chief Medical Officer (ex officio member, without vote);
(p) Medical Director(s) of Care Coordination (ex officio, without vote)
(q) Other representation as necessary may be appointed by the Chief of Staff and approved by the majority vote of the Medical Executive Committee.

8.3-2 **Elections, Terms, Vacancies and Removals**

(a) **Elections**
The Medical Staff officers and Members-At-Large serving on MEC shall be elected in the manner prescribed in Sections 6.4. Department Chairs shall be nominated in the manner prescribed in Section 7.4-2 and elected in the manner prescribed in Section 6.4.

(b) **Terms of office**
With the exception of ex officio members, all members of MEC shall serve a two-year term and may serve subsequent terms if so elected. General staff officers shall serve terms that terminate December 31 in even numbered years. Department chairs shall serve terms that terminate December 31 in odd-numbered years. Members serving on MEC by virtue of appointment by the Chief of Staff shall serve two-year terms that terminate on December 31 of odd-numbered years. The Chief of Staff may appoint these members to subsequent two-year terms with approval of the MEC, or appoint new members, with approval of the MEC.

(c) **Removals and vacancies**
Removals and vacancies of General Staff Officers, Department Chairs, and other MEC members, will be handled in the manners prescribed in Section 6.4 and Section 7.4.

8.3-3 **Duties**
The duties and authority of MEC are to:

(a) Act on all matters of Medical Staff business, except for the election of general Staff officers and for the approval of Medical Staff Bylaws;
(b) Receive and act upon reports and recommendations from Medical Staff departments and committees and other assigned activity groups;
(c) Coordinate and implement the professional and organizational activities and policies of the Medical Staff;
(d) Make recommendations to the Board regarding the organized Medical Staff structure, and the process used to review credentials and delineate privileges;
(e) Review the qualifications, credentials, performance, and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding Medical Staff membership and privileges;
(f) Make recommendations directly to the Board on changes to these Bylaws, the Medical Staff Rules and Regulations and Department Rules and Regulations;
(g) Coordinate and implement the professional and organizational activities and policies of the Medical Staff;

(h) Review aggregate quality performance data and make recommendations for quality improvement;
(i) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;
(j) Make recommendations to the CEO and to the Board on Medical Center medico-administrative matters;
(k) Account to the Board for the quality and efficiency of medical care provided to patients in the Medical Center,
(l) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of the Medical Staff Members;
(m) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees;
(n) Assist in obtaining and maintaining accreditation and licensure of the Medical Center.
(o) Act on behalf of the organized Medical Staff between meetings of the organized Medical Staff within the scope of its responsibilities as defined by the organized Medical Staff.
(p) Appoint a subcommittee to make credentialing recommendations directly to the governing body on behalf of the MEC for months when there is no meeting of the Medical Executive Committee.

8.3-4 **Meetings**

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

8.3-5 **Attendance Requirements**

All members of the MEC are required to attend a minimum of 50% of the meetings every twelve months. If attendance does not meet the minimum requirement, the member's stipend may be forfeited, and the Chief of Staff may appoint a representative for the MEC to replace that member except where the representative is a Department Chair.

8.4 CREDENTIALS COMMITTEE

8.4-1 **Composition**

The Credentials Committee shall be composed of at least five members of the Active Staff appointed by the Chief of Staff who shall serve two-year terms. When possible, the Chief of Staff shall appoint a Past Chief of Staff or appoint a designee with the approval of MEC, to serve as Chair and shall appoint additional Past Chiefs of Staff to the committee.

8.4-2 **Meetings**

The Credentials Committee shall meet as often as necessary. The time and place shall be determined by the Chair. At least two members must be present to constitute a quorum (not including the Chair). The Committee may approve items electronically.

8.4-3 **Duties**

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

8.5 BYLAWS COMMITTEE

8.5-1 **Composition**

The Bylaws Committee shall consist of at least three Members of the Active Staff. The Chair shall be appointed by the Chief of Staff.

8.5-2 **Duties**

The Bylaws Committee shall annually review the Medical Staff Bylaws. The Bylaws Committee shall review proposed amendments to the Bylaws prior to the MEC's consideration

of such amendments. The Committee shall meet as needed but shall meet at least once a year. The Committee shall report as necessary to MEC.

8.6 PHARMACY AND THERAPEUTICS COMMITTEE

8.6-1 Composition

The Pharmacy and Therapeutics Committee shall be a multi-disciplinary committee reporting to the Quality Committee. It shall consist of at least three Members of the Medical Staff, representatives from administration and nursing, and the Medical Center pharmacist. The Physician Chairman shall be designated by the Chief of Staff. It shall meet as often as necessary.

8.6-2 Duties

The Committee shall monitor and evaluate the use of drugs and shall formulate policies in order to improve patient care. Its specific purpose and functions will be:

- To create policies and procedures to address adequate oversight for the safe administration and monitoring of medications utilized in clinical settings;
- To recommend and maintain a list of drugs accepted for use in the Medical Center;
- Serve in an advisory capacity to the Medical Staff and Pharmacy Department in the selection or choice of medications which meet the most effective therapeutic quality standards;
- Evaluation objectively the clinical data regarding new medications or agents proposed for use in the hospital;
- To evaluate clinical data concerning new drugs and preparations requested for use in the Medical Center.

8.7 BIOETHICS COMMITTEE

8.7-1 Composition

The Bioethics Committee shall consist of physicians and such other Staff Members as the MEC may deem appropriate. It may also include nursing, lay representatives from the community, social workers, clergy, attorneys, Risk Management, and Administrators.

8.7-2 Duties

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

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

8.8 PROFESSIONAL REVIEW COMMITTEE

8.8-1 Composition and Authority

The Professional Review Committee (PRC) shall consist of an adequate number of voting members to meet the needs of the committee including the Chief Medical Officer who shall serve as Co-Chair. A Co-Chair will also be appointed by the Chief Medical Officer with input from the PRC members. The Chief of Staff and a representative of Administration shall serve as ex-officio members of the PRC without vote.

8.8-2 **Authority**

The PRC will have authority to take any steps necessary to ensure the competency and professional conduct of providers and the safety of patient care.

8.8-3 **Membership Selection Process**

The Professional Review Committee shall serve as the selection committee for new members. A majority decision is required to select any PRC member. The MEC will periodically review the performance of PRC members and may remove any member from the committee for failure to maintain qualifications and/or uphold the duties of the position as outlined in the Bylaws.

8.8-4 **Qualifications**

PRC members must continuously satisfy the qualifications and complete the requirements set forth in Article 3. Members shall be on the Staff, in good standing, and be willing to serve on a consistent basis. Members must demonstrate leadership skills and may not have any disabling conflict of interests. If an ad hoc member is needed for clinical expertise, the Active Staff status may be required.

8.8-5 **Removal**

Voting members of PRC who do not meet the required meeting attendance, unless there are extenuating circumstances, will be automatically removed from the PRC. The Chief of Staff and CMO may jointly recommend to MEC that a member of the PRC be removed. Removal shall be confirmed by MEC and is effective immediately. Reasons for removal would include untimely review of assigned cases, disruption of the Committee, violations of confidentiality, or promotion of personal agenda and bias.

8.8-6 **Duties**

The Professional Review Committee shall:

- Within the scope of its authority as granted in these Bylaws, enforce the Bylaws, rules and regulations, and policies of the Medical Staff, departments and the Medical Center.
- Review sentinel events, near misses, and complex clinical issues.
- Investigate, review and resolve reports of behavioral or disruptive conduct involving any member of the Medical or Advanced Practice Providers and Allied Health staff. The PRC will trend information and take/recommend further action, if warranted.
- Review potential conflicts of interest, ethical and moral issues and recommend actions to address actual conflicts impacting clinical quality.
- Monitor and evaluate quality and appropriateness of patient care and professional performance of Medical Staff, Advanced Practice Providers and Allied Health Staff members.
- Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical, Advanced Practice and Allied Health Staff Members.
- Review professional competence issues as identified through ongoing quality and performance improvement, clinical, administrative and educational functions as well as issues referred by Medical Directors, Department Chairs or others.
- Review aggregate quality performance data of individual practitioners and make recommendations for quality improvement in the context of peer review.
- Implement investigative and precautionary tools as required, including required education/health assessments, consultation, supervision as warranted.
- Recommend to the Medical Executive Committee, as required, the limitation, revocation or termination of Medical Staff membership and/or privileges.
- Share information with the Departments and Committees to provide opportunities for learning and process improvement.
- Seek peer review assistance from qualified sources, including practitioners on the Medical Staff and/or practitioners not on the Medical Staff, if and when the PRC/CMO determines that such assistance is appropriate and/or necessary.

- 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.

8.9 PROFESSIONAL HEALTH & WELLNESS COMMITTEE

8.9-1 Composition

The Professional Health and Wellness Committee will have a Chair appointed by the Chief of Staff. The Committee shall consist of at least three members chosen by the Chief of Staff upon recommendation of the Chair of the Professional Health and Wellness Committee. Members shall serve a two-year term. When possible, the Committee shall include professionals who are recovering from chemical or alcohol dependency, or emotional or physical impairment.

8.9-2 Responsibilities

The Professional Health and Wellness Committee shall be responsible for identifying and managing matters of health for individual physicians, Advanced Practice Providers (APPs) and Allied Health Professionals (AHP) by offering assistance, support and guidance in retaining/regaining optimal professional health and functioning. The Committee shall assist in the assessment of members of the Medical and APP/AHP Staffs who have been identified as impaired or potentially impaired and to monitor such member's participation in treatment until such time as rehabilitation or any disciplinary process is complete. The Committee shall assist in the assessment of members of the Medical and APP/AHP Staffs who have been identified as having a disability to recommend accommodations if appropriate. The Committee shall have no disciplinary authority and shall report directly to the MEC.

8.9-3 Duties

The Professional Health and Wellness Committee shall:

- Provide ongoing education to the Medical Staff, Hospital Staff and Administrative leadership regarding physician, APP and AHP health impairment recognition, types and levels of impairment, problems associated with impairment, resources available for the prevention, diagnosis, treatment and rehabilitation of impairment, and the process for referral to the committee;
- Provide ongoing education to the Medical Staff, Hospital Staff and Administrative leadership regarding disabilities, disability recognition, resources available for diagnosis, treatment and rehabilitation, the process for referral to the committee, and accommodations;
- Evaluate the credibility of a complaint, allegation, or concern;
- Make recommendations to the Credentials Committee and MEC regarding a practitioner's ability to engage safely in the practice of medicine;
- Maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened;
- Recommend available resources for diagnosis and/or treatment of physicians, advanced practice providers and allied health professionals experiencing possible illness and impairment issues;
- Serve as a resource for physicians, advanced practice providers and allied health professionals experiencing illness and impairment issues;
- Assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
- Assist Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee;
- Recommend to the affected practitioner when either a psychological, psychiatric and/or physical examination should be obtained;

- Ensure the recommendations of the committee/subcommittee and the treating provider are followed;
- Monitor the practitioner and the safety of patients until the rehabilitation is
- complete and periodically thereafter, if required;
- Require the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the Professional Peer Support Committee or appropriate department chairman; and
- Advise the appropriate Department Chair/MEC if a practitioner may be unable to provide safe patient care or if a practitioner fails to adhere with the committee's recommendations;
- Initiate appropriate actions when a practitioner fails to complete the required rehabilitation program.

8.10 CLINICAL RESOURCE MANAGEMENT COMMITTEE (CRMC)

8.10-1 **Composition**

The CRMC shall consist of at least three Medical Staff members appointed by the Chief of Staff in Collaboration with Administration. Required participation shall include the Medical Director of Care Coordination, Chief Nursing Officer, the Director of Case Management, Director of HIMS, Director of Quality Management (or their designee), the Chief Medical Officer and representatives from Finance.

8.10-2 **Duties**

The duties of the Clinical Resource Management Committee (CRMC) shall include:

- Supporting and directing the Clinical Resource Management program.
- Reviewing the appropriateness of admissions, level of care, continued stays, professional services (procedures, testing and treatment), discharges and transfers.
- Suggesting and coordinating education to address specific processes with regard to medical and utilization management.
- Recommending changes to workflows as necessary to best meet the needs of the facility and organization.
- Ensuring adherence to established policies, procedures, regulatory and accreditation requirements as well as applicable professional standards.

8.10-3 **Meetings**

The CRMC will meet monthly, at least eight times per year, and will report to MEC.

8.11 MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING COMMITTEE

8.10-1 **Composition:**

The Medical Staff Leadership Development & Nominating Committee shall consist of the General Staff Officers. The Chief of Staff shall serve as the Chair. If the Chief of Staff, Vice Chief of Staff, and Secretary/Treasurer are candidates, then the Chair shall be a Member-at-Large or another member of the MEC as selected by the Chief of Staff and approved by the MEC. The Chief Executive Officer and the Chief Medical Officer shall serve as *ex officio* members without vote. No candidate for election may serve as a member of the Medical Staff Leadership Development & Nominating Committee. Additional members may be added by the Chair of the Committee.

8.10-2 **Duties:**

The Medical Staff Leadership Development & Nominating Committee shall define desired leadership characteristics, identify and recruit future potential Medical Staff leaders from among the Active Medical Staff Members of the Medical Staff, and advise the Chief Executive Officer, the Chief Medical Officer, and the Medical Executive Committee of the education

and development needs of potential Medical Staff leaders so as to be successful in future roles. The committee shall solicit and accept nominations for elected General Staff Officer and Medical Executive Committee positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election process.

8.10-3 **Meetings and Reports:**

The Medical Staff Leadership Development & Nominating Committee shall meet at least annually and shall report its recommendations and activities to the MEC.

ARTICLE NINE: CORRECTIVE ACTION

9.1 CRITERIA FOR INITIATING AN INVESTIGATION OR CORRECTIVE ACTION

An investigation or corrective action may be initiated against a practitioner if it appears that the practitioner does not meet the standards and qualifications required by these Bylaws or the Medical Staff Rules, Regulations or 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, lower than the standards or aims of the Medical Staff, or that is inconsistent with the provisions of Section 1.2-5 of these Bylaws.

9.2 PROCEDURES FOR INITIATING AN EVALUATION OR INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

Whenever a practitioner is requested to refrain from practice because of concerns about his/her ability to engage safely in the practice of medicine, the Chief of Staff or CMO or their designee will request that the practitioner refrain from practice at all Banner facilities.

Investigation:

- An investigation is a targeted evaluation of the competence or conduct of a practitioner by the Medical Executive Committee, a Department or a standing peer review committee.
- If a determination as stated in (a) is made, the investigation is deemed to be initiated when the practitioners is informed in writing that an investigation is being undertaken.
- Routine peer review activities and focused professional practice evaluations (FPPE) as part of initial appointment or privileges does not constitute an investigation.
- FPPE undertaken to determine whether a substantial likelihood exists that a practitioners' competence or conduct fails to meet required standards does not constitute an investigation.
- FPPE undertaken following a determination that a substantial likelihood exists that a practitioner's competence or conduct fails to meet applicable standards, for the purpose of determining the nature and/or extent of such substandard performance, shall constitute an investigation and notice of the initiation of the investigation shall be given to the practitioner in writing.

Once begun, an investigation does not conclude until the medical staff takes a final action of recommendation, or a decision is made to close the investigation. When closed, the practitioner is informed of the closure of the investigation.

9.2-1 **Request for Investigation/Corrective Action**

A request for an evaluation, investigation or corrective action may be submitted to the Chief of Staff or Vice Chief of Staff by any Member of the Medical Staff, the Chief Executive Officer or his or her designated administrator, or the Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request. The Chief of Staff shall notify the practitioner of the general nature of the request and may communicate additional information regarding the request. The Chief of Staff may notify the Medical Executive Committee if the matter is, in his or her opinion, plainly without merit. The Medical Executive Committee may dismiss such a matter with notation on its

record to that effect. If the matter may have merit, the Chief of Staff shall refer the request to the Professional Review Committee.

9.2-2 **Determination Whether an Investigation is Warranted**

(a) Within 30 days, the Professional Review Committee shall consider the request and determine whether or not an investigation is warranted. The Professional Review Committee may use one or more of the "evaluation tools" described below to determine if an investigation is warranted. The use of these evaluation tools does not constitute an investigation. Evaluation tools include an interview with the practitioner, concurrent or retrospective chart review and/or consultation requirements. A practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension of privileges pursuant to Section 9.5-6 of these Bylaws. The affected practitioner has the right to an interview with the Professional Review Committee if such practitioner believes the Professional Review Committee should reconsider the use of any such evaluation tools. However, the practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such evaluation tools.

(b) If it appears that an investigation is warranted, the Professional Review Committee shall notify the Chief of Staff and Department Chairman and shall initiate the investigation. In certain instances, the Medical Executive Committee may conduct its own investigation directly or through a designated ad hoc committee.

9.2-3 **Procedure for Professional Review**

(a) Within 60 days after a determination that an investigation is warranted, the Professional Review Committee shall conclude its investigation, document its findings and make a report and recommendations to the Department Chairman and Medical Executive Committee for dealing with the request. If the Professional Review Committee deems it necessary and appropriate, the Professional Review Committee may use persons not on the Medical Staff to assist it in evaluating matters that it is investigation. Prior to making any adverse recommendation to the Department Chairman and Medical Executive Committee, the affected practitioner shall be notified of the general nature of the complaint and he or she shall have the 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 or the Fair Hearing Plan shall apply thereto.

(b) A record of such interview shall be made by the Professional Review Committee and included with its report and recommendation which shall be forwarded to the Department Chairman and the Medical Executive Committee by the Professional Review Committee chairman.

(c) In certain instances, an investigation may not be concluded within 60 days. In such instances, the investigation shall be conducted as soon as reasonably practicable and a 60 day interim report from the Professional Review Committee chairman must be made to the department chairman and the Medical Executive Committee stating the estimated completion date. The affected practitioner shall have no procedural rights arising out of such delay.

(d) In the event that the Professional Review Committee recommends that corrective action is warranted, the Chairman of the Professional Review Committee and the affected practitioner shall be invited to discuss the findings of the Professional Review Committee with the Medical Executive Committee.

(e) The Medical Executive Committee shall consider the report and recommendation of the Professional Review Committee. After its deliberations, the Medical Executive Committee may uphold, modify or reject the recommendation and shall forward any adverse recommendation to the Board. If the recommendation includes reviewable corrective action, the affected practitioner shall be given notice and a right to a hearing as

set forth in these Bylaws and the Fair Hearing Plan to be held, if timely requested, before the Board takes action.

9.2-4 **Indemnification**

Prior to the appointment of hearing committee members, the appointing Medical Executive Committee member shall submit to the Administrator the names of the proposed hearing committee members. The Administrator, upon advice of BH legal counsel, shall promptly inform the appointing Executive Committee member of any reasons why any proposed member should not serve. Such reasons shall be based upon federal or state law restrictions or requirements. During the entire hearing process, the Administrator and BH legal counsel shall assess the hearing process and shall advise the Medical Staff representatives who have any part in the hearing process of legal requirements, deficiencies in the process, conflicts of interest, problems with competitors, biases or other matters which in the opinion of legal counsel present substantial risk to the Medical Center and the BH Board of Directors by virtue of the Board's indemnification of Medical Staff Members. Participants in the hearing process shall make every effort to comply with recommendations of BH legal counsel. Legal counsel shall make no recommendations which interfere with clinical opinions of Medical Staff Members but may comment on the relevancy, effectiveness and appropriateness of the evidence to be considered. In exchange for this right of participation, BH will defend, indemnify and hold harmless all physicians participating in the corrective action and hearing processes from any and all claims or liability arising out of their participation in such actions or processes.

9.3 SUMMARY SUPERVISION

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

- Chief of Staff, or designee
- Applicable department chairman or vice chairman
- Chief Executive Officer or designated administrator

9.4 SUMMARY SUSPENSION

9.4-1 **Initiation**

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

- Chief of Staff, or designee
- Applicable department chairman, or vice chairman
- Chief Executive Officer or designated administrator

A summary suspension is effective immediately upon imposition and shall be followed promptly by special notice to the affected practitioner, which notice shall include a description of the grounds for the suspension.

9.4-2 **Review by the Medical Executive Committee**

The Medical Executive Committee or a subcommittee of the Medical Executive Committee, having no less than four members appointed by the Chief of Staff, shall review the summary suspension within ten days. The affected practitioner shall be notified of the date and time of

the review and shall be given the opportunity to present evidence in his or her defense. The Chief of Staff may request persons not on the Medical Executive Committee to provide clinical assistance to the Committee or subcommittee. After deliberation, the Medical Executive Committee or a subcommittee may direct that the summary suspension be terminated or continued. Summary supervision may be imposed pending completion of an ongoing investigation.

9.4-3 **Expedited Hearing Rights**

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

9.4-4 **Alternative Coverage**

Immediately upon imposition of summary suspension, the Chief of Staff or the department chairman shall arrange alternative medical coverage for the patients of the suspended practitioner who are in the Medical Center. Patients' wishes shall be considered in the selection of an alternative practitioner.

9.5 AUTOMATIC SUSPENSION

Automatic action shall be imposed immediately under the conditions described in this Section 9.5 without prior action by the Medical Executive Committee or the Board. The Chief of Staff shall notify the practitioner of the action. In addition, further corrective action may be recommended in accordance with the provisions contained in these Bylaws whenever any of the actions described below occur.

Any of the occurrences described in this Section will constitute grounds for the automatic action set forth below.

Except as otherwise provided below, an automatic action set forth below will be effective immediately. Automatic actions do not afford the practitioner any hearing or appeal rights under these Bylaws

9.5-1 **Failure to Satisfy Threshold Eligibility Criteria**

Failure of a Practitioner to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in these Bylaws will result in automatic relinquishment of his or her Medical Staff appointment and clinical privileges.

9.5-2 **License**

(a) Revocation

Whenever a practitioner's license to practice in this state is revoked, his or her Medical Staff appointment and clinical privileges shall be immediately and automatically revoked.

(b) Restriction

Whenever a practitioner's license is limited or restricted in any way, his or her clinical privileges that are within the scope of the limitation or restriction shall be similarly, immediately and automatically restricted.

(c) Suspension

Whenever a practitioner's license is suspended, his or her Medical Staff appointment and clinical privileges shall be immediately and automatically suspended for the term of the licensure suspension.

(d) Probation

Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.

(e) Expiration of License

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

9.5-3 **Controlled Substances Registration**

Whenever a practitioner's Arizona DEA or other controlled substances registration is revoked, restricted or suspended, the practitioner's right to prescribe medications covered by the registration shall be immediately and automatically revoked, restricted or suspended.

9.5-4 **Professional Liability Insurance**

A practitioner's Medical Staff appointment and clinical privileges shall be automatically suspended for failure to maintain the minimum amount of professional liability insurance as established by the Banner Board. Affected practitioners may request reinstatement during a period of 30 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.

9.5-5 **Medical Records**

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

9.5-6 **Failure to Respond to Requests for Information or to Satisfy Special Appearance Requirement**

A practitioner who fails without good cause (as determined by the Chief of Staff) to respond when contacted by an Officer of the Medical Staff, Department Chairman, Chief Medical Officer, or Professional Review Committee member, or to appear at a meeting where his or her special appearance is required, in accordance with Section 10.4, shall be automatically suspended from exercising clinical privileges. Privileges may be reinstated upon response or appearance as determined by the Chief of Staff or designee. If a practitioner fails to respond to a contact or appear when required within 90 days, he or she shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

9.5-7 **Failure to Execute Releases and/or Provide Documents**

A practitioner who fails to execute a general or specific release and/or provide documents, including but not limited to assessment reports, stipulation agreements, or correspondence to/from other facilities, when requested by the Chief of Staff, Chief Medical Officer, Department Chairman, or a Medical Staff committee, automatically shall 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. Otherwise, the practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

9.5-8 **Failure to Provide Evidence of Current Office Location and Covering Physician**

A practitioner who fails to provide Medical Staff Services written documentation evidencing such practitioner’s current practice location and/or covering physician within (30) days of a request shall automatically be suspended from the Medical Staff. If the written documentation is provided within thirty (30) days of notification of suspension, the practitioner shall be reinstated. Otherwise the practitioner shall be deemed to have resigned voluntarily from the Staff and must reapply for Staff membership and privileges.

9.5-9 **Failure to Establish Freedom from Infectious TB**

A practitioner’s medical staff membership and clinical privileges shall be immediately suspended for failure to establish freedom from infectious TB whenever such evidence is requested. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of freedom from infectious TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

9.5-10 **Failure to Obtain Influenza Vaccination**

A practitioner who fails to provide evidence of annual influenza vaccination or approved exemption as required by Section 2.1-5 of these Bylaws automatically shall be suspended. Privileges shall be reinstated when evidence of vaccination is provided or when influenza season is deemed to have ended (as determined by the Chief of Staff). Providers whose services are delivered solely through means of telemedicine and who never physically present to the hospital are exempt from this requirement.

9.5-11 **Exclusion from Medicare/State Programs**

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

9.5-12 **Failure to Pay Staff Dues**

A practitioner who fails to pay staff dues as set forth in Section 11.3 automatically shall be suspended from the Medical Staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Otherwise, the practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

9.5-13 **Failure to Complete EMR Training, ID Verification, New Provider Orientation (NPO) or Other Training/Educational Requirements**

Practitioners who are appointed to the Medical Staff, Advanced Practice or Allied Health Staff pending Banner electronic medical record training (EMR – if applicable), ID verification and completion of NPO and who have not completed such training within sixty (60) days of appointment automatically shall be deemed to have voluntarily resigned from the staff**.** Practitioners will be advised of the requirements at or prior to appointment and reminded of the requirements 30 days months from the date of appointment. Exceptions will be made on a case by case basis for good cause to be determined by the facility CEO or designee.

Failure of a Practitioner to comply with or complete within required time limits any other general training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board will result in the automatic relinquishment of Clinical Privileges.

9.5-14 **Expiration of ACLS, PALS and/or NRP Certification**

If ACLS, PALS and/or NRP is required for overall privileges in a specialty, a practitioner's appointment and clinical privileges automatically shall be suspended for failure to maintain certification as required. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of certification is provided. Otherwise, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

If ACLS, PALS and/or NRP is required for a specific privilege (i.e. sedation), this privilege automatically shall be suspended for failure to maintain certification as required. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of certification is provided. Otherwise, this privilege shall be deemed to have been voluntarily relinquished and the provider must reapply for the privilege.

9.5-15 **Criminal Activity**

The occurrence of specific criminal actions will result in the automatic relinquishment of Membership and Clinical Privileges. Specifically, with respect to any felony, or any misdemeanor pertaining to the following items: (a) Medicare, Medicaid, or other federal or

state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) domestic, child or elder abuse:

(1) a conviction, plea of guilty or plea of no contest will result in an automatic relinquishment of Membership and all Clinical Privileges; and

(2) an arrest, charge, or indictment will result in automatic suspension of Clinical Privileges until such time as the appropriate individual or body (MEC, Board, CEO, or CMO) can review the matter to determine whether the circumstances surrounding the arrest, charge, or indictment are such that reinstatement pending resolution of the matter can be granted without affecting patient safety, quality of care, and hospital operations. The burden is on the Practitioner to provide evidence showing that reinstatement is appropriate despite the unresolved concerns raised by the arrest, charge, or indictment. Reinstatement will be within the discretion of the appropriate individual or body (MEC, Board, CEO, or CMO), the decision of which shall be final without recourse to the hearing and appeal processes or any other procedures.

9.5-16 **Failure to Participate in an Evaluation**

A practitioner who fails to participate in an evaluation of his or her qualifications for Medical Staff membership and/or privileges as required by a Medical Staff committee automatically shall be suspended. Such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges if the evaluation is not successfully completed within 30 days.

9.5-17 **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. Otherwise, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

Failure of an Applicant or Practitioner to undergo a requested fitness for practice evaluation or clinical competency evaluation and to do so within the requested time frame, to submit to diagnostic testing (such as blood, urine, or hair testing) immediately upon request, or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will, for Applicants, be considered a voluntary withdrawal of the Application or, for Practitioners, will result in the automatic relinquishment of Membership and Clinical Privileges.

9.6 REINSTATEMENT FROM AUTOMATIC ACTION

(1) Delinquent records: A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff and resignation of all Clinical Privileges.

(2) Requests for reinstatement from an automatic action following the expiration or lapse of a license, controlled substance authorization, insurance coverage, or any other failure to satisfy any of the threshold eligibility criteria by virtue of the natural expiration of the Practitioner's qualification, will be processed by the Medical Staff Services Department. If any questions or concerns are

noted, the Medical Staff Services Department will refer the matter for further review in accordance with subsection (4) of this Section, below.

(3) Requests for reinstatement from an automatic action related to a criminal arrest or charge will be as set forth in 9.6 (2) above.

(4) All other requests for reinstatement from an automatic action will be reviewed by the relevant Department Chair, the chairperson of the Credentials Committee, the Chief of Staff, the Chief Medical Officer, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Practitioner may immediately resume clinical practice at the Hospital. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation.

(5) The Practitioner requesting reinstatement bears the burden of demonstrating that the matter leading to automatic action has been resolved.

(6) Unless otherwise specified, failure, within 60 days of an action, to resolve the matter leading to the automatic action, provide notice to the Medical Staff Services Department of the resolution, provide any additional requested information, and be reinstated as set forth above, will result in an automatic resignation from the Medical Staff and resignation of all clinical privileges without any hearing or appeal rights under these Bylaws.

9.7 NONREVIEWABLE CORRECTIVE ACTION

Not every form of corrective action entitles the practitioner to the procedural rights provided by the Bylaws and the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension or limitation as set forth in Section 9.5 are not reviewable pursuant to the Fair Hearing Plan. In addition, the following actions or occurrences are also nonreviewable:

9.7-1 Imposition of observation pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
9.7-2 Issuance of a warning or a letter of admonition or reprimand.
9.7-3 Imposition of monitoring of professional practices, other than direct observation, for a period of less than 180 days.
9.7-4 Denial, termination or limitation of temporary privileges.
9.7-5 Supervision and other requirements or limitations imposed during the practitioner's provisional period.
9.7-6 Termination of any employment or independent contractor contract with the Medical Center.
9.7-7 Any recommendation accepted by a practitioner.
9.7-8 Denial of membership and privileges for failure to complete an application for member-ship or privileges.
9.7-9 Removal of membership and privileges for failure to complete observation within the time period granted by these Bylaws or any applicable Rules and Regulations.
9.7-10 Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
9.7-11 Removal of membership and privileges for failure to pay staff dues.
9.7-12 Reduction or change in Staff category. A Medical Staff Member who feels he or she has unjustly been moved from the Active Staff category may request reconsideration of the change by the Medical Executive Committee.
9.7-13 Refusal of the Credentials Committee, department or the Medical Executive Committee to consider a request for appointment, reappointment, Staff category, department/section assignment, or privileges within one year of a final adverse decision of a substantially similar request.

9.7-14 Recommendation by the Medical Executive Committee that a practitioner obtain CME in his specialty or ACLS certification.

9.7-15 Termination of Medical Staff membership for excessively or repeatedly delinquent medical records in accordance with the provisions as set forth in the Medical Staff Rules and Regulations.

9.7-16 Denial of a Staff Member's request to be put on, or the removal of a Staff Member from, the on-call roster.

9.7-17 Any requirement to complete an educational assessment or training program.

9.7-18 Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.

9.7-19 Failure to become board certified or maintain board certification in compliance with these bylaws or applicable department rules and regulations.

9.7-20 Denial, termination or limitation of membership and/or privileges as a result of: (1) a decision by the Medical Center to enter into, terminate or modify an Exclusive Agreement for certain professional services; or (2) the termination or modification of the practitioner's relationship with the practitioner or group of practitioners with whom the Medical Center has an Exclusive Agreement.

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

9.8 HEARING AND APPEAL RIGHTS

9.8-1 **Hearings and Appellate Review**

When a reviewable action has been taken against an applicant or member of the Medical Staff, such practitioner shall be afforded the rights set forth in the Fair Hearing Plan, including a right to a hearing and appellate review in accordance with the terms of the Fair Hearing Plan and Banner Health's Appellate Review Policy (as such Policy is included in the Fair Hearing Plan).

9.8-2 **Request for Hearing**

When a practitioner's hearing rights are triggered, the practitioner shall be 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, all as is further set forth in the Fair Hearing Plan.

9.8-3 **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.

9-8.4 **Scheduling the Hearing**

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

9.8-5 **Hearing Process**

The Medical 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.

9.8-6 **Scheduling the Appellate Review**

Upon receipt of a timely and proper request for appellate review, the General Counsel of Banner Health 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.

9.8-7 **Appellate Review Process**

The practitioner and the Medical Executive Committee may submit written and oral statements in support of their respective positions in accordance with the terms of the Fair Hearing Plan. The practitioner has the burden of demonstrating, by a preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, the Fair Hearing Plan or applicable law, and created demonstrable prejudice; or that the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record.

ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 **Regular Meetings**

The General Medical Staff shall meet at least annually for conducting regular business unless this meeting is cancelled by vote of the MEC at least 30 days in advance of the scheduled meeting.

10.1-3 **Special Meetings**

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

10.2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

10.2-1 **Regular Meetings**

Clinical departments or committees may, by resolution, provide the time for holding regular meetings. No special notice of such regular meetings is required. A department must meet at least quarterly. Committees must meet often as necessary or as required under Article 8.

10.2-2 **Special Meetings**

A special meeting of any department or committee may be called by the chair thereof and must be called by the chair at the written request of the Chief of Staff, the Medical Executive Committee, or 25% of the members of the department or committee. Notice of such special meeting will be given to all members of the department or committee at least 48 hours prior to the time set for the special meeting.

10.2-3 **Executive Session**

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

10.3 INTER-FACILITY MEDICAL STAFF COMMITTEE ACTIVITIES

10.3-1 With approval from the Chief of Staff and Department or Committee Chair, representatives of a Banner Thunderbird Medical Staff Department or Committee may participate in joint committees that may conduct Medical Staff activities, including peer review activities, with representatives of department or committees of other Banner Medical Staffs.

a. Department or committee chair may assign one or more members to serve on a joint committee.
b. Recommendations of the joint committee will be presented to the applicable department or committee for approval.
c. Peer review information relating to the activities of the joint peer review committees may be shared with the joint committees.

10.3-2 The Chief of Staff, other Medical Staff Officers, Departments or Committees may participate in joint committees or Departments of other Banner Medical Staffs. Recommendations of such committees or Departments will be presented to the Medical Executive Committee for approval, as needed.

10.4 ATTENDANCE REQUIREMENTS

10.4-1 **Special Appearance or Conferences**

(a) A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the department or committee chair to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to attend will result in automatic suspension under Section 9.5-5.

(b) Whenever a department perceives an education program or clinical conference is needed based on findings of quality review, risk management, utilization management or other monitoring activities, the practitioner whose patterns of performance prompted the program will be notified by the department chair of the time, date and place of the program and the subject matter to be covered. Attendance is mandatory. Failure to attend may result in initiation of corrective action proceedings or automatic suspension pursuant to Section 9.5-5.

(c) Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance, the Chief of Staff, the Chair of the Professional Review Committee or the applicable department chair may require the practitioner to confer with him or her or with the department or committee considering the matter. The practitioner will be notified of the date, time and place of the conference, and the reasons therefor. Failure of a practitioner to appear at any such meeting may result in the initiation of corrective action proceedings or automatic suspension pursuant to Section 9.5-5.

10.5 QUORUM

10.5-1 **General Staff Meetings**

A quorum is not required.

10.5-2 **Committee Meetings**

The presence of 25% of the members of the Medical Executive Committee shall constitute a quorum. The presence of two voting members shall constitute a quorum at any other committee meeting.

10.5-3 **Department Meetings**

Each department shall establish what constitutes a quorum for the transaction of business at meetings of the department.

ARTICLE ELEVEN: GENERAL PROVISIONS

11.1 MEDICAL STAFF RULES AND REGULATIONS

Subject to approval by the Board, the MEC shall adopt such Medical Staff Rules and Regulations and other policies 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 shall not conflict with the Banner Health Bylaws or Banner Health policies.

11.2 DEPARTMENT RULES AND REGULATIONS

Each Department 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 these Bylaws, the Medical Staff Rules and Regulations, and Medical Center policies. These Department Rules and Regulations must be reviewed by the Department as needed but must be reviewed at least every two years; any changes affecting qualifications, privileges, supervision, and call coverage must be approved by the MEC and the Board.

11.3 STAFF DUES

Dues for all categories of Staff membership of the Medical Center will be determined by the MEC on an annual basis. Notice for dues shall also be given to the Medical Staff at the time of reappointment at which time dues for two years must be paid. Failure to render payment shall result in non-processing of a reappointment. Community Based providers and Honorary staff are exempt from paying dues. If dues are not received with reappointment, the practitioner will be notified electronically and by certified mail, return receipt requested, that Medical Staff membership will be terminated unless full payment of such annual dues and late fee is received within 30 days following the mailing of such notification. The practitioner shall be deemed to have resigned voluntarily from the Medical Staff and must reapply for Medical Staff membership and clinical privileges. Dues are non-refundable with the exception of a provider who resigns before his/her next reappointment term begins. A proration in this scenario will be considered.

11.4 SPECIAL NOTICE

When special notice is required, the Medical Staff Services Department shall send such notice by US certified mail, return receipt requested, by any trackable/traceable method (such as FedEx or UPS with signature required), or by e-mail or facsimile with confirmation of receipt. If the post office indicates that the letter has been refused, such notice shall be deemed to be delivered on the date delivery was first attempted. If the post office indicates the letter is undeliverable, the Medical Staff Services Department shall attempt to contact the practitioner at the location last identified by him or her. If such attempt is unsuccessful, notice shall be deemed to be delivered on the date delivery was first attempted.

11.5 CONSTRUCTION OF TERMS AND HEADINGS

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

11.6 SUPPORT STAFF

The Medical Staff recognizes that the organizational structure required to carry out the credentialing, peer review, and corrective action processes of the Medical Staff require the support of certain members of the administrative staff of the Medical Center who may or may not be members of the Medical Staff including, but not necessarily limited to, the Medical Center's CEO, Chief Medical Officer, Chief Nursing Officer and/or designees, and Support Staff consisting of, but not limited to, Quality Management, members of the Medical Staff Services Department, members of the Banner Board and Banner leadership, members of the Legal Department, and members of Business Health Department, including Loss Control and Claims and Litigation Management staff. All activities of such Support Staff provided in support of the Medical Staff's credentialing, peer review, and corrective action activities shall be conducted in a confidential manner and shall be afforded all of the privileges available to members of the Medical Staff performing such activities under these Bylaws and under applicable state and federal law. The activities of the Support Staff covered by this provision include, but are not limited to, activities involved in reviewing practitioner applications, reviewing

practitioners' care in and outside of the Medical Center, participating in investigations, identifying trends, participating in the resolution of issues involving Medical Staff members and other practitioners working in the Medical Center, and any other activities as may be delegated from time to time by the officers, department or committee chairs or committees of the Medical Staff.

11.7 CONFLICT RESOLUTION

11.7-1 Staff Member Challenge

Any member of the Medical Staff may challenge any rule or policy established by the MEC by submitting to the Chief of Staff written notification of the challenge. Any such challenge must be supported by a petition signed by 20% of the members of the Active Medical Staff and must set forth the basis for the challenge and recommended changes to the rule or policy.

11.7-2 Medical Executive Committee Review

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

11.7-3 Conflict Resolution Resources and Board Responsibility

A recommendation to use either internal or external resources to resolve a conflict may be made by the Board, the CEO, the MEC, or members of the Medical Staff. Any conflict regarding the use of such resources or the process to be followed will be decided by the Board through the Medical Staff Subcommittee.

11.8 HISTORIES AND PHYSICALS

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

11.9 PARLIAMENTARY PROCEDURE

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

11.10 COMMUNICATION

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

11.11 COMMUNITY BASED PROVIDER STAFF

11.11-1 Qualifications

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

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

(a) Arizona licensure in good standing;
(b) Ability to participate in Medicare/AHCCCS and other federally funded health programs;

11.11-2 **Prerogatives**

The Community Based Provider Staff may:

- Make courtesy visits to patients, but may not document in the medical record;
- Access Medical Center information, via Clinical Connectivity, for their own patients;
- Be appointed to committees unless otherwise specified by these Bylaws. Community Based Provider Staff may not hold an elected office.
- Vote on matters presented at committees to which he or she has been appointed, unless otherwise specified by these Bylaws or by applicable Rules and Regulations;
- Attend General Staff meetings, without vote
- Receive Medical Staff Newsletters and other publications; and
- Attend Medical Center continuing medical education programs.

11.11-3 **Obligations**

The Community Based Provider Staff must use Medical Center patient information only as necessary for treatment, payment or healthcare operations regarding their own patients in accordance with HIPAA laws and regulations.

11.11-4 **Change in Staff Category**

Members of the Community Based Provider Staff who wish to join the Medical Staff and exercise clinical privileges at the Medical Center must meet the requirements under Article Three of these Bylaws and complete the application process.

11.11-5 **Denial or Termination**

Members of the Community Based Provider Staff or physicians, physician assistants or advance practice nurses seeking Community Based Provider Staff status are not entitled to due process rights under the Fair Hearing Plan. The MEC's decision to deny or terminate Community Based Provider status will be final.

ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY & RELEASES

12.1 AUTHORIZATION AND RELEASES

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

12.1-1 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;

12.1-2 Agrees to be bound by these Bylaws and the Fair Hearing Plan regardless of whether membership or clinical privileges are denied or granted or are subsequently limited;

12.1-3 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;

12.1-4 Agrees to release from legal liability and hold harmless Banner Heath, the Medical Center, Medical Staff, Medical Staff committees, and all persons who engaged in peer review activities, which include but are not limited to those activities identified in Section 12.3 of these Bylaws as well as other Medical Staff functions provided for, or permitted, in these Bylaws, the Fair Hearing Plan or any applicable federal or state statute or regulations;

12.1-5 Agrees that his/her sole remedy for any 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.

12.1-6 Agrees to release from legal liability and hold harmless any person who, or entity which, provides information regarding the practitioner to the Medical Center, the Medical Staff, or their representatives; and

12.1-7 Authorizes the release of information about the practitioner to other Banner facilities where the practitioner has or requests membership or privileges, including pursuant to the Banner Sharing of Peer Review Information policy.

12.2 CONFIDENTIALITY OF INFORMATION

Information obtained or prepared by any representative of the Medical Center or the Medical Staff for the purpose of evaluating or improving the quality and efficiency of patient care or 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 in the preceding sentence or as otherwise specifically authorized by law. Such confidentiality shall also extend to information provided by third parties.

Patient information shall be used only as necessary for treatment, payment and healthcare operations in accordance with the Health Insurance Portability and Accountability Act (HIPAA). and shall only be disclosed in accordance with HIPAA.

12.3 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:

- Application for appointment, reappointment, clinical privileges or specified services;
- Periodic reappraisals for reappointment, clinical privileges or specified services;
- Corrective or disciplinary actions;
- Hearings or appellate reviews;
- Quality review program activities;
- Utilization review and management activities;
- Claim reviews;
- Profiles and profile analysis;
- Significant clinical event review;
- Risk management activities; and
- Other hospital, committee, department or staff activities related to monitoring, maintaining and improving quality and efficiency of patient care and appropriate professional conduct.

12.4 RELEASES AND PROVISION OF 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 Chair of Department or Committees or their respective designees. 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 such documents upon request during a term of appointment to the staff shall result in automatic suspension as provided in Article 9.5 of these Bylaws.

12.5 CUMULATIVE EFFECT

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

not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE 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, the Fair Hearing Plan, the Credentials Manual, Medical Staff Rules and Regulations, and APP/AHP Rules and Regulations, which must be consistent with Medical Center policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely, and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board, and the community. In the event that a law or regulatory requirement changes, such change will govern these Bylaws as legally required by operation of law.

13.2 BOARD OF DIRECTORS ACTION

13.2-1 When Favorable to Medical Staff Recommendation

Medical Staff recommendations regarding proposed amendments to these Bylaws, the Fair Hearing Plan, the Credentials Manual, Medical Staff Rules and Regulations, and APP/AHP Rules and Regulations shall be effective upon the approval of the Board.

13.2-2 Board Concerns

In the event the Board has concerns regarding any provision or provisions of the Bylaws, the Fair Hearing Plan, the Credentials Manual, Rules and Regulations, and APP/AHP Rules and Regulations or proposed amendments thereto, the Board shall advise the Medical Staff of its concerns. The Medical Staff may request, and if so requested, the Board will establish a Joint Conference Committee comprised of three representatives of each body to resolve such concerns.

13.3 BYLAWS REVIEW

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

13.4 UNILATERAL BOARD AMENDMENTS

Neither body may unilaterally amend the Medical Staff Bylaws, except the Board may take action if the Medical Staff fails to act within sixty (60) days following receipt of notice from the Board to assure compliance with state and federal laws, in the event of substantial circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of optimal care to patients, or in the event the Medical Staff fails to perform its functions delegated hereunder. Such action may be taken only after consideration of the matter by a Joint Conference Committee as specified in Section 13.11.

13.5 URGENT PROCESS

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law, regulation, emergency declaration 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 11.7 shall be implemented, and a revised amendment shall be submitted to the Board.

13.6 MEDICAL EXECUTIVE COMMITTEE PROCESS

The Bylaws Committee will consider amendments to the Bylaws and make proposals to the MEC. The MEC shall consider the Bylaws Committee's recommendations and, if approved, send Bylaw amendments to the Active Staff for vote. The MEC may approve Bylaw amendments that have not been considered or recommended by the Bylaws Committee.

13.7 APPROVAL PROCESS

The Bylaws of the Medical Staff are adopted by the Medical Staff and approved by the Board prior to becoming effective. Amendments to these Bylaws may be adopted upon approval 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 vote.

13.8 MEDICAL STAFF PROCESS

The Medical Staff may propose Bylaws or amendments thereto directly to the Board, including amendments to remove authority given to the Medical Executive Committee. A petition seeking approval of proposed amendments signed by at least 20% of the Active Medical Staff members shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendment at its next meeting and determine whether to recommend the proposed amendments. The Medical Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Medical Executive Committee. Where the Medical Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Active Medical Staff for vote in accordance with Section 13.6. The comments of the Medical Executive Committee shall be sent with the ballots. If the proposed amendment(s) is accepted by the Medical Staff by a majority of those voting, the amendment(s), along with the Medical Executive Committee comments, will be forwarded to the Board for action.

13.9 CREDENTIALS MANUAL, FAIR HEARING PLAN, MEDICAL STAFF RULES AND REGULATIONS AND ADVANCED PRACTICE/ALLIED HEALTH RULES AND REGULATIONS

13.9-1 Periodic Review

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

13.9-2 Adoption and Amendment

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

13.9-3 Communication to the Medical Staff

(a) Routine matters. Absent a documented need for urgent action, before acting on amendments to the Fair Hearing Plan, the Credentials Manual, Medical Staff Rules and Regulations, and APP/AHP Rules and Regulations, the Medical Executive Committee will communicate to the Active Medical Staff by email proposed changes before submitting such changes to the Board. Members may submit comments and concerns to the Chief of Staff within 10 Days. If no comments are received within 10 Days, the Medical Executive Committee's recommendation relating to the proposed changes will be submitted to the Board for approval. If any comments are received by the Chief of Staff, the Medical Executive Committee will determine whether to approve, modify, or reject such proposed changes.

(b) Urgent matters. In cases of a documented need for urgent amendment, the Medical Executive Committee and Board may provisionally adopt an urgent amendment to the Fair Hearing Plan, the Credentials Manual, Medical Staff Rules and Regulations, and/or APP/AHP Rules and Regulations without prior notification to the Medical Staff. The Medical Executive Committee will immediately notify the Active Medical Staff of the amendment and provide an opportunity for comment. If comments are not received within 10 Days, the amendments stand.

(c) Conflict(s). If there is a conflict and at least 20% of the Active Staff oppose the amendments, the Medical Executive Committee will utilize the conflict resolution process set forth in Section 11.7. If necessary, revised amendments will be submitted to the Medical Staff and, if approved, to the Board for action.

13.9-4 **Medical Staff Amendments**

The Medical Staff may propose amendments to the Credentials Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, or Advanced Practice/Allied Health Rules and Regulations to the Bylaws Committee or directly to the Board. To submit the amendments directly to the Board, a petition seeking approval of proposed amendments signed by at least 20% of the Active Staff members shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendment at its next meeting and determine whether to recommend such amendments. The Medical Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Medical Executive Committee. Where the Medical Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Board, along with the recommendation of the Medical Executive Committee. If the Medical Executive Committee does not agree with the proposed amendments, ballots shall be sent to each Active Staff member by email, along with the comments of the Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 Days after their mailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

13.10 TECHNICAL AND EDITORIAL AMENDMENTS

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

13.11 JOINT CONFERENCE COMMITTEE

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

ADOPTED by the Banner Thunderbird Medical Center Medical Staff:

Revised: December 1989
Revised: November 1990
Revised: June 1991
Revised: December 1991
Revised: December 1992
Revised: September 1993
Revised: January 1994
Revised: May 1994

Revised: December 1994
Revised: December 1995
Revised: September 1996
Revised: December 1996
Revised: February 1998
Revised: November 1998
Revised: September 1999
Revised: June 16, 2005
Revised: July 19, 2007
Revised: March 25, 2008
Revised: April 28, 2009
Revised: May 17, 2011
Revised: November 22, 2011
Revised: January 24, 2012
Revised: July 21, 2014
Revised: June 8, 2017
Revised: July 12, 2018
Revised: July 18, 2018

APPROVED by the Operating Board of Banner Health Arizona upon recommendation of the Medical Staff.

Revised:	Medical Executive Committee - 10/2000
Approved:	General Staff Meeting - October 2000
	Banner Health Arizona Board - January 2001
Revised:	General Staff Meeting - August 2003
Approved:	Banner Health Board - October 2003
Revised:	General Staff - May, 2004
	Banner Health Board - June, 2004
Revised:	General Staff – November 9, 2004
Approved:	Banner Health Board – November 18, 2004
Revised:	General Staff – May 17, 2005
Approved:	Banner Health Board – June 16, 2005
Revised:	General Staff – August 30, 2005
Approved:	Banner Health Board – October 20, 2005
Revised:	General Staff – August 31, 2007
Approved:	Banner Health Board - September 20, 2007
Revised:	General Staff – May 20, 2008
Approved:	Banner Health Board – June 12, 2008
Revised:	General Staff – August 19, 2008
Approved:	Banner Health Board – September 11, 2008
Revised:	General Staff – May 19, 2009
Approved:	Banner Health Board – June 11, 2009
Revised:	General Staff – November 16, 2010
Approved:	Banner Health Board – November 11, 2010
Revised:	General Staff – May 17, 2011
Approved:	Banner Health Board – June 9, 2011
Revised:	General Staff – November 22, 2011
Approved:	Banner Health Board – December 8, 2011
Revised:	General Staff – November 20, 2012
Approved:	Banner Health Board – December 13, 2012
Revised:	Email vote of Active Staff – July 10, 2014
Approved:	Banner Health Board – July 21, 2014
Revised:	Email vote of Active Staff – July, 2016
Approved:	Banner Health Board – August 11, 2016
Revised:	Email vote of the Active Staff – May 23, 2017
Approved:	Banner Health Board – June 8, 2017
Revised:	Email vote of the Active Staff – June15, 2018
Approved	Banner Health Board – July 12, 2018
Revised:	Email vote of the Active Staff- February 25, 2019
Approved:	Banner Health Board – March 14, 2019
Revised:	Email vote of the Active Staff – February 18, 2020

Approved:	Banner Board – March 12, 2020
Revised:	Email vote of the Active Staff – March 26, 2020
Approved:	Banner Board – May 14, 2020
Revised:	Email vote of the Active Staff – May 27, 2020
Approved:	Banner Board – June 18, 2020
Revised:	Email vote of the Active Staff – December 8, 2020
Approved:	Banner Board – January 14, 2021